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

PRINTED: 06/10/2020 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) DATE SURVEY COMPLETED	
		185047	B. WING			05/27/2020	
NAME OF PROVIDER OR SUPPLIER  FULTON NURSING AND REHABILITATION, LLC			•	STREET ADDRESS, CITY, STATE, ZIP CODE  1004 HOLIDAY LANE  FULTON, KY 42041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 000	was initiated on 05/20 05/27/2020. There was found with 42 CFR 40 regulations and the fa Centers for Medicare and Centers for Disea	d Infection Control Survey 6/2020 and concluded on as no deficient practice 83.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention It practices to prepare for	F	000			
I ARORATORY I	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.

Facility ID: 100132

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

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NAME OF PROVIDER OR SUPPLIER  FULTON NURSING AND REHABILITATION, LLC  (A4)1)  SUMMARY STATEMEND OF EFFCIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 05/26/2020 and concluded on 05/27/2020. There was no deficient practice identified with 42 CFR 483.73 related to E-0024 (b)(6).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  FULTON NURSING AND REHABILITATION, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000 Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 05/26/2020 and concluded on 05/27/2020. There was no deficient practice identified with 42 CFR 483.73 related to			185047 B. WING			05/27/2020		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  E 000 Initial Comments  E 000  A COVID-19 Focused Emergency Preparedness Survey was initiated on 05/26/2020 and concluded on 05/27/2020. There was no deficient practice identified with 42 CFR 483.73 related to	NAME OF PROVIDER OR SUPPLIER				1	004 HOLIDAY LANE		
A COVID-19 Focused Emergency Preparedness Survey was initiated on 05/26/2020 and concluded on 05/27/2020. There was no deficient practice identified with 42 CFR 483.73 related to	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
		Initial Comments  A COVID-19 Focused Survey was initiated to concluded on 05/27/2 practice identified with	d Emergency Preparedness on 05/26/2020 and 020. There was no deficient	•				

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

TITLE (X6) DATE

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Office of Inspector General

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED		
100132			B. WING	B. WING				
NAME OF P	100132     B. WING     05/27/2020       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE							
FULTON NURSING AND REHABILITATION, LLC  1004 HOLIDAY LANE  FULTON, KY 42041								
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 000	A COVID-19 Focused was initiated 05/26/20	as no deficient practice	N 000					

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TITLE (X6) DATE