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

PRINTED: 06/12/2020 FORM APPROVED OMB NO. 0938-0391

CENTERS TOR MEDICARE & INEDICALD SERVICES			/V2) MI # 7151 5 555	UCTOUCTION	- 1	(Y2) DATE BUDGEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		-	(X3) DATE SURVEY COMPLETED	
185379			B. WING	B, WING			
	ROVIDER OR SUPPLIER	FACILITY	62 MA	ET ADDRESS, CITY, STATE, Z AUDE ROAD , KY 41224	IP CODE	06/11/2020	
(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 (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIA		
F 000	INITIAL COMMENTS	S	F 000		20		
	to be in compliance Control and has imp Medicare & Medical Centers for Disease	d infection control survey was /2020. The facility was found with 42 CFR 483.80 Infection lemented the Centers for d Services (CMS) and Control and Prevention d practices to prepare for					
		cient practice was identified.		26		α	
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LABORATORY	DIRECTOR'S OR PROVIDE	R/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.

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

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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		
185379		185379	B. WING			06/11/2020	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD INEZ, KY 41224				
(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 CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
E 000	Initial Comments A COVID-19 focused survey was conducte was found to be in course 483.73 Emergency P	I Emergency Preparedness d on 06/11/2020. The facility ompliance with 42 CFR reparedness related to practice was identified.		0000			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER RÉPRESENTATIVE'S SIGNATURE			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,

Office of Inspector General									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED				
		İ							
		100661	B. WING		06/11/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
MARTIN COUNTY HEALTH CARE FACILITY 62 MAUDE ROAD									
MARTING	OOM THEALIN OAKE	INEZ, KY	41224						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	=ID	PROVIDER'S PLAN OF CORRECTION)			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPL				
TAG	KEGODATOKT OK		1/2	DEFICIENCY)					
<u> </u>	<u> </u>								
N 000	Initial Comments		N 000		1				
	A COVID-19 focused	infection control survey was	l i						
	conducted on 06/11/2	2020. The facility was found	100						
		oursuant to 42 CFR 483.80.							
	No deficient practice	was identified.	**						
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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