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

PRINTED: 07/14/2020 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU	MOCO	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 06/25/2020	
185266						
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIF	CODE	0012	23/2020	
ELIZABETHTOWN NURSING AND REHABILITATIO	1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		FIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
An Abbreviated Survey investigating K' and a COVID-19 Focused Infection Col Survey was initiated on 06/23/2020 and concluded on 06/25/2020. Complaint K was unsubstantiated with no deficiencie The facility was found to be in complian CFR 483.80 infection control regulation implemented the Centers for Medicare Medicaid Services (CMS) and Centers Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 57.	Y#31879 Introl I XY#31879 Introl I XY#31879 Interes its second its	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.

(X6) DATE

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STATEMENT AND PLAN C	PLANCE CORRECTION I INCRITICATION NUMBER.			(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
185266		B. WING			C 06/25/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701							
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)			HOULD BE COMPLETION	
E 000	Survey was initiated concluded on 06/25	sed Emergency Preparedness d on 06/23/2020 and 5/2020. The facility was found with 42 CFR 483.73 related	ΕO	00			
1.0							
LABORATOR\	OIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

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PRINTED: 07/14/2020 FORM APPROVED 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 B. WING 100161 06/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE **ELIZABETHTOWN NURSING AND REHABILITA ELIZABETHTOWN, KY 42701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) N 000 Initial Comments N 000 A Complaint Survey investigating KY#31879 and a COVID-19 Focused Infection Control Survey was initiated on 06/23/2020 and concluded on 06/25/2020. Complaint KY#31879 was unsubstantiated with no deficiencies cited. 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