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

PRINTED: 06/10/2020 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	
		185337	B. WING _			/09/2020	
NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 246 EAST MAIN STREET BEATTYVILLE, KY 41311	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	INITIAL COMMENT A COVID-19 focuse conducted on 06/09 to be in compliance Control and has implemented to the control of the co	s d infection control survey was /2020. The facility was found with 42 CFR 483.80 Infection elemented the Centers for d Services (CMS) and Control and Prevention ed practices to prepare for cient practice was identified.	FC	DEFICIENCY			
	(0)50707070	R/SLIPPLIFR REPRESENTATIVE'S SIGNATU	105	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.

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

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CENTER	3 FOR MEDICARE OF	MEDICAID SERVICES			OIVID INC	7. 0930-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185337	B. WNG		06/	09/2020	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
E 000	Initial Comments		E 00	00			
	survey was conducte facility was found to to CFR 483.73 Emerge	d Emergency Preparedness d on 06/09/2020. The period in compliance with 42 ncy Preparedness related to practice was identified.					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUL	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.

Office of Inspector General

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		100284	B WING		06/09/2020		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LEE COUNTY CARE AND REHABILITATION CENTER BEATTYVILLE, KY 41311							
(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 APPROPE DEFICIENCY)	BE COMPLETE		
N 000	Initial Comments		N 000				
*	conducted on 06/09/2	infection control survey was 2020. The facility was found oursuant to 42 CFR 483.80. was identified.					
				2			
			:				

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

TITLE

(X6) DATE