DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185146	B. WING		1:	2/09/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
FOUNTAIN	I CIRCLE CARE & REHA			200 GLENWAY ROAD			
				WINCHESTER, KY 40391			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	HOULD BE COMPLETION		
F 000	INITIAL COMMENTS	;	F 00	00			
	was initiated on 12/08 12/09/2020. The faci compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	Control and Prevention I practices to prepare for					
LABUKATURY	DIRECTORS OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	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.

PRINTED: 01/14/2021

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185146	B. WING			12/	09/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER				200 GLENWAY ROAD			
FOUNTAIN	CINCLE CARE & REHA	BILITATION CENTER		WINCHESTER, KY 40391			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIZ TAG				
IAG					DEFICIENCY)		
E 000	Survey was initiated of concluded on 12/09/2	d Emergency Preparedness on 12/08/2020 and 2020. The facility was found vith 42 CFR 483.73 related	E	000	DEFICIENCY)		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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.

PRINTED: 01/14/2021

PRINTED: 01/14/2021 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100074			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 12/09/2020	
		B. WING				
	ROVIDER OR SUPPLIER	200 GLE	DDRESS, CITY, STATE, Z NWAY ROAD STER, KY 40391	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)			(X5) COMPLE DATE
N 000	was initiated on 12/0 12/09/2020. The fac compliance with 42 regulations and has Medicare & Medicai Centers for Disease	ed Infection Control Survey 08/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for d Services (CMS) and Control and Prevention d practices to prepare for hsus 119.	N 000			

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

TITLE

(X6) DATE