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

PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185329	B. WING	B. WING		09/13/2021	
NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, Z 509 NORTH CARRIER STREET MORGANFIELD, KY 42437	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 09/10 09/13/2021. There widentified at 42 CFR 4 regulations and has in Medicare & Medicaid Centers for Disease 0 (CDC) recommended COVID-19. Total cens	d Infection Control Survey 0/2021and concluded on tas no deficient practice 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for		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: 100400

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	185329		B. WING			09/13/2021	
NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING AND REHABILITATION CENTER				STREET ADDRESS, 509 NORTH CARR MORGANFIELD,		,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP		3E	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 09/10/2021 and		E	00			
	concluded on 09/13/2	2021. There was no deficient 42 CFR 483.73 related to					
I AROPATORY	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

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE S	(X3) DATE SURVEY COMPLETED		
100400			B. WING 09/13/2			13/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIED STREET								
MORGANFIELD NURSING AND REHABILITATION CEN MORGANFIELD, KY 42437								
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 000	A COVID-19 Focused was initiated 09/10/20	d Infection Control Survey 021and concluded on vas no deficient practice to 42 CFR 483.80.	N 000					

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

TITLE (X6) DATE