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

PRINTED: 11/18/2020 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	
		185402	B. WING	B. WING		11/17/2020	
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIF 2500 NORTH ELM STREET HENDERSON, KY 42420	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	was initiated on 11/16 11/17/2020. The facil compliance with 42 C regulations and has i Medicare & Medicaid Centers for Disease	d Infection Control Survey 6/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention	F	000			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	-	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.

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185402		B. WING			11/17/2020		
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER				STREET ADDRESS, C 2500 NORTH ELM S HENDERSON, KY		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000		d Emergency Preparedness	E	00			
		on 11/16/2020 and 2020. The facility was found vith 42 CFR 483.73 related					
LABORATORY .		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

(X6) DATE TITLE

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: 100175

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Office of Inspector General

A. BUILDING:								
100175 B. WING	11/17/2020							
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTI ### Company of the com								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PROVIDER'S PLAN OF PROFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENT	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE							
N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 11/16/2020 and concluded on 11/17/2020. 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