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

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

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		185094	B. WNG			04/30/2020	
NAME OF PROVIDER OR SUPPLIER  PIKEVILLE NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  260 SOUTH MAYO TRAIL  PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	a COVID-19 focused initiated on 04/29/202 04/30/2020. The cor and no deficient pracfacility was found to CFR 483.80 Infectior implemented the Certain 1985 1986 1986 1986 1986 1986 1986 1986 1986	dard survey (KY31593) and infection control survey was 20 and concluded on inplaint was unsubstantiated attice was identified. The pe in compliance with 42 in Control and has inters for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for	F 00				
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATU	JRE	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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		100367	B. WING		04/3	0/2020
	ROVIDER OR SUPPLIER E NURSING AND REHA	B CENTER 260 SOU	DDRESS, CITY, STATI TH MAYO TRAIL LE, KY 41501	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETE DATE
N 000	COVID-19 focused initiated on 04/29/20 04/30/2020. The count and no deficient pra	nation (KY31593) and a infection control survey was 020 and concluded on emplaint was unsubstantiated actice was identified. The be in compliance pursuant to	N 000			

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
11 ==		185094	B. WNG			C 04/30/2020	
NAME OF PROVIDER OR SUPPLIER PIKEVILLE NURSING AND REHAB CENTER				26	TREET ADDRESS, CITY, STATE, ZIP CODE 50 SOUTH MAYO TRAIL IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	survey was initiated of concluded on 04/30/2 to be in compliance v	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	E	000	DEFICIENCY)		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			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.