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

PRINTED: 06/24/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185052	B. WNG				06/23/2020	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT SUMMIT MANOR REHAB & WELLN				400 BO	ADDRESS, CITY, STATE, ZIP CODE MAR HEIGHTS MBIA, KY 42728			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			κ	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 000	initiated on 06/22/202 06/23/2020. The fact compliance with 42 C and has implemented Medicaid Services (C Disease Control and recommended practic COVID-19. No deficit The total census was	d infection control survey was 20 and concluded on ility was found to be in CFR 483.80 Infection Control of the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for ient practice was identified.		000	TITLE			(XS) 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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	ROVIDER OR SUPPLIER	SUMMIT MANOR REHAB & WELLN	400	EET ADDRESS, CITY, STATE, ZIP O BOMAR HEIGHTS LUMBIA, KY 42728	CODE	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 000	survey was initiate concluded on 06/2 to be in compliant	sed Emergency Preparedness ed on 06/22/2020 and 23/2020. The facility was found the with 42 CFR 483.73 aredness related to E0024. No was identified.	E 000			
LABORATORY	DIDECTORIS OF PROVI	DER/SHOPHER REPRESENTATIVE'S SYGNATHE		TITLE		(YA) DATE

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**FORM APPROVED** Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING\_ 100003 06/23/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 BOMAR HEIGHTS** SIGNATURE HEALTHCARE AT SUMMIT MANOR REHA COLUMBIA, KY 42728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was initiated on 06/22/2020 and concluded on 06/23/2020. 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

3ZPB11