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

PRINTED: 10/05/2021 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		
185094		B. WING			09/23/2021		
NAME OF PROVIDER OR SUPPLIER PIKEVILLE NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	conducted on 09/23 was identified with Control and the fac Centers for Medica and Centers for Dis	ed infection control survey was 3/2021. No deficient practice 42 CFR 483.80 Infection ility has implemented the re & Medicaid Services (CMS) sease Control and Prevention ed practices to prepare for	F	000	DEPICIENCY)		
L 40004700		SERVENTATIVE'S SIGN			TITLE		(YE) 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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E 000			E	000			
:	A COVID-19 focused Emergency Preparedness survey was conducted on 09/23/2021. No deficient practice was identified with 42 CFR 483.73 Emergency Preparedness related to E0024.						
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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Office of Inspector General
STATEMENT OF DEFICIENCIES

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED			
100367			B. WING		09/2	09/23/2021			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
DIKEMITI	E NUBEING AND BE	260 SOUT	H MAYO TR	AIL					
PINEVILL	E NURSING AND RE	PIKEVILL	E, KY 41501	1					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETE DATE			
N 000	Initial Comments		N 000						
	A COVID 10 feeting	ad infantian annual account							
	conducted on 09/2	ed infection control survey was 3/2021. No deficient practice							
		uant to 42 CFR 483.80.							
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE