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

PRINTED: 11/18/2021 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		
		185052	B. WING			C	
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	06/2021
SIGNATU	IRE HEALTHCARE A	T SUMMIT MANOR REHAB & WE	LLN	l	00 BOMAR HEIGHTS OLUMBIA, KY 42728		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 000	initiated on 10/06/2 10/06/2021. The facompliance with 42 and has implement Medicaid Services Disease Control an recommended practice.	ed infection control survey was 021 and concluded on acility was found to be in 2 CFR 483.80 Infection Control ted the Centers for Medicare & (CMS) and Centers for id Prevention (CDC) ctices to prepare for icient practice was identified.	F	000	DEFICIENCY)		
LABORATOR	V DIDECTOR'S OR PROVIN	DER/SUPPLIER REPRESENTATIVE'S SIGI	LATILISE.		TITLE		000 000
WYDOLKY I OK	I DIVECTOR 2 OK PROVI	JENGUTTLIER REPRESENTATIVE'S SIGI	WAIUKE		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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Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C B. WING 100003 10/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 BOMAR HEIGHTS** SIGNATURE HEALTHCARE AT SUMMIT MANO COLUMBIA, KY 42728 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was initiated on 10/06/2021 and concluded on 10/06/2021. 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

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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			
		185052	B, WING				C 10/06/2021	
NAME OF F	PROVIDER OR SUPPLIER	.0000			STREET ADDRESS, CITY, STATE, ZIP CODE	10/	00/2021	
		T SUMMIT MANOR REHAB & WE	IIN	4	100 BOMAR HEIGHTS			
SIGNATO	ME HEALIHOAKE A			COLUMBIA, KY 42728				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
E 000	Initial Comments		E 000					
	survey was initiated concluded on 10/06	ed Emergency Preparedness d on 10/06/2021 and 6/2021. No deficient practice 42 CFR 483.73 Emergency ted to E0024.						
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:								
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	! NATURE		TITLE		(X6) DATE	

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