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

PRINTED: 09/23/2021 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	
185006		185006	B. WING		09	09/17/2021	
NAME OF PROVIDER OR SUPPLIER  MORGANTOWN CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 000	was initiated 09/14/20 09/17/2021. There was identified at 42 CFR 4 regulations and the fa Centers for Medicare and Centers for Disea	d Infection Control Survey 021 and concluded as no deficient practice 183.80 Infection Control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention practices to prepare for	F	000			

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.

Facility ID: 100045

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(	(X3) DATE SURVEY COMPLETED	
	185006		B. WING			09/17/2021	
NAME OF PROVIDER OR SUPPLIER  MORGANTOWN CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  201 SOUTH WARREN STREET  MORGANTOWN, KY 42261			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOUL			
E 000	A COVID-19 Focused Emergency Preparedness		Ēί	000			
	09/17/2021. There wa	ed 09/14/2021 through as no deficient practice 483.73 related to E-0024 (b)					
AROPATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

(X6) DATE TITLE

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER  THE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:					
MORGANTOWN CARE & REHABILITATION CENTER  (X4) ID PREFIX TAG  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 09/14/2021 and concluded 09/17/2021. There was no deficient practice  201 SOUTH WARREN STREET MORGANTOWN, KY 42261  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)  N 000	100045			B. WING	B. WING				
MORGANTOWN, KY 42261  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 09/14/2021and concluded 09/17/2021. There was no deficient practice  MORGANTOWN, KY 42261  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 09/14/2021and concluded 09/17/2021. There was no deficient practice  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE  N 000  N 000  N 000	MORGAN	MODGANTOWN CARE & REHARII ITATION CENTER							
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		PREGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 09/14/2021and concluded 09/17/2021. There was no deficient practice							

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