

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

PRINTED: 09/24/2021
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185325 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 09/20/2021 |
| NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY ROAD SCOTTSVILLE, KY 42164 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated and concluded on 09/20/2021. There was no deficient practice identified at 42 CFR 483.80 Infection Control regulations and the facility has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Census 94. | F 000 | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | 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.

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| E 000 | Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated and concluded on 09/20/2021. There was no deficient practice identified at 42 CFR 483.73 related to E-0024 (b) (6). | E 000 | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | 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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100006 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/20/2021 |
|--|---|---|---|

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|--|--|
| NAME OF PROVIDER OR SUPPLIER CAL TURNER REHAB AND SPECIALTY CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY ROAD SCOTTSVILLE, KY 42164 |
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|--------------------|---|---------------|---|--------------------|
| N 000 | <p>Initial Comments</p> <p>A COVID-19 Focused Infection Control Survey was conducted on 09/20/2021. There was no deficient practice identified pursuant to 42 CFR 483.80.</p> | N 000 | | |

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

TITLE

(X6) DATE