DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185127	B. WING			04/	08/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	CENTRE FOR HEALTH	& REHABILITATION		6	42 NORTH THIRD STREET		
DANNELL	OENTRE FOR MEAEIN			0	DANVILLE, KY 40422		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF TAG				COMPLETION DATE
					DEFICIENCY)		
F 000	conducted on 04/08/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention I practices to prepare for ent practice was identified.	F	000			
		SUPPLIER REPRESENTATIVE'S SIGNATUR	2E		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.

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CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0838-039 AND PLAN OF CORRECTION IN IPROVIDEBURE URCIAL IN IDENT SERVICES POY MALTELE CONSTRUCTION AND PLAN OF CORRECTION IN IPROVIDE URCEAL IN IDENT SERVICES POY MALTELE CONSTRUCTION NAME OF PROVIDER OR SUMPLIER ISTREET ADDRESS, CITY STATE, 2/P CODE 94/08/2020 DANNEL CENTRE FOR HEALTH & REHABILITATION STREET ADDRESS, CITY STATE, 2/P CODE 94/08/2020 PARCINE FOR HEALTH & REHABILITATION IPROVIDER PARCINES PROVIDER PARCINES 90/08/2020 PARCINE FOR HEALTH & REHABILITATION IPRETIX PROVIDER PARCINES TO THE ADDRESS, CITY STATE, 2/P CODE 94/08/2020 PARCINE FOR HEALTH & REHABILITATION IPRETIX PROVIDER PARCINES 00/08/07/00 URLE 00/08/07/07/07/07/07/07/07/07/07/07/07/07/07/	DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					M APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 185127 B. WING 04/08/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE CENTRE FOR HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) YAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG E 000 Initial Comments E 000 A COVID-19 focused Emergency Preparedness survey was conducted on 04/08/2020. The facility was found to be in compliance with 42 E 000 E 000 Initial Comments related to E 000	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	D. 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DANVILLE CENTRE FOR HEALTH & REHABILITATION Gave a contract of the contract									
642 NORTH THIRD STREET DANVILLE, KY 40422 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETION DATE E 000 Initial Comments E 000 A COVID-19 focused Emergency Preparedness survey was conducted on 04/08/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E 000			185127	B. WING			04/	/08/2020	
DANVILLE CENTRE FOR HEALTH & REHABILITATION DANVILLE, KY 40422 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE E 000 Initial Comments E 000 E 000 Initial Comments E 000 A COVID-19 focused Emergency Preparedness survey was conducted on 04/08/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E 000 Initial Comments Image: CFR 483.73 Emergency Preparedness related to	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
IDANVILLE, KY 40422 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE E 000 Initial Comments E 000 E 000 A COVID-19 focused Emergency Preparedness survey was conducted on 04/08/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E 000 Initial Comments <					6	42 NORTH THIRD STREET			
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	E 000	A COVID-19 focused survey was conducted facility was found to b CFR 483.73 Emerger	d on 04/08/2020. The e in compliance with 42 ncy Preparedness related to	E	0000	DEFICIENCY)			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								(YE) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100036	B. WING		04/08/2020		
ME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
ANVILLE	CENTRE FOR HEALTH	H & REHABILITATION	RTH THIRD STREET LE, KY 40422				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN) REGULATORY OR	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
N 000	Initial Comments		N 000				
	conducted on 04/08/	d infection control survey was /2020. The facility was found pursuant to 42 CFR 483.80. e was identified.					

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

TITLE

(X6) DATE