DEPARTI		FORM APPROVED						
CENTER	S FOR MEDICARE &	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		
		185240	B. WING _			12/07/2020		
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE			
	MIDDLESBORO NURSING AND REHABILITATION FACILITY			235 NEW WILSON LANE				
WIDDLES	SORO NURSING AND RI			MIDDLESBORO, KY 40965				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	OULD BE COMPLETION		
F 000	INITIAL COMMENTS		F 0	000				
	conducted on 12/07/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	Control and Prevention I practices to prepare for ent practice was identified.						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	κE	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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DEPARTMENT OF HEALTH AND 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:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185240	B. WING			12/07/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
				2	35 NEW WILSON LANE			
MIDDLLSI	MIDDLESBORO NURSING AND REHABILITATION FACILITY			MIDDLESBORO, KY 40965				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION	
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/			
			_		DEFICIENCY)			
E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 12/07/2020. The		E	000				
	CFR 483.73 Emerger	e in compliance with 42 ncy Preparedness related to						
	E0024. No delicient	practice was identified.						
		SUPPLIER REPRESENTATIVE'S SIGNATU			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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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100639			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		100639	B. WING		12/07/2020	
ame of Pr	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
IDDLESE	ORO NURSING AND R	EHABILITATION FAC	V WILSON LANE SBORO, KY 40965			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	ION SHOULD BE COMPL THE APPROPRIATE DAT	
N 000	Initial Comments		N 000			
	conducted on 12/07/2	I infection control survey was 2020. The facility was found bursuant to 42 CFR 483.80. was identified.				
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

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