## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2020 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	
		185164	B. WING			10/27/2020	
	ROVIDER OR SUPPLIER RVILLE HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 65 MINTON HICKORY FARM ROA BARBOURVILLE, KY 40906			
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 000	conducted on 10/27/2 to be in compliance v Control and has impl Medicare & Medicaid Centers for Disease (CDC) recommended	d 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 d practices to prepare for ient practice was identified.	F	000			
ABORATORY	DIRECTOR'S OR PROVIDE	VSUPPLIER REPRESENTATIVE'S SIGNATURI		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 & MEDICAID SERVICES

PRINTED: 11/16/2020 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		
		185164	B. WNG			10/	27/2020
NAME OF PROVIDER OR SUPPLIER  BARBOURVILLE HEALTH AND REHABILITATION CENTER				65	REET ADDRESS, CITY, STATE, ZIP CODE MINTON HICKORY FARM ROAD IRBOURVILLE, KY 40906		
(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 CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
E 000	survey was conducted facility was found to CFR 483.73 Emerge	d Emergency Preparedness ed on 10/27/2020. The be in compliance with 42 ency Preparedness related to practice was identified.	E	000			69
V.							
LABORATORY	DIRECTOR'S OR PROVINCES	RISUPPI IER REPRESENTATIVE'S SIGNATUR			TITLE		(XR) 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.

PRINTED: 11/16/2020 FORM APPROVED Office of Inspector General (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WNG\_ 100275 10/27/2020 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) (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE 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 10/27/2020. 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