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

PRINTED: 09/24/2020 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDIOARE & MED					(VE) DATE SHOWEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185240	B. WING		09/15/2020	
NAME OF PE						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 000	A COVID-19 focused	d infection control survey was 20 and concluded on	F 000			
TE	09/15/2020. The factory compliance with 42 (and has implemente Medicaid Services (Disease Control and recommended practi	cility was found to be in CFR 483.80 Infection Control de the Centers for Medicare & CMS) and Centers for Prevention (CDC) ices to prepare for cient practice was identified.				
		00 54.1				
LABORATOR)	OIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	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;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
	185240		B. WING	B. WING			
	ROVIDER OR SUPPLIER BORO NURSING AND	REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO, KY 40965				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	survey was initiated concluded on 09/15 to be in compliance	sed Emergency Preparedness d on 09/14/2020 and 5/2020. The facility was found a with 42 CFR 483.73 redness related to E0024. No was identified.	E 000	DEFICIENCY			
ADODATOR	DIDENTARY OF POSTA	ED/SLIDDI IED BEDDESSNTATIV/ES SIGNATI I	05	TITLE	:	(X6) DATE	

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Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING_ 09/15/2020 100639 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 235 NEW WILSON LANE MIDDLESBORO NURSING AND REHABILITATION FAC MIDDLESBORO, KY 40965 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATÉ REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was initiated on 09/14/2020 and concluded on 09/15/2020. 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