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

PRINTED: 12/15/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185221	B. WING			12/09/2020	
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CODE 662 PARKWAY DRIVE SALYERSVILLE, KY 41465			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	conducted on 12/09/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended COVID-19. No defici The total census was	I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention I practices to prepare for ent practice was identified. 95.		000			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RF.	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.

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIF 662 PARKWAY DRIVE SALYERSVILLE, KY 41465	STREET ADDRESS, CITY, STATE, ZIP CODE 662 PARKWAY DRIVE		
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E 000	Initial Comments A COVID-19 focused survey was conducted facility was found to be CFR 483.73 Emerge	d Emergency Preparedness of on 12/09/2020. The pe in compliance with 42 ncy Preparedness related to practice was identified.				TE .	DATE
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUI	RF	TITLE			(X6) DATE

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S	(X3) DATE SURVEY COMPLETED	
100519				B. WING 12/09/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 662 PARKWAY DRIVE 662 PARKWAY DRIVE								
			SALYERSV	ILLE, KY 414			(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 000	Initial Comments			N 000				
N 000	A COVID-19 focused conducted on 12/09/2	infection control survey 2020. The facility was fo oursuant to 42 CFR 483. was identified.	ound	N 000				

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

TITLE (X6) DATE