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

PRINTED: 11/24/2020 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	
185201			B. WING				11/24/2020	
		AT TANBARK REHAB & WELLNE	ss c	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD LEXINGTON, KY 40515				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	ID PREFI TAG		PROVIDER (EACH CORR CROSS-REFER	JLD BE	(X5) COMPLETIO DATE		
F 000	INITIAL COMMEN	NTS	F 0	000			11	
	was initiated on 1 11/24/2020. The compliance with 4 regulations and ha Medicare & Medic Centers for Disea	used Infection Control Survey 1/24/2020 and concluded on facility was found to be in 1/2 CFR 483.80 infection control 1/2 as implemented the Centers for 1/2 caid Services (CMS) and 1/2 se Control and Prevention 1/2 ded practices to prepare for 1/2 census 7						
	OOVID-13. Total C	ochous r						
								.52
		* 8			590			
	8 22							
							*	
- 2								
ORATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITL	F		(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) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		185201	B. WING	8	11/24/2020						
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT TANBARK REHAB & WELLNESS C STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD LEXINGTON, KY 40515											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG			DBE	(X5) COMPLETION DATE				
E 000	Initial Comments A COVID-19 Focus Survey was initiated	used Emergency Preparedne ed on 11/24/2020 and	E 0	00							
	concluded on 11/24/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).										
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			92	:: ::							
ABORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S	SIGNATURE		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 100630 11/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD SIGNATURE HEALTHCARE AT TANBARK REHA **LEXINGTON, KY 40515** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 11/24/2020 and concluded on 11/24/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 7

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

TITLE

(X6) DATE