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

PRINTED: 01/14/2021 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	
		185015	B. WING _	B. WING		01/05/2021	
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 PREFI: TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 01/04 01/05/2021. The faci compliance with 42 C regulations and has in Medicare & Medicaid for Disease Control a recommended practic COVID-19. Total cen	d Infection Control Survey 4/2021 and concluded on lity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Center nd Prevention (CDC) tes to prepare for		DOO			(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

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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		
		185015	B. WING			01/05/2021		
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	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
E 000	Survey was initiated concluded on 01/05/	ed Emergency Preparedness on 01/04/2021 and /2021. The facility was found with 42 CFR 483.73 related	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.

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

TITLE

(X6) DATE

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA' COI		(X3) DATE : COMPI	TE SURVEY MPLETED		
		100185	B. WING 01/05/2021					
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				PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE			
N 000	Initial Comments		N 000					
N 000	A COVID-19 Focused was initiated on 01/0-	d Infection Control Survey 4/2021 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