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

PRINTED: 08/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185286	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH AND REHABILITATION	1 SPARKS AVENUE JAMESTOWN, KY 42629

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 focused infection control survey was initiated on 07/22/2020 and concluded on 07/31/2020. The facility was found to be out of compliance with 42 CFR 483.80 Infection Control. Deficient practice was identified with the highest scope and severity at "E" level. The total census was 102.	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		9/01/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jill Spurgeon | TITLE: Adm. | (X6) DATE: 8/21/2020

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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F 880	Continued From page 1 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880	F880 POC 1.Resident H 14 day isolation precautions Were discontinued on 8/5/2020. Resident #3 14 day isolation precautions were discontinued on 8-4-2020 Resident #8 14 day isolation precautions were discontinued on 7-29-2020 Resident # 15 14 day isolation precautions were discontinued on 7-23-2020 Resident #7 isolation precautions were discontinued on 7-25-2020 Assessment completed by licensed nurse on 8-20-2020 showed no adverse findings were identified for resident #4, #6, #11, unsampled residents A, J and K. Resident # 17 COVID-19 results were negative and isolation precautions were discontinued on 7/25/2020 Assessment completed by licensed nurse on 8-20-2020 showed no adverse findings were identified for resident G Assessment completed by licensed nurse on 8-20-2020 showed no adverse findings were identified for resident #2	

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F 880	Continued From page 2 Based on observation, interview, record review, review of the facility's policies/procedures, and review of the Centers for Disease Control and Prevention (CDC) guidelines, it was determined the facility failed to prevent the possible spread of COVID-19. Observations on 07/22/2020 and revealed three (3) sampled residents, Resident #3, Resident #8 and Resident #15, were not placed on infection control precautions despite being admitted to the facility within fourteen (14) days. The Dietary manager and Administrator were observed on 07/22/2020, wearing their facemasks pulled down below their nose and mouth. Observation of the noon meal on 07/22/2020, revealed staff delivered resident trays and fed residents without performing hand hygiene between residents. Observation of incontinence care on 07/23/2020 revealed staff assisted a resident to clean themselves after toileting and did not perform hand hygiene or change gloves prior to transferring the resident, and did not assist the resident to wash his/her hands. Further observations revealed biohazard containers for residents in infection control precautions were located in the hallway outside the resident's room. Furthermore, observation and interviews revealed residents who exhibited symptoms, or were suspected to have COVID-19, and resided in a semi-private room, remained in the room with a roommate. Additionally, Personal Care Attendants (PCA) were scheduled to provide care to COVID-19 positive residents and residents in isolation precautions, despite not being allowed to do so per facility policy and State mandate. The findings include: Interview with the Administrator on 07/22/2020,	F 880	2.All residents have the potential to be affected by the alleged deficient practice. Currently, the facility has zero positive COVID-19 residents or staff. Precautions remain in place as recommended by the CDC and CHFS DPH for infection control practices, including monitoring staff and residents for COVID-19 symptoms, universal masking and hand hygiene. All current resident COVID assessments were reviewed for new onset of infection by the Regional Director of Clinical Services on 8/19/2020 with no new indication of infections identified. On 8-19-2020 all resident rooms on current isolation precautions were audited by the Regional Director of Clinical Services to ensure all appropriate/required isolation equipment was available for use to include but not limited to PPE, isolation type signage outside of resident's rooms and biohazard container located inside the resident's room. 3.The Administrator and Director of Nursing	

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F 880	Continued From page 3 revealed the facility had dismantled their COVID Unit on 07/21/2020, due to the facility not having any positive COVID-19 cases. Review of a waiver from the Kentucky Inspector General dated 04/14/2020 titled Temporary COVID-19 Personal Care Attendant (PCA) revealed the temporary waiver permits a long-term care facility to employ a trained PCA to perform defined resident care procedures that do not require the skill or training required for a State Registered Nurse Aide ("SRNA"). The waiver stated that the facility must fully notify its certified and licensed staff members that PCAs have a limited scope of permissible work, and detail what duties may not be delegated to PCAs. If the facility learns that any PCA is performing duties outside the limited scope of permissible work, it must immediately intervene, stop the PCA, and reassign those duties to authorized personnel. According to the waiver, the PCA should not be assigned or provide care or services to a resident in Isolation Precautions. Review of the facility's policy "Temporary COVID-19 Personal Care Attendant" dated 04/14/2020 revealed a temporary waiver would permit a long-term care facility to employ a trained PCA to perform defined resident care procedures. The PCA position is a temporary accommodation made by the Commonwealth to address work increases and staffing shortages caused by the COVID-19 pandemic. The policy also stated the PCA would not be assigned or provide care or services to a resident in Isolation Precautions. Review of the facility's "COVID-19 Standard of Practice" policy and procedure revised	F 880	completed education on Keep COVID-19 Out!, Facemask dos and don'ts and COVID-19 Module Overview for Long Term Care Facilities along with an attestation statement of completion per the directed plan of correction for F880 on 8-18-2020 The Infection Preventionist completed education on Keep COVID-19 Out!, Facemask dos and don'ts on 8-18-2020 and COVID-19 Module Overview for Long Term Care Facilities on 8-31-2020 along with an attestation statement of completion per the directed plan of correction for F880 . The Director of Nursing and or the Infection Preventionist conveyed the following information to all current staff on Keep COVID-19 Out, Facemask dos and don'ts and obtain an attestation statement of completion of above-mentioned videos/education from all current staff by 8/21/2020. The Director of Nursing and or the Infection Preventionist educated all current staff on properly wearing a facemask, new/re-admissions will be placed in droplet isolation precautions on COVID-19	

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F 880	Continued From page 4 04/03/2020, revealed if a resident was suspected to have COVID-19, and resided in a private room, the resident would remain isolated in the private room. If a resident in a semi-private room were suspected to have COVID-19, one of the resident's would be moved to a private room if available. Review of the facility's policy "Control of COVID-19" with a review date of 03/05/2020 revealed all staff would adhere to standard precautions including performing hand hygiene with soap and water or alcohol based hand rubs frequently and before and after all resident contact, and contact with potentially infectious material. Continued review of the policy revealed droplet precautions would be implemented for residents with suspected or confirmed COVID-19 until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Residents with suspected or confirmed COVID-19 would be placed in a private room or area. Review of the facility's protocol "Identification of Possible COVID-19" with a revision date of 04/09/2020, revealed The facility would identify dedicated employees to care for COVID-19 patients and would provide the correct supplies to ensure easy and accurate use of PPE. Signage would be posted outside of the resident room that clearly described the type of precautions needed and the required PPE, make PPE, including facemasks, eye protection, gowns, and gloves available immediately outside of the resident room, and position a trash can near the exit inside of the resident room to make it easy for employees to discard PPE.	F 880	designated unit x 14 days, signage will be posted by the resident's door to indicate required isolation precautions with PPE located outside the resident's door, biohazard containers are to be placed inside the resident's room with a lid in place on top of the biohazard container, residents who exhibit COVID-19 symptoms or residents who are suspected to have COVID-19 will be moved to a private room on the designated COVID unit pending results of COVID-19 as facility room availability allows and staff must perform hand hygiene after any contact with a resident by 8/21/2020. In addition to the above education licensed nursing staff and nursing assistants received education provided by the Director of Nursing and or the Infection Preventionist on personal care attendants are not allowed to provide care or services to any residents in isolation precautions, COVID-19 confirmed, suspected residents or residents with COVID-19 tests pending are to have	

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F 880	Continued From page 5 Review of the "CDC Preparing for COVID-19 in Nursing Homes" updated 06/25/2020, revealed as demonstrated by the COVID-19 pandemic, a strong infection prevention and control (ICP) program was critical to protect residents and healthcare personnel (HCP). The facility should position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room. The facility should identify space that could be dedicated to monitor and care for residents with COVID-19 as well as identify HCP who would be assigned to work only on the COVID-19 care unit when it was in use. Continued review of CDC guidance revealed the facility should create a plan for managing new admissions and readmissions whose COVID-19 status was unknown to include: placing the resident in a single person room or in a separate observation area so the resident can be monitored for evidence of COVID-19; and HCP should wear an N95 or higher level respirator, eye protection (goggles or a face shield that covered the front and sides of the face), gloves, and gown when caring for these residents. Further review revealed residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Review of the CDC "Responding to COVID-19 in Nursing Homes Considerations for the Public Health Response to COVID-19 in Nursing Homes" updated 04/30/2020, revealed all facilities should adhere to current CDC infection prevention and control recommendations. The guidance stated when establishing a designated COVID-19 care unit for residents with confirmed COVID-19, the unit should be physically separated from other rooms or units housing	F 880	dedicated staff to provide care only to those residents, the staff dedicated staff caring for COVID-19 confirmed or suspected residents are not to be assigned to any other residents in the facility, staff will assist residents with hand hygiene after using the restroom, before mealtime and when visually soiled by 8/21/2020. Staff who have not completed the education by 8/21/2020 will not be permitted to return to work before education listed above has been completed. The Director of Nursing, Assistant Director of Nursing and or the Staff Development Coordinator will educate new employees on the above education in orientation. 4.On 8/20/2020, the QA Committee (Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing.) met to discuss the event set forth in the notice of alleged deficient practice.	

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F 880	Continued From page 6 residents without confirmed COVID-19 (a separate floor, wing, or cluster of rooms). Dedicated staff should be assigned to work only on the COVID-19 care unit and at a minimum should include primary nursing assistants (NAs) and nurses. Continued review of guidance revealed residents with new-onset suspected or confirmed COVID-19 should be isolated and placed in a single room if possible pending results of COVID-19 testing. 1. Observations of Resident #7 on 07/22/2020 at 9:40 AM revealed the resident required infection control precautions. Further observation revealed the biohazard disposal bin, utilized by staff to discard contaminated items utilized for Resident #7, was located out in the hallway adjacent to the resident's door, requiring staff to remove contaminated items out of the resident's room without being covered or contained. In addition, the contaminated items in the biohazard bin were accessible to anyone passing by Resident #7's room, including cognitively impaired and wandering residents. 2. Review of Resident #3's medical record revealed the facility admitted the resident on 07/21/2020. Observation on 07/22/2020 at 10:05 AM revealed there was no signage posted adjacent to the resident's room or PPE located outside the resident's door. Subsequent observation on 07/22/2020 at 1:34 PM revealed signage and PPE had been placed outside the resident's room. However, the biohazard bin was also located outside the resident's room in the hallway. Interviews with SRNA #15 and SRNA #16, on 07/22/2020 at 1:34 PM revealed they began their	F 880	5.An audit was developed and will be implemented on 8/21/2020 to observe staff on the units daily to ensure proper use of PPE including masks, gloves, hand hygiene, isolation rooms required signage, PPE, biohazard container placement, Personal care attendants providing care/services not to include residents in isolation, COVID-19 suspected residents in a private isolation room and designated staff if the facility has positive or suspected COVID-19 residents. This audit will be completed on various shifts by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and or Unit Manager daily x 2 weeks then 3x a week x 4 weeks then 2x a week x 4 weeks then 1x a week x 2 weeks. The results of this audit will be reviewed by the QAPI committee weekly x 90 days then monthly. All areas of concern will be addressed immediately with re-education. A root cause analysis was conducted with the assistance of the Infection Preventionist, QAPI committee and Governing Body and has been incorporated into the intervention plan on 8/21/2020	

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F 880	Continued From page 7 shift on 07/22/2020 at 6:00 AM and was not told that Resident #3 required infection control precautions, and had provided care to the resident without utilizing PPE. They stated when they returned from lunch at approximately 11:30 AM Resident #3 had a PPE cart with supplies, signage, and a biohazard trash bin outside of the room. Observation on 07/23/2020 at 9:39 AM revealed the biohazard trash bin without a lid remained outside in the hallway adjacent to Resident #3's room. 3. Review of Resident #8's medical record revealed the resident required isolation precautions. However, the biohazard bin utilized to dispose of contaminated items used for Resident #8, was located outside the resident's room in the hallway. 4. Observation of the facilities kitchen on 07/22/2020 at 10:02 AM revealed the Dietary Manager was wearing her facemask pulled down below her chin. A post survey interview conducted with the Dietary Manager on 08/03/2020 at 3:40 PM revealed she was educated to wear her facemask covering her nose and mouth when working. However, stated she had pulled her facemask down below her chin because she was hot. 5. Observations on 07/22/2020 revealed at 10:16 AM the Administrator was standing at the C/D Nurse's station talking with staff in close proximity with her facemask pulled down below her chin. At 11:36 AM, the Administrator was observed in the hallway outside the Activity Room with her mask again pulled down below her chin talking to staff. Continued observation on 07/23/2020 at 9:24 AM	F 880	The root cause analysis identified the staff did not comprehend certain aspects of infection control/prevention and required re-education on face masks being worn appropriately, isolation room set up, proper hand hygiene, PCA's not providing care/services to resident's in isolation, resident with positive or suspected COVID being transferred to a private room and having designated staff assigned. Date of Compliance: 9/1/2020	

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F 880	Continued From page 8 revealed the Administrator standing in the hallway outside of her office with her facemask pulled down below her chin talking with facility staff within close proximity. A post survey interview with the Administrator on 08/03/2020 at 5:00 PM revealed she pulled her facemask down below her mouth without thinking when she was talking to someone. 6. Observations of the noon meal on 07/22/2020 from 11:44 AM until approximately 12:13 PM revealed State Registered Nurse Aide (SRNA) #10 delivered and setup meal trays to Resident #4, Resident #6, Resident #11, Unsampled Resident A, Unsampled Resident J, and Unsampled Resident K, without washing or sanitizing her hands between trays. Further observations of SRNA #10 revealed she attempted to feed Resident #6, then exited the resident's room and entered Resident #11's room and sat down and began to feed the resident lunch without performing hand hygiene. Interview with SRNA #10 on 07/27/2020 at 3:30 PM revealed she should have performed hand hygiene between each tray she delivered and before and after feeding a resident. 7. Observation on 07/22/2020 at 12:45 PM revealed Licensed Practical Nurse (LPN) #2 was at the C/D Nurse's Station with her facemask under her chin, not covering her nose or mouth. A post survey interview with LPN #2 on 08/13/2020 at 1:30 PM revealed she was trained to wear her facemask covering her nose and mouth. However, she stated because the facemask caused her glasses to fog up, she had	F 880		

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F 880	Continued From page 9 placed the facemask below her chin. 8. Observation on 07/23/2020 at 9:45 AM revealed Unsampled Resident H was in isolation precautions due to being admitted to the facility on 07/22/2020. Further observation revealed an uncovered biohazard bin, utilized to dispose on contaminated equipment used for Unsampled Resident H was placed outside the resident's room in the hallway. 9. Review of Resident #17's medical record revealed the resident was in isolation precautions. Observation of Resident #17 on 07/23/2020 at 9:22 AM revealed the biohazard bin, used to dispose of contaminated items used for Resident #17, was located outside the resident's room in the hallway. In addition, Resident G, who did not require infection control precautions, was residing in the room with Resident #17. Interview with LPN #6 on 07/23/2020 at 9:23 AM revealed Resident #17 was placed in droplet precautions due to a pending COVID-19 test that was performed on 07/22/2020. 10. Observation of perineal care performed by SRNA #11 on Resident #2 on 07/23/2020 at 11:20 AM revealed Resident #2 attempted to clean him/herself after toileting. However, when the resident was not able to adequately perform the care, SRNA #11 finished cleaning the resident after toileting. Continued observation revealed SRNA #11 failed to wash or remind Resident #2's to perform hand hygiene after the resident attempted to perform personal hygiene. Further observation revealed SRNA #11 did not remove her soiled gloves prior to transferring Resident #2 with a gait belt from the commode to the	F 880		

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F 880	Continued From page 10 resident's wheelchair. Interview with SRNA #11 on 07/23/2020 at 11:40 AM revealed she should have offered to assist Resident #2 with hand hygiene and should have removed her gloves and washed her hands prior to transferring Resident #2 with a gait belt from the commode to the resident's wheelchair. 11. Interview with LPN #3 on 07/29/2020 at 9:09 PM revealed she routinely worked night shift at the facility. The LPN stated when she was scheduled to work, she was the primary nurse for the C/D/E wings which included the COVID-19 Unit, prior to it being dismantled. LPN #3 stated due to a lack of staff, she had to provide care to residents that were COVID-19 positive, then remove and discard her PPE and care for residents that were not Covid-19 positive. 12. Interviews with Personal Care Attendant (PCA) #6 on 07/24/2020 at 7:05 PM, PCA #1 on 07/28/2020 at 9:00 AM, PCA #2 on 07/28/2020 at 9:12 AM, PCA #4 on 07/28/2020 at 11:34 AM, PCA #3 on 07/28/2020 at 11:37 AM and PCA #7 on 08/04/2020 at 12:23 PM, revealed they had all worked with residents that were in infection control precautions including residents that were diagnosed with COVID-19. A post interview with the Infection Control Preventionist (ICP) who also serves as the facility's Staff Development Coordinator (SDC) on 08/03/2020 at 12:24 PM revealed she was not aware that PCAs were not permitted to work with residents in isolation precautions. She also stated that staff were required to work on the COVID-19 unit when it was operational and then care for negative resident, because the facility did	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185286	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH AND REHABILITATION	1 SPARKS AVENUE JAMESTOWN, KY 42629

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F 880	Continued From page 11 not have enough staff to allow for dedicated staff in the COVID-19 unit. She stated she when she was working, she was responsible for placing PPE and signage outside rooms of residents who required infection control precautions, and when she was not scheduled to work, she had PPE carts prepared for staff to place outside resident rooms in isolation. She further stated that new admissions and re-admissions were placed in droplet isolation precautions for 14 days to monitor for signs and symptoms of COVID-19. She stated she was not sure why Resident #2, Resident #8, and Resident #15 were not in droplet precautions on 07/22/2020. She further stated she was not aware that biohazard trashcans were supposed to be placed inside the resident's room, she was trained to place them outside of the resident's room. Continued interview with the ICP revealed residents suspected of COVID-19 were placed in droplet precautions, however the resident was not moved to another room nor was there roommate because the roommate was already exposed. She stated she did not perform audits to ensure infection controls requirements were implemented by staff. She stated when she worked, if she observed staff not performing infection control measures, she would perform "on the spot" training with the staff member observed. She further stated staff were expected to wear a facemask covering their nose and mouth when in the facility. She also stated staff were expected to perform hand hygiene with soap and water or hand sanitizer between passing food trays to residents and before and after feeding residents. Furthermore, she stated staff were expected to perform hand hygiene after removing their gloves when providing personal hygiene and should also offer/assist the resident	F 880		

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	185286	A. BUILDING _____ B. WING _____	07/31/2020

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F 880	Continued From page 12 in performing hand hygiene after they attempt personal hygiene as well. A post survey interview with the ADON on 08/03/2020 at 2:41 PM revealed she was responsible for scheduling nursing staff and SRNAs. She stated she was not aware that PCAs were not allowed to work with residents in isolation precautions or COVID-19 positive residents. She further stated on night shift when the facilities COVID-19 unit was operational, the nurse had to provide care to both positive and negative residents due to staffing constraints.	F 880		

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 07/22/2020 and concluded on 07/31/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100466	A. BUILDING: _____ B. WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTH AND REHABILITATION	1 SPARKS AVENUE JAMESTOWN, KY 42629

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N 000	Initial Comments A COVID-19 focused infection control survey was initiated on 07/22/2020 and concluded on 07/31/2020. Deficient practice was identified pursuant to 42 CFR 483.80.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE