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

PRINTED: 08/14/2020 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
		185414	B. WING	8 0	C 08/05/2020
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN MANOR OF PAINTSVILLE			10	REET ADDRESS, CITY, STATE, ZIP CODE 126 EUCLID AVENUE AINTSVILLE, KY 41240	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	COVID-19 focused in initiated on 08/03/202 08/05/2020. The cor and no deficient practicality was found to I CFR 483.80 Infection implemented the Cer	dard survey (KY32110) and a affection control survey was 20 and concluded on applaint was unsubstantiated tice was identified. The pe in compliance with 42 a Control and has afters for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for	F 000		
21				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.

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		185414	B WNG_		C 08/05/2020
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
E 000	survey was initiated concluded on 08/05 to be in compliance	ed Emergency Preparedness on 08/03/2020 and 6/2020. The facility was found with 42 CFR 483.73 edness related to E0024. No as identified.	E		
LABORATORY	A DIDECTORIE OR PROVID	FR/SUPPLIER REPRESENTATIVE'S SIGNATU	IDC	TITLE	(X6) DATE

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Facility ID: 100688

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ B. WNG 100688 08/05/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1025 EUCLID AVENUE MOUNTAIN MANOR OF PAINTSVILLE** PAINTSVILLE, KY 41240 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY32110) and a COVID-19 focused infection control survey was initiated on 08/03/2020 and concluded on 08/05/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE