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

PRINTED: 11/25/2020 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			
		185180	B. WING			11/04/2020		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WEL				STREET ADDRESS, CITY, STATE, ZIP CODE				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT AG CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)		BE	(X5) COMPLETION DATE		
	was conducted on a found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) reprepare for COVID-	sed Infection Control Survey 11/04/2020. The facility was pliance with 42 CFR 483.80 gulations and has implemented dicare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 95.			TITLE		(X8) 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 CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		185180	B. WING		11/	11/04/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WEL				STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE ROAD RADCLIFF, KY 40160		· .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHOU	D BE	(X5) COMPLETION DATE	
E 000	Survey was conduct	sed Emergency Preparedness sted on 11/04/2020. The be in compliance with 42 if to E-0024 (b)(6).	EC	DEFICIENCY)			
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATLIDE	TITI F		(XR) DATE	

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(X6) DATE

If continuation sheet 1 of 1

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED 100570 B. WING _ 11/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **599 ROGERSVILLE ROAD** SIGNATURE HEALTHCARE AT NORTH HARDIN RADCLIFF, KY 40160 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 11/04/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

TITLE

678P11

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

STATE FORM