DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
185168			B. WING	05/20/2020	
	ROVIDER OR SUPPLIER	ONROE COUNTY REHAB & WELL	706 8	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAGNOLIA STREET IPKINSVILLE, KY 42167	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 000	A COVID-19 focused initiated on 05/19/20/20/2020. The fact compliance with 42 cand has implemented Medicaid Services (C Disease Control and recommended practi	d infection control survey was 20 and concluded on ility was found to be in CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for ient practice was identified.	F 000	DEFICIENCY)	
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	RE	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.

Event ID: 4STT11

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185168		B. WNG				05/20/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MONROE COUNTY REHAB & WELL					STREET ADDRESS, CITY, 706 NORTH MAGNOLIA TOMPKINSVILLE, KY	STREET			
(X4) ID PREFIX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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		7	E 00					
de.	survey was initiated concluded on 05/20 to be in compliance	/2020. The facility was fo with 42 CFR 483.73 edness related to E0024.	und	i ii				7 " I	
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	W								
5				,a		327			
				-:					
4.		ENSUPPLIER REPRESENTATIVE			717	15		(X6) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WNG 05/20/2020 100337 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **706 NORTH MAGNOLIA STREET** SIGNATURE HEALTHCARE OF MONROE COUNTY RE **TOMPKINSVILLE, KY 42167** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was initiated on 05/19/2020 and concluded on 05/20/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE