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

PRINTED: 09/04/2020 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	
		185028	B. WING			08/11/2020	
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 000	KY#00031939, Comp COVID-19 Focused II initiated on 08/10/202 08/11/2020. Complai Complaint KY#00032 with no deficiencies of to be in compliance we control regulations and Centers for Medicare and Centers for Disea (CDC) recommended COVID-19. Total cens	ey investigating Complaint blaint KY#00032180 and a infection Control Survey was 0 and concluded on int KY#00031939 and 180 was unsubstantiated itied. The facility was found with 42 CFR 483.80 infection ind has implemented the & Medicaid Services (CMS) ase Control and Prevention I practices to prepare for		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.

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

PRINTED: 09/03/2020 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	
185028		185028	B. WING			C 08/11/2020	
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CO 2323 CONCRETE ROAD CARLISLE, KY 40311	ODE	0011112020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		TIVE ACTION SHOULD BE COMPLÉTION DATE		
E 000	Initial Comments		ΕC	000			
F 000	An Abbreviated Survey investigating Complaint KY#00031939, Complaint KY#00032180 and a COVID-19 Focused Infection Control Survey was initiated on 08/10/2020 and concluded on 08/11/2020. Complaint KY#00031939 and Complaint KY#00032180 was unsubstantiated with no deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention		FO	000			
	(CDC) recommende COVID-19. Total ce	ed practices to prepare for nsus 93.					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	MATURE	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: 09/03/2020 FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ C B. WING 100349 08/11/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD **JOHNSON MATHERS NURSING HOME** CARLISLE, KY 40311 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031939, Complaint KY#00032180 and a COVID-19 Focused Infection Control Survey was initiated on 08/10/2020 and concluded on 08/11/2020. Complaint KY#00031939 and Complaint KY#00032180 were unsubstantiated with no deficiencies cited. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 93.

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

TITLE

(X6) DATE