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

PRINTED: 09/01/2020 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	
		185200	B. WNG		08	C 08/27/2020	
NAME OF PE	MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETION DATE		
F 000	INITIAL COMMENT	rs	F 00	00			
-	KY32263) and a Co control survey was	ndard survey (KY32015 and OVID-19 focused infection initiated on 08/25/2020 and 7/2020. The complaints were		# 15 m			
	unsubstantiated an identified. The facil compliance with 42	d no deficient practice was lity was found to be in CFR 483.80 Infection Control ed the Centers for Medicare &			3. 40	70	
	Medicaid Services Disease Control an recommended prac	(CMS) and Centers for d Prevention (CDC) ctices to prepare for tal census was 123.				;	
			2				
LABORATORY	DIRECTOR'S OR PROVING	ER/SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	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		
185200			B. WING			C 08/27/2020	
NAME OF PE	MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(XS) COMPLETION DATE		
E 000	survey was initiated concluded on 08/27 to be in compliance	ed Emergency Preparedness I on 08/25/2020 and I/2020. The facility was found with 42 CFR 483.73 edness related to E0024. No as identified.	E 000				
				r\			
LABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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PRINTED: 09/01/2020 FORM APPROVED Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING_ 100604 08/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **73 PIEDMONT DRIVE LETCHER MANOR** WHITESBURG, KY 41858 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY32015 and KY32263) and a COVID-19 focused infection control survey was initiated on 08/25/2020 and concluded on 08/27/2020. The complaints were unsubstantiated and no deficient practice was identified. 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