DEPARTMENT OF HEALTH AND HUMAN SERVICES					FORM APPROVED		
CENTERS FOR ME	DICARE &	MEDICAID SERVICES			(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	
		185142	B. WING			11/25/2020	
NAME OF PROVIDER OR	SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
MAYFIELD HEALTH	ND REHABI	LITATION		401 INDIANA AVE MAYFIELD, KY 42066			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECT CROSS-REFERENC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000 INITIAL (A COVIE was initia 11/25/20 complian regulation Medicare Centers f (CDC) re	COMMENTS 0-19 Focuse ted on 11/24 20. The facil ce with 42 C hs and has i & Medicaid or Disease (d Infection Control Survey 4/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for	F 0	DE		TE DATE	
		SUPPLIER REPRESENTATIVE'S SIGNATU	RE	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: 11/25/2020

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185142	B. WING			11/	25/2020	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MAYFIELD HEALTH AND REHABILITATION				401 INDIANA AVE MAYFIELD, KY 42066				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION			
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX (EACH CORRECTIVE ACTION SHOULD BE C CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
E 000	Initial Comments		E	000				
	Survey was initiated of concluded on 11/25/2	d Emergency Preparedness on 11/24/2020 and 2020. The facility was found <i>v</i> ith 42 CFR 483.73 related						
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE		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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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		100481	B. WING		11/25/2020	
AME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
AYFIELD	HEALTH AND REHABI	LITATION	ANA AVE			
		MAYFIEI	LD, KY 42066			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE	
N 000	Initial Comments		N 000			
	was initiated 11/24/20	d Infection Control Survey 020 and concluded on lity was found to be in to 42 CFR 483.80.				

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

TITLE

(X6) DATE