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

PRINTED: 12/18/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	185142	B. WING _			12/18/2020	
NAME OF PROVIDER OR SUPPLIER MAYFIELD HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP C 401 INDIANA AVE MAYFIELD, KY 42066	ODE		
PREFIX (EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PI REGULATORY OR LSC IDENTIFYING INFORMATION)		((EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
was initiated on 12/12/18/2020. The fact compliance with 42 regulations and has Medicare & Medicare Centers for Disease (CDC) recommende COVID-19. Total ce	ned Infection Control Survey 15/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and c Control and Prevention ed practices to prepare for	F	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185142	B. WING _	B. WING		12/18/2020	
NAME OF PROVIDER OR SUPPLIER MAYFIELD HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 12/18/2	d Emergency Preparedness on 12/15/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	DEFICIE	NCY)		
I ABORATORY I	DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATUR	SE SE	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.

Facility ID: 100481

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Office of Inspector General

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			7 BOILBING					
		100481	B. WING		12/18/2020			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MAYFIELD HEALTH AND REHABILITATION MAYFIELD, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 000	A COVID-19 Focused was initiated 12/15/20	d Infection Control Survey D20 and concluded on lity was found to be in to 42 CFR 483.80.	N 000					

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

TITLE (X6) DATE