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

PRINTED: 09/03/2021 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		
		185304	B. WING			08/31/2021	
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER				147 NORTH HIG	S, CITY, STATE, ZIP CODE HLAND AVENUE IRG, KY 41653		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH C	/IDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	conducted 08/31/20 identified with 42 C and the facility has Medicare & Medica Centers for Disease (CDC) recommend COVID-19. The to	ed infection control survey was 021. No deficient practice was FR 483.80 Infection Control implemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for		000	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.

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING \_ 100126 08/31/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG HEALTH CARE CENTER PRESTONSBURG, KY 41653 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted 08/31/2021. No deficient practice was identified pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE

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		185304	B. WING	B. WING		08/31/2021	
	PROVIDER OR SUPPLIER	ARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 47 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	·	
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E 000	survey was conduct deficient practice w	ed Emergency Preparedness sted on 08/31/2021. No vas identified with 42 CFR varied Preparedness related to	E	0000	1		
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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