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

PRINTED: 01/13/2021 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	
		185325	B. WING		12	12/31/2020	
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 CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	INITIAL COMMENTS  A COVID-19 Focused was initiated on 12/30 12/31/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease 0	d Infection Control Survey 0/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for	TAG	CROSS-REFERENCED TO THE APPRO			

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.

Facility ID: 100006

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

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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	
		185325	B. WING _	B. WING		12/31/2020	
NAME OF PROVIDER OR SUPPLIER  CAL TURNER REHAB AND SPECIALTY CARE				STREET ADDRESS, CITY, STATE, Z 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 PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Survey was initiated of concluded on 12/31/2	d Emergency Preparedness on 12/30/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	000			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	!E	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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Office of Inspector General

MAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						) DATE SURVEY COMPLETED		
CAL TURNER REHAB AND SPECIALTY CARE  456 BURNLEY ROAD SCOTTSVILLE, KY 42164  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/30/2020 and concluded on 12/31/2020. The facility was found to be in	100006				B. WING			12/31/2020	
CAL TURNER REHAB AND SPECIALTY CARE  SCOTTSVILLE, KY 42164  (X4) ID PREFIX TAG  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/30/2020 and concluded on 12/31/2020. The facility was found to be in	NAME OF PI								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/30/2020 and concluded on 12/31/2020. The facility was found to be in	L CAL TURNER REHAB AND SPECIALTY CARE								
A COVID-19 Focused Infection Control Survey was initiated 12/30/2020 and concluded on 12/31/2020. The facility was found to be in	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	COMPLETE		
was initiated 12/30/2020 and concluded on 12/31/2020. The facility was found to be in	N 000	Initial Comments			N 000				
	N 000	O Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/30/2020 and concluded on 12/31/2020. The facility was found to be in			14 000				

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

TITLE (X6) DATE