DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		185379	B. WING _	B. WING			/07/2020
NAME OF PF	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	OUNTY HEALTH CARE			62	MAUDE ROAD		
	OONTI HEAEIN OANE			INE	EZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	conducted on 12/07/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	Control and Prevention I practices to prepare for ent practice was identified.					
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
LADURAIURII	JINEUTUR O UR PRUVIDER/	JULI LIEN NEFREJEN IAHVE J JIGNALUH	\L				

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.

		ID HUMAN SERVICES			FOR	M APPROVED
		MEDICAID SERVICES				0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185379	B. WING		12	2/07/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARTIN C	OUNTY HEALTH CARE	FACILITY		62 MAUDE ROAD INEZ, KY 41224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
	survey was conducte facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 12/07/2020. The be in compliance with 42 ncy Preparedness related to practice was identified.				
ABORATORY	DIRECTOR'S OR DROVIDER	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.

PRINTED: 12/18/2020

PRINTED: 12/18/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100661			(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING		12/07/2020	
	OVIDER OR SUPPLIER		DDRESS, CITY, STATE		12/07/2020
		62 MAUI	DERESS, CHT, STATE		
ARTIN C	OUNTY HEALTH CARE	FACILITY INEZ, KY			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLET
N 000	Initial Comments		N 000		
	conducted on 12/07/	d infection control survey was 2020. The facility was found pursuant to 42 CFR 483.80. • was identified.			