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

PRINTED: 12/23/2020 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) DA CO	(X3) DATE SURVEY COMPLETED	
185286		185286	B. WING		_ 12	12/22/2020	
NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STA 1 SPARKS AVENUE JAMESTOWN, KY 4262			
(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 CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		E ACTION SHOULD BE D TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	conducted on 12/2 to be in compliance Control and has im Medicare & Medica Centers for Diseas (CDC) recommenc COVID-19. No de The total census w	sed infection control survey was 2/2020. The facility was found e with 42 CFR 483.80 Infection aplemented the Centers for aid Services (CMS) and se Control and Prevention ded practices to prepare for ficient practice was identified. vas 75.		000			
LABORATOR	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	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 & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
Δ.		185286	B. WING			12/22/2020			
NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY		SHOULD BE COMPLÉTION			
E 000		d Samuel Daniel de la constant	E	000	1)	ill.	W		
	survey was conduct facility was found to CFR 483.73 Emerg	ed Emergency Preparedness sted on 12/22/2020. The bein compliance with 42 gency Preparedness related to nt practice was identified.							
		şi	į						
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TiTLE	· -	(X6) DATE		

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Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 100466 12/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE FAIR OAKS HEALTH AND REHABILITATION JAMESTOWN, KY 42629 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 12/22/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE