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

PRINTED: 12/10/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | <u> </u> | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|--|--|------------|--|----------------------------|
| | | 185360 | B. WING | | | 12/07/2020 | | |
| NAME OF PROVIDER OR SUPPLIER GALLATIN NURSING & REHAB | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | X (E. | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 000 | was conducted on 1 found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re | ed Infection Control Survey 12/07/2020. The facility was sliance with 42 CFR 483.80 ulations and has implemented licare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 87. | F | 000 | | | | |
| | | | | | | | 7 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | |
| ABORATORY | DIRECTOR'S OR PROVIDE | R/SUPPLIER REPRESENTATIVE'S SIGN/ | ATURE | | 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 tollowing 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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|----|---|---|-----------|
| | | 185360 | B. WING | | | 12/07/2020 | |
| NAME OF PROVIDER OR SUPPLIER GALLATIN NURSING & REHAB | | | | 49 | TREET ADDRESS, CITY, STATE, ZIP CODE 99 CENTER STREET /ARSAW, KY 41095 | 1 12 | 0112020 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | IX | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | /E ACTION SHOULD BE D TO THE APPROPRIATE | |
| E 000 | Initial Comments | | E 000 | | | | |
| | Survey was conduc | ted Emergency Preparedness ted on 12/07/2020. The be in compliance with 42 to E-0024 (b)(6). | | | | | |
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| ABORATORY | DIFFOTORIO CO COO | | | | | | |
| THUINHUGE | PINECIONS ON PHOVIDE | R/SUPPLIER REPRESENTATIVE'S SIGN. | ATURE | | 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: 12/10/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 100632 B. WING_ 12/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **499 CENTER STREET GALLATIN NURSING & REHAB WARSAW, KY 41095** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 12/07/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE