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	
		185408	B. WNG		<u> </u>	05/08/2020	
NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER				6	STREET ADDRESS, CITY, STATE, ZIP CODE 116 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLETION	
F 000	INITIAL COMMENTS	;	F	000			
8	initiated on 05/07/202 05/08/2020. The fac compliance with 42 C and has implemented Medicaid Services (C Disease Control and recommended practi	ility was found to be in CFR 483.80 Infection Control If the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for ient practice was identified.					
					¥7		
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATURE	11.1		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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: 100685 B. WING 05/08/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY CARE AND REHABILITATION CENTER LIBERTY, KY 42539 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was initiated on 05/07/2020 and concluded on 05/08/2020. 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

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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	
		185408	B. WING			05/08/2020	
NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539				12.0
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
E 000	Initial Comments	i Emangaray Proparadnass	E	000			
	A COVID-19 focused Emergency Preparedness survey was initiated on 05/07/2020 and concluded on 05/08/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No				u.		
	deficient practice was						7
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	0.0000000000000000000000000000000000000	AN HODE IED DEDDESENTATIVE'S SIGNATUDE			TITLE		(Y6) DATE

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