## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|--|---|--|-------------------------------|----------------------------|--|
|  |   | 185249   | B. WING                                |   |  | 05/15/2020                    |                            |  |
| NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL |   |  |  | STREET ADDRESS, CITY, STATE, ZIP C<br>96 HIGHWAY 3444<br>ANNVILLE, KY 40402 | STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444  |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG                     | X (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 000  | a COVID-19 focused initiated on 05/13/202 05/15/2020. The con and no deficient prace facility was found to be CFR 483.80 Infection implemented the Cer Medicaid Services (C Disease Control and recommended practic COVID-19. The total | dard survey (KY31682) and infection control survey was 20 and concluded on applaint was unsubstantiated tice was identified. The pe in compliance with 42 a Control and has atters for Medicare & EMS) and Centers for Prevention (CDC) ces to prepare for |  | DOOD TITLE  |  |                               | (X6) DATE                  |  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 100602

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Office of Inspector General

| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPI DAT TAG (EACH CORRECTI |          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                             | ' '               | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |                          |  |  |
|--|----------|---|-----------------------------|-------------------|--|--|--------------------------|--|--|
| SIGNATURE HEALTHCARE AT JACKSON MANOR REI  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  96 HIGHWAY 3444 ANNVILLE, KY 40402  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DEFICIENCY)  N 000 Initial Comments  N 000  | 100602   |   |                             | B. WING           | B. WING                                  |  |                          |  |  |
| ANNVILLE, KY 40402  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  N 000 Initial Comments  N 000   |          |   | CKSON MANOR RE              | 6 HIGHWAY 3444    |  |  |                          |  |  |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  | OIOMATOI | NE HEAEITIOANE AT OF  | Al                          | NNVILLE, KY 40402 |  |  |                          |  |  |
|  | PREFIX   | (EACH DEFICIENC   | CY MUST BE PRECEDED BY FULL | PREFIX            | (EACH CORRECTIVE A<br>CROSS-REFERENCED T | ACTION SHOULD BE<br>FO THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |  |
| A complaint investigation (KY31682) and a  | N 000    | Initial Comments  |                             | N 000             |  |  |                          |  |  |
| COVID-19 focused infection control survey was initiated on 05/13/2020 and concluded on 05/15/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.   |          | Initial Comments  A complaint investigation (KY31682) and a COVID-19 focused infection control survey was initiated on 05/13/2020 and concluded on 05/15/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to |                             | od                |  |  |                          |  |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                         | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|--|--|--|---|-------------------------------|----------------------------|--|
|  |  | 185249   | B. WING                                |  |   | 05/15/2020                    |                            |  |
| NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CO<br>96 HIGHWAY 3444<br>ANNVILLE, KY 40402 | STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444   |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFI<br>TAG                     | X (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| E 000  | survey was initiated of<br>concluded on 05/15/2<br>to be in compliance v   | 2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No | E                                      | 000  |   |                               |                            |  |
| LABORATORY   | DIRECTOR'S OR PROVIDER/  | SUPPLIER REPRESENTATIVE'S SIGNATURE  |  | TITLE  |   |                               | (X6) DATE                  |  |

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