DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		185047	B. WING			08/	/13/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
FULTON N	URSING AND REHABIL	ITATION. LLC			004 HOLIDAY LANE		
		·····,		FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was initiated on 08/12 08/13/2020. There was identified with 42 CFF regulations and the fa Centers for Medicare and Centers for Disea	d Infection Control Survey 2/2020 and concluded on as no deficient practice 8 483.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention 9 practices to prepare for sus 41.					
LABORATORY I	DIRECTOR'S 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: 08/13/2020

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 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			08/	13/2020
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FULTON NURSING AND REHABILITATION, LLC				1004 HOLIDAY LANE			
				F	ULTON, KY 42041		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFOR			PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
E 000	Initial Comments		E	000			
	A COVID-19 Focused Emergency Preparedness Survey was initiated on 08/12/2020 and concluded on 08/13/2020. The facility was found to be in compliance with 42 CFR 483.73 related						
	to E-0024 (b)(6).						
		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: 08/13/2020 FORM APPROVED

Office of Inspector General         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         100132			(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		08/13/2020			
		STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
	URSING AND REHABI	FULTON	I, KY 42041				
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	VE ACTION SHOULD BE COMPLE ED TO THE APPROPRIATE DATE		
N 000	Initial Comments		N 000				
	was initiated 08/12/2	ed Infection Control Survey 2020 and concluded on was no deficient practice o 42 CFR 483.80.					