DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185338	B. WING			05/	21/2020	
NAME OF PF	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE				
CUDICTIA		ND REHABILITATION CENTE		124 WEST NASHVILLE STREET				
CHRISTIA	N HEIGHTS NORSING A	ND REHABILITATION CENTE		PEMBROKE, KY 42266				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIZ TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO			COMPLETION DATE	
IAG		,			DEFICIENCY)			
F 000	was conducted on 05 found to be in complia infection control regul the Centers for Medic (CMS) and Centers for	d Infection Control Survey /21/2020. The facility was ance with 42 CFR 483.80 lations and has implemented care and Medicaid Services or Disease Control and commended practices to	F	000	DEFICIENCY)			
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	?F		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.

## PRINTED: 06/10/2020

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185338	B. WING	B. WING		05/21/2020		
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
			124 WEST NASHVILLE STREET					
CHRISTIA	N HEIGHTS NURSING A	ND REHABILITATION CENTE		PEMBROKE, KY 42266				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
IAG					DEFICIENCY)			
E 000	Survey was conducte	d Emergency Preparedness d on 05/21/2020. The facility mpliance with 42 CFR 024 (b)(6).	EO	000				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	F		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.

## PRINTED: 06/10/2020

## PRINTED: 06/10/2020 FORM APPROVED

Office of Inspector General         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         100069			(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		05	05/21/2020		
AME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
HRISTIAN	N HEIGHTS NURSING A	ND REHABII ITATIO		EET			
	SI IMMARY ST		DKE, KY 42266	PROVIDER'S PLAN O		(275)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000				
	was conducted on 05	d Infection Control Survey v/21/2020. The facility was ance pursuant to 42 CFR					

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

TITLE

(X6) DATE