DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/31/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	- No. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10		Oil	NB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M		2) MULTIPLE CONSTRUCTION BUILDING		3) DATE SURVEY COMPLETED
		185173	B. WING			C 08/20/2020
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE .	***************************************
	•	EHABILITATION CENTER		200 NORFLEET DRIVE		
				SOMERSET, KY 42501		i
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 000			FO	00		
	a COVID-19 focused initiated on 08/19/20 08/20/2020. The column and no deficient practicality was found to CFR 483.80 Infectio implemented the Ce	nters for Medicare & CMS) and Centers for I Prevention (CDC) ices to prepare for				
			3	70000		1975
		DISTRIBUTED DEDOCCENTATIVES SIGNATI	IDE	TITLE		/XS\ 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/31/2020 FORM APPROVED OMB NO 0938-0391

OCIVICIA	O I OIVINEDIONILE G	WILDICAID SERVICES			ONID NO. 0930-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185173	B WNG		C 08/20/2020		
	ROVIDER OR SUPPLIER AND NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORFLEET DRIVE SOMERSET, KY 42501				
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE COMPLETION		
E 000	survey was initiated of concluded on 08/20/2 to be in compliance w	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	E 000				
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	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.

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C 100373 B. WING 08/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **200 NORFLEET DRIVE CUMBERLAND NURSING AND REHABILITATION CEN** SOMERSET, KY 42501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A complaint investigation (KY31423) and a COVID-19 focused infection control survey was initiated on 08/19/2020 and concluded on 08/20/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE