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

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PIKEVILLE NURSING AND REHAB CENTER PIKEVILLE, KY 41591 O(A) ID PREFIX TAG FOOD INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 111/10/2020. The facility was found to be in compilance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified. The total census was 74.	(X5) COMPLETION DATE
PIKEVILLE NURSING AND REHAB CENTER 256 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	COMPLETION
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 11/10/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.	COMPLETION
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE	==

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	*	185094	B. WNG	<u>^^</u>	11/	10/2020	
	ROVIDER OR SUPPLIER E NURSING AND REHAE	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501				
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE		
E 000	A COVID-19 focused survey was conducte was found to be in co 483.73 Emergency P	I Emergency Preparedness d on 11/10/2020. The facility empliance with 42 CFR reparedness related to practice was identified.	E 000		2		
5.				2			
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE	· · · · · · · · · · · · · · · · · · ·	(X6) DATE	

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Office of Inspector General

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	112	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		100367	B. WNG		11/10/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE NURSING AND REHAB CENTER PIKEVILLE, KY 41501									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL.			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
N 000	A COVID-19 focused conducted on 11/10/2	infection control survey was 2020. The facility was found oursuant to 42 CFR 483.80. was identified.	N 000						
		ж							

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

TITLE

(X6) DATE