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

PRINTED: 08/31/2020 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
		185211	B. WING		C 08/18/2020
	ROVIDER OR SUPPLIER	CCREARY COUNTY REHAB & WE	5	TREET ADDRESS, CITY, STATE, ZIP CODE 8 CAL HILL ROAD PINE KNOT, KY 42635	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTION
F 000	a COVID-19 focused initiated on 08/17/202   08/18/2020. The corrand no deficient practicity was found to I CFR 483.80 Infectior implemented the Certain state of the control of the correction o	dard survey (KY32229) and infection control survey was 20 and concluded on implaint was unsubstantiated attice was identified. The be in compliance with 42 in Control and has inters for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for	F 000		
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	RE .	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C 08/18/2020		
		185211	B. WING				i
	ROVIDER OR SUPPLIER	MCCREARY COUNTY REHAB & WE	STREET ADDRESS, CITY, STATE, ZIP CODE  58 CAL HILL ROAD  PINE KNOT, KY 42635				
(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 CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 000	survey was initiate concluded on 08/1 to be in compliance	sed Emergency Preparedness d on 08/17/2020 and 8/2020. The facility was found e with 42 CFR 483.73 redness related to E0024. No was identified.	E 000				
LABORATORY	DIRECTOR'S OR PROVID	BER/SUPPLIER REPRESENTATIVE'S SIGNATUR	₹	TITLE		(X6) DATE	

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Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING\_ 100635 08/18/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **58 CAL HILL ROAD** SIGNATURE HEALTHCARE OF MCCREARY COUNTY PINE KNOT, KY 42635 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) N 000 N 000 Initial Comments A complaint investigation (KY32229) and a COVID-19 focused infection control survey was initiated on 08/17/2020 and concluded on 08/18/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE