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

PRINTED: 12/11/2020 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	
		185125	B. WING			12/	09/2020
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 1245 AMERICAN GREETING ROAD CORBIN, KY 40702			
(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 CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 000	conducted on 12/09/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended COVID-19. No defici The total census was	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention d practices to prepare for ent practice was identified.					
I ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	!F	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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		185125	B. WING			12/09/2020	
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZI 1245 AMERICAN GREETING ROA CORBIN, KY 40702			
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E 000	Initial Comments A COVID-19 focused survey was conducte facility was found to b CFR 483.73 Emerger	I Emergency Preparedness d on 12/09/2020. The pe in compliance with 42 ncy Preparedness related to practice was identified.					
LADODATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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Facility ID: 100425

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Office of Inspector General

A. BUILDING:	_ COMPLETED									
100425 B. WING										
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETING ROAD CORBIN, KY 40702										
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE	'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DATE DEFICIENCY)									
N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 12/09/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.										

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

TITLE (X6) DATE