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

PRINTED: 11/02/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		O	(X3) DATE SURVEY COMPLETED		
V.		185112	B. WING			10/13/2020		
	ROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339					
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	(X5) COMPLETION DATE			
F 000	A COVID-19 focused conducted on 10/13/2 to be in compliance vicontrol and has implimedicare & Medicaid Centers for Disease (CDC) recommended	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for I Services (CMS) and Control and Prevention d practices to prepare for ient practice was identified.	F 000	DEFICIENCY				
ADODATOS	(DIRECTOR'S OR BROWNS	VSUPPLIER REPRESENTATIVE'S SIGNATUI	25	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.

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WING _ 100040 10/13/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 420 JETT DRIVE NIM HENSON GERIATRIC CENTER JACKSON, KY 41339 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 10/13/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE

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E 000	survey was conductor facility was found to CFR 483.73 Emerge	d Emergency Preparedness ed on 10/13/2020. The be in compliance with 42 ency Preparedness related to t practice was identified.	E 000				
APAPATORY	DIDECTOR'S OF SPONTS	R/SUPPLIER REPRESENTATIVE'S SIGNATI	IDE	TITLE	(X6) DATE		

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