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

PRINTED: 09/04/2020 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	
		185234	B. WING			08/27/2020	
	ROVIDER OR SUPPLIER CITY CONVALESCENT	CENTER		STREET ADDRESS, CITY, STATE, ZI 1201 FIFTH AVE CALVERT CITY, KY 42029	IP CODE		
(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 A CROSS-REFERENCED 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 08/26 08/27/2020. The facil compliance with 42 C regulations and has it Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 6/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention		DOO			(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: 100329

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	185234		B. WING _			08/27/2020		
NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  1201 FIFTH AVE  CALVERT CITY, KY 42029				
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	Initial Comments  A COVID-19 Focuse Survey was initiated of concluded on 08/27/2	d Emergency Preparedness	E 0	DEFICIEN		DATE		

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

TITLE (X6) DATE

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1201 FIFTH AVE  CALVERT CITY CONVALESCENT CENTER  CALVERT CITY, KY 42029  PROVIDER'S PLAN OF CORRECTION  GRADH DEFICIENCY WIST SE PERCECTED BY FIAL  GRADH DEFICIENCY WIST SE PERCECTED BY FIAL  RESULATORY OR LSG DEATFFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 08/26/2020 and concluded on 08/27/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				o) DATE SURVEY COMPLETED	
CALVERT CITY CONVALESCENT CENTER  CALVERT CITY, KY 42029  (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 08/26/2020 and concluded on 08/27/2020. The facility was found to be in	100329			B. WING			08/27/2020	
CALVERT CITY, KY 42029  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (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 08/26/2020 and concluded on 08/27/2020. The facility was found to be in	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1201 FIFTH AVF							
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was initiated 08/26/2020 and concluded on 08/27/2020. The facility was found to be in	N 000	Initial Comments		N 000				
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