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

PRINTED: 08/31/2020 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	
100		185240	B. WING		08/	08/26/2020	
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO, KY 40965				
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DULD BE	(X5) COMPLETION DATE	
F 000	A COVID-19 focused conducted on 08/26// to be in compliance we Control and has implemented the Medicare & Medicare & Control for Disease (CDC) recommended	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for I Services (CMS) and Control and Prevention d practices to prepare for ient practice was identified.	F	000			
LABORATORY	DIRECTOR'S OR PROVIDER	R/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.

Facility ID: 100639

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		185240	B. WING		08	08/26/2020	
	ROVIDER OR SUPPLIER BORO NURSING AND R	EHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 236 NEW WILSON LANE MIDDLESBORO, KY 40965				
(X4) ID PREFIX TAG	(EACH DEFICIENC	UMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWN ACTION OF CROSS-REFERENCED TO THE APPRINT DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE		
E 000	Initial Comments		E 000				
	survey was conducted facility was found to CFR 483.73 Emerge	d Emergency Preparedness of on 08/26/2020. The be in compliance with 42 ncy Preparedness related to practice was identified.					
				6			
						0	
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATI	URE	TITLE		(X6) DATE	

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Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING 100639 08/26/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO NURSING AND REHABILITATION FAC MIDDLESBORO, KY 40965 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 PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 08/26/2020. 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