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

PRINTED: 11/17/2020 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	
		185150	B. WING			10/27/2020	
NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822			
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE	
F 000	conducted on 10/27/2 to be in compliance v Control and has impl Medicare & Medicaid Centers for Disease (CDC) recommended	I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for I Services (CMS) and Control and Prevention I practices to prepare for ient practice was identified.	F	DEFICIENCY)			
LABORATORY	DIDECTOR'S OR DROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	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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	ROVIDER OR SUPPLIER DUNTY HEALTH AND RE	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822					
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E 000	Initial Comments		E 000					
	survey was conducte facility was found to I CFR 483.73 Emerge	d Emergency Preparedness and on 10/27/2020. The period in compliance with 42 ncy Preparedness related to practice was identified.				Vi.		
	5			65				
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	A DIDECTORIO OD DEGMES	VSLIDDI IED REDRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE		

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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: ___ B. WNG_ 100495 10/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **388 PERKINS MADDEN ROAD** KNOTT COUNTY HEALTH AND REHABILITATION CEN HINDMAN, KY 41822 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 10/27/2020. 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