		AND HUMAN SERVICES			FORM	: 12/30/2020 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
******		185360	B. WING _		12/	29/2020
	PROVIDER OR SUPPLIER  N NURSING & REHAL	В		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00		
	was conducted on 1 found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re	sed Infection Control Survey 12/29/2020. The facility was pliance with 42 CFR 483.80 gulations and has implemented dicare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 84.				

LABORATORY 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.

		& MEDICAID SERVICES	T		OMB NO	M APPROVE D. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		185360	B. WING _		12	2/29/2020
	PROVIDER OR SUPPLIER IN NURSING & REHA	В	}	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		20/2020
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
E 000	Initial Comments		E 000	0		
	Survey was conduct	sed Emergency Preparedness sted on 12/29/2020. The facility compliance with 42 CFR -0024 (b)(6).	y			

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.

TITLE

(X6) DATE

PRINTED: 12/30/2020

Office of Inspector General

STATE FORM

AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED	
		100632				
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GALLATI	N NURSING & REHA	8	ER STREET , KY 41095	•		
(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 CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		OULD BE COMPLETE	
N 000	Initial Comments		N 000			
	was conducted on1	ed Infection Control Survey 2/29/2020. The facility was bliance pursuant to 42 CFR	·			
n de						
BORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE	

11LK11

(X6) DATE

If continuation sheet 1 of 1