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

PRINTED: 06/09/2020 FORM APPROVED

CENTERO I OR MEDIOARE & MEDIOARD SERVICES						OIVID INC	<u>, บยงช-บงช เ</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185164	B. WNG			06/	04/2020
	ROVIDER OR SUPPLIER	HABILITATION CENTER		6:	TREET ADDRESS, CITY, STATE, ZIP CODE 5 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 000	A COVID-19 focused conducted on 06/04/2 to be in compliance we Control and has imple Medicare & Medicaid Centers for Disease (CDC) recommended	I 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			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(Y6) 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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OLITICIT	STOR MEDICANE AT	MEDIONID OLIVIOLO			OND NO. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185164	B. WNG		06/04/2020	
	ROVIDER OR SUPPLIER RVILLE HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
E 000	survey was conducte facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 06/04/2020. The period in compliance with 42 may preparedness related to practice was identified.	E 00			
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	DE	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 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_ B. WNG 100275 06/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 MINTON HICKORY FARM ROAD** BARBOURVILLE HEALTH AND REHABILITATION CEN BARBOURVILLE, KY 40906 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 06/04/2020. 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