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

PRINTED: 11/13/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED			
	185168		B. WING		1.				
		OF MONROE COUNTY REHAB & V	WELL	STREET ADDRESS, CITY, STATE, ZIP CODE					
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
F 000	initiated on 11/10/2 11/11/2020. The facompliance with 42 and has implement Medicaid Services Disease Control ar recommended pract COVID-19. No defect The total census with the	sed infection control survey was 2020 and concluded on acility was found to be in 2 CFR 483.80 Infection Control ted the Centers for Medicare & (CMS) and Centers for nd Prevention (CDC) ctices to prepare for ficient practice was identified.	F O	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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185168			B. WING				11/11/2020	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MONROE COUNTY REHAB & V				STREET ADDRESS, CITY, STATE, ZIP CODE 706 NORTH MAGNOLIA STREET TOMPKINSVILLE, KY 42167				
(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 CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE	
E 000	survey was initiated on 11/11/2020. The compliance with 42	ed Emergency Preparedness I on 11/10/2020 and concluded e facility was found to be in CFR 483.73 Emergency ed to E0024. No deficient ied.	EO	000				
ARORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IDE		TITLE		(X6) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING 100337 11/11/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 706 NORTH MAGNOLIA STREET SIGNATURE HEALTHCARE OF MONROE COU! **TOMPKINSVILLE, KY 42167** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG 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 11/10/2020 and concluded on 11/11/2020. 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