DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/19/2020 FORM APPROVED

CLIVILI	10 I OK MEDICAKE	A MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185415	B. WING	B. WING		06/12/2020	
	PROVIDER OR SUPPLIER NURSING AND REH	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP RT 32 EAST, HOWARD CREEK RI SANDY HOOK, KY 41171	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	F 000)			
	was initiated and co facility was found to CFR 483.80 infection implemented the Co Medicaid Services of	sed Infection Control Survey oncluded on 06/12/2020. The be in compliance with 42 on control regulations and has enters for Medicare & (CMS) and Centers for d Prevention (CDC) stices to prepare for ensus 66.					
						s	
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
185415			B. WING_		ne	06/12/2020	
NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, 2 RT 32 EAST, HOWARD CREEK SANDY HOOK, KY 41171	ZIP CODE	1 00/12/2020	
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	JLD BE COMPLÉTION	
E 000	Initial Comments		E 00	00			
	Survey was initiate 06/12/2020. The f	used Emergency Preparedness ed and concluded on acility was found to be in 2 CFR 483.73 related to					
					×		
		DER/SUPPLIER REPRESENTATIVE'S SIGN					

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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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: _ B. WING_ 100690 06/12/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD **ELLIOTT NURSING AND REHABILITATION** SANDY HOOK, KY 41171 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated and concluded on 06/12/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

STATE FORM

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

6899

S9TP11

TITLE

(X6) DATE