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

PRINTED: 10/16/2020 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	
		185015	B. WING		10	/16/2020	
NAME OF PROVIDER OR SUPPLIER MADISONVILLE HEALTH AND REHABILITATION, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST MADISONVILLE, KY 42431			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 10/18 10/16/2020. The facil compliance with 42 C regulations and has i Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 5/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention	F	DOO		(X6) DATE	

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

(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.

Facility ID: 100185

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

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NAME OF PROVIDER OR SUPPLIER MADISONVILLE HEALTH AND REHABILITATION, LLC SUMMANY STEMADISONVILLE, KY 42431 PRETX 1AQ SUMMANY STEMADISONVILLE, KY 42431 RECOULATORY OR IS. IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 10/15/2020 and concluded on 10/16/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MADISONVILLE HEALTH AND REHABILITATION, LLC (X4) ID PREFIX TAG (Description of the precision			185015	B. WING	B. WING		10/16/2020	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 10/15/2020 and concluded on 10/16/2020. The facility was found to be in compliance with 42 CFR 483.73 related PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY OUT THE APPROPRIATE DEFICIENCY DEFICIENCY OUT TAG COMPLÉTION DATE COMPLÉTION DATE COMPLÉTION DATE				•	STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST			
A COVID-19 Focused Emergency Preparedness Survey was initiated on 10/15/2020 and concluded on 10/16/2020. The facility was found to be in compliance with 42 CFR 483.73 related	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPR		COMPLETION	
	E 000	A COVID-19 Focuse Survey was initiated of concluded on 10/16/2 to be in compliance w	on 10/15/2020 and 2020. The facility was found	E				

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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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
100185			B. WING 10/16/2020			6/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 NORTH SEMINARY ST							
MADISONVILLE HEALTH AND REHABILITATION, LLC MADISONVILLE, KY 42431							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000				
N 000	A COVID-19 Focused was initiated 10/15/20	d Infection Control Survey 020 and concluded on ility was found to be in to 42 CFR 483.80.	N 000				

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

TITLE (X6) DATE