DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X:	3) DATE SURVEY COMPLETED
		185279	B. WING				06/23/2020
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MILLS NU	RSING & REHABILITATI	ON					
				MA	YFIELD, KY 42066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	was initiated on 06/22 06/23/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for					
LABORATORY I	DIRECTOR'S OR PROVIDER/S	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: 06/29/2020

CENTERS FOR MEDICARE & MEDICARD SERVICES   ONE NO. 0988-03     AND PLAN OF CORRECTION   ID PROVIDERUPERCULA   Org MULTIPLE CONSTRUCTION   PROVIDER OF SUPERIOR   PROVIDE	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED   185279 B. WING 06/23/2020   NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE   MILLS NURSING & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE   PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (cach correction should be   PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE (compLetion   TAG NOT ON LSC IDENTIFYING INFORMATION) PREFIX PREFIX CONSS-REFERENCED TO THE APPROPRIATE COMPLETIO   DEFICIENCY NURS IDENTIFY OR LSC IDENTIFY OR PREparedness E 000 E 000 Initial Comments E 000 E 000 A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/22/2020 and IDENTIFY WAS found to be in compliance with 42 CFR 483.73 related IDENTIFY IDENTIFY IDENTIFY	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   MILLS NURSING & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES   (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIO DATE   E 000 Initial Comments E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/22/2020 and concluded on 06/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related E 000								
MILLS NURSING & REHABILITATION 500 BECK LANE MAYFIELD, KY 42066   (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETIO DATE   E 000 Initial Comments E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/22/2020 and concluded on 06/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related E 000			185279	B. WING			06/	23/2020
MILLS NURSING & REHABILITATION MAYFIELD, KY 42066   (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIO DATE   E 000 Initial Comments E 000 E 000 E 000 Initial Comments E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/22/2020 and concluded on 06/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related E 000 Initial Comments Initial Comments Initial Compliance with 42 CFR 483.73 related	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIO DATE   E 000 Initial Comments E 000 E 000 Initial Comments E 000   A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/22/2020 and concluded on 06/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related E 000 Initial Comments	MILLS NU	RSING & REHABILITATI	ON					
A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/22/2020 and concluded on 06/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
Survey was initiated on 06/22/2020 and concluded on 06/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related	E 000	Initial Comments		E	000			
		Survey was initiated of concluded on 06/23/2 to be in compliance w	on 06/22/2020 and 2020. The facility was found					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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: 06/29/2020

## PRINTED: 06/29/2020 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
		100472	B. WING				
IAME OF PF	OVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE			
IILLS NUI	RSING & REHABILITATI	ON	K LANE LD, KY 42066				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)		
N 000	Initial Comments		N 000				
	was initiated 06/22/20	d Infection Control Survey 020 and concluded on lity was found to be in to 42 CFR 483.80.					

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

TITLE

(X6) DATE