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

PRINTED: 12/11/2020 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	
185338		185338	B. WING		12/10/2020		
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, ZIP CODE  124 WEST NASHVILLE STREET  PEMBROKE, KY 42266			
(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 CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRECT ACTION SHOUTH ACTION SHOUTH CORRECT ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHO	OULD BE	(X5) COMPLETION DATE	
F 000	was initiated on 12/05 12/10/2020. The facil compliance with 42 Cregulations and has in Medicare & Medicaid Centers for Disease Cregory (CDC) recommended COVID-19. Total cens	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		TITLE		(X6) DATE	

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

(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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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE  PARTY MASHVILLE STREET PEMBROKE, KY 42266  ONG ID SUMMARY STATEMENT OF REPRESENDENT WILL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION  E 000 Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/09/2020 and concluded on 12/10/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/09/2020 and concluded on 12/10/2020. The facility was found to be in compliance with 42 CFR 483.73 related			185338	B. WING			12/10/2020	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  E 000  A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/09/2020 and concluded on 12/10/2020. The facility was found to be in compliance with 42 CFR 483.73 related	NAME OF PROVIDER OR SUPPLIER			•	124 WEST NASHVILLE STREET	E		
A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/09/2020 and concluded on 12/10/2020. The facility was found to be in compliance with 42 CFR 483.73 related	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRO		COMPLETION	
	E 000	A COVID-19 Focused Survey was initiated of concluded on 12/10/2 to be in compliance w	on 12/09/2020 and 2020. The facility was found	E				

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Office of Inspector General

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		100069	B. WING		12	/10/2020		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CHRISTIAN HEIGHTS NURSING AND REHABILITATIO  124 WEST NASHVILLE STREET  PEMBROKE, KY 42266								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 0000	A COVID-19 Focused was initiated 12/09/20	Infection Control Survey 020 and concluded on lity was found to be in to 42 CFR 483.80.	N 000					

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

TITLE (X6) DATE