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

PRINTED: 03/10/2021 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		0:	02/08/2021	
NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 388 PERKINS MADDEN ROAD HINDMAN, KY 41822	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORF FIX (EACH CORRECTIVE ACTION S G CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	A COVID-19 focus conducted on 02/0 to be in compliance Control and has im Medicare & Medica Centers for Diseas (CDC) recommend	ed infection control survey was 8/2021. The facility was found with 42 CFR 483.80 Infection plemented the Centers for aid Services (CMS) and e Control and Prevention led practices to prepare for ficient practice was identified.					
LABORATOR	N DIRECTORIS OF BEGU	IDED/SLIDDI IER BEDRESENTATIVE'S SIG	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.

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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			02/08/2021	
NAME OF PROVIDER OR SUPPLIER KNOTT COUNTY HEALTH AND REHABILITATION CENTER				3	TREET ADDRESS, CITY, STATE, ZIP CODE 88 PERKINS MADDEN ROAD INDMAN, KY 41822		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments		E 000				
	A COVID-19 focused Emergency Preparedness survey was conducted on 02/08/2021. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.				£:		
			i				(6
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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: __ 100495 B. WING 02/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD KNOTT COUNTY HEALTH AND REHABILITATIC HINDMAN, KY 41822 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 02/08/2021. 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