DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		185240	B. WING _			12	/16/2020
NAME OF PF	ROVIDER OR SUPPLIER	•	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION FACILITY		23	5 NEW WILSON LANE		
MIDDLLOI				MI	DDLESBORO, KY 40965		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	conducted on 12/16/2 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.					
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
	JINEUTUR O UR PRUVIDER/	JULI LIEN NEFREJEN IAHVE J JIGNALUH	\L		IIILE		(AU) DAIL

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.

PRINTED: 12/21/2020 

DEPART	MENT OF HEALTH AN	ID 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/	16/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION FACILITY		23	5 NEW WILSON LANE		
WIDDLESS	SORO NURSING AND RE			M	IDDLESBORO, KY 40965		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	survey was conducted facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 12/16/2020. The be in compliance with 42 ncy Preparedness related to practice was identified.					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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.

PRINTED: 01/11/2021 

## PRINTED: 01/11/2021 FORM APPROVED

Office of Inspector General         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         100639			(X2) MULTIPLE CO A. BUILDING:	INSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		12/16/2020			
AME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,				
IDDLESE	BORO NURSING AND R	ΈΗΔΒΙΙ ΙΤΔΤΙΟΝ ΕΔΟ	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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E ACTION SHOULD BE COMPL D TO THE APPROPRIATE DATE		
N 000	Initial Comments		N 000				
	conducted on 12/16/	I infection control survey was 2020. The facility was found oursuant to 42 CFR 483.80. was identified.					

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

TITLE

(X6) DATE