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

PRINTED: 08/13/2020 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	
		185207	B. WING			C 07/14/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		077	14/2020
				620 PARKER ROAD			
MAYSVILI	LE NURSING AND REHA	BILITATION FACILITY		MAYSVILLE, KY 41056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	An Abbreviated Surv KY#00031955 and a Infection Control Surv 07/13/2020 and conc Complaint KY#00031 The facility was found CFR 483.80 infection implemented the CM Control and Preventic	ey investigating Complaint COVID-19 Focused vey was initiated on					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'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.

Facility ID: 100333

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		405207				С		
185207			B. WING_	B. WING			07/14/2020	
NAME OF PROVIDER OR SUPPLIER				:	STREET ADDRESS, CITY, STATE, ZIP CODE			
MAYSVILLE NURSING AND REHABILITATION FACILITY			620 PARKER ROAD					
INATOVILL	L NONOINO AND REHA	BILITATION FACILITY			MAYSVILLE, KY 41056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 07/13/2020 and		E	000				
	concluded on 07/14/2	2020. The facility was found vith 42 CFR 483.73 related						
LABORATORY		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		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:		С			
100333		B. WING	B. WING		/2020			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MAYSVILL	MAYSVILLE NURSING AND REHABILITATION FACILIT 620 PARKER ROAD MAYSVILLE, KY 41056							
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (2)				
N 000	A Complaint Survey KY#00031955 and a		N 000					
	Complaint KY#0003 ^c The facility was foun pursuant to 42 CFR or regulations and has	cluded on 07/14/2020. 1955 was unsubstantiated. d to be in compliance 483.80 infection control mplemented the CMS and						
		Control and Prevention d practices to prepare for l census was 107.						

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

TITLE (X6) DATE