| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CALVERT CITY CONVALESCENT CENTER 1201 FIFTH AVE (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) F 000 INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for F 000 | APPROVED |
|--|----------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET 185234 B. WING 01/22 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY CONVALESCENT CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE OF F 000 INITIAL COMMENTS F 000 F 000 F 000 F 000 F 000 A COVID-19 Focused Infection Control Survey was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for F 000 | 0938-0391 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CALVERT CITY CONVALESCENT CENTER 1201 FIFTH AVE (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for | |
| 1201 FIFTH AVE CALVERT CITY CONVALESCENT CENTER Image: Constraint of the constr | 2/2021 |
| CALVERT CITY CONVALESCENT CENTER CALVERT CITY CONVALESCENT CENTER CALVERT CITY CONVALESCENT CENTER (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for F 000 | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for F 000 | |
| A COVID-19 Focused Infection Control Survey was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for | (X5) COMPLETION DATE |
| was initiated on 01/20/2021 and concluded on 01/22/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for | |
| COVID-19. Total census 73. | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6 | 6) 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: 02/01/2021

| DEPARTI | MENT OF HEALTH AN | ID HUMAN SERVICES | | | | | APPROVED |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | | 0. 0938-0391 |
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 185234 | B. WING | | | 01/ | 22/2021 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CALVERT | CITY CONVALESCENT | CENTER | | | 201 FIFTH AVE CALVERT CITY, KY 42029 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E | 000 | | | |
| | Survey was initiated of concluded on 01/22/2 | d Emergency Preparedness on 01/20/2021 and 020. The facility was found ith 42 CFR 483.73 related | | | | | |
| | | | | | | | |
| | DIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATUR | 2F | | 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 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CC A. BUILDING: | DNSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--|------------------------|--|----------------------------------|-------------|---|------------|--|--|
| 100329 | | | B. WING | | 01 | 01/22/2021 | | |
| AME OF PR | OVIDER OR SUPPLIER | STREET | DDRESS, CITY, STATE, | ZIP CODE | | | | |
| ALVERT | | CENTER 1201 FIF | TH AVE RT CITY, KY 42029 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED | | | OF CORRECTION (X5) ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE ENCY) | | | |
| N 000 | Initial Comments | | N 000 | | | | | |
| | was initiated 01/20/20 | d Infection Control Survey 021 and concluded on lity was found to be in to 42 CFR 483.80. | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

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

TITLE

(X6) DATE

WH9U11