DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			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 _		.	12/07/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ΜΟΠΝΤΑΙ	N MANOR OF PAINTSVI	IF		1025 EUCLID AVENUE			
				PAINTSVILLE, KY 41240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	(X5) COMPLETION DATE		
F 000	INITIAL COMMENTS		FC	000			
	conducted 12/07/202 be in compliance with Control and has imple Medicare & Medicaid Centers for Disease ( (CDC) recommended	Control and Prevention I practices to prepare for ent practice was identified.					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	2F	TITLE		(X6) DATE	
LADURAIURII	DIVECTOR S OK FROVIDER/S	JULI LIER REFREGENIATIVE & SIGNATUP	\L			(AU) 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: 12/17/2020

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		185414	B. WING	B. WING		12/07/2020	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N MANOR OF PAINTSVII	LE		1	025 EUCLID AVENUE		
				P	PAINTSVILLE, KY 41240		
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E 000	Initial Comments		E	000			
	survey was conducted facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 12/07/2020. The be in compliance with 42 hcy Preparedness related to practice was identified.					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	25		TITLE		(X6) DATE

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## PRINTED: 12/17/2020 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 12/07/2020	
		100688	B. WING			
IAME OF PF	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STATE,		12/01/2020	
	N MANOR OF PAINTSVI	IIF	CLID AVENUE			
		PAINTS	/ILLE, KY 41240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
N 000	Initial Comments		N 000			
	conducted on 12/07/2	I infection control survey was 2020. The facility was found oursuant to 42 CFR 483.80. was identified.				

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

TITLE

(X6) DATE