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

PRINTED: 01/12/2021 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	
		185217	B. WING			12/28/2020	
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER				7	STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	conducted on 12/20 to be in compliance Control and has im Medicare & Medica Centers for Diseas (CDC) recommend	ed infection control survey was 8/2020. The facility was found a with 42 CFR 483.80 Infection plemented the Centers for aid Services (CMS) and e Control and Prevention led practices to prepare for ficient practice was identified.	F	0000			
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	VATURE		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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		185217	B. WING			12	12/28/2020	
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER				70	TREET ADDRESS, CITY, STATE, ZIP CODE OF SKYLINE DRIVE DMONTON, KY 42129	1 12	20/2020	
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E 000	Initial Comments		E	000			23	
	survey was conduct facility was found to CFR 483.73 Emerg	ed Emergency Preparedness sted on 12/28/2020. The be in compliance with 42 gency Preparedness related to nt practice was identified.					C	
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	1		_	:	F.)			
	2:							
							*	
:							2	
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE	

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Office of Inspector General (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: ___ B. WING 100470 12/28/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 SKYLINE DRIVE METCALFE HEALTH CARE CENTER EDMONTON, KY 42129 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 **Initial Comments** A COVID-19 focused infection control survey was conducted on 12/28/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE