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

PRINTED: 12/04/2020 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	
	185168		B. WING			11/17/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MONROE COUNTY REHAB & WELL				STREET ADDRESS, CITY, STATE, ZIP CO 706 NORTH MAGNOLIA STREET TOMPKINSVILLE, KY 42167	DDE		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION E DATE	
F 000	conducted on 11/17/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended COVID-19. No deficie The total census was	I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention practices to prepare for ent practice was identified.	FO	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.

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

PRINTED: 12/08/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MONROE COUNTY REHAB & WELL PROPERTY SUPPLIES SU	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
SIGNATURE HEALTHCARE OF MONROE COUNTY REHAB & WELL TO NORTH MAGNOLLA STREET TOMPKINSVILLE, KY 42167 (MA) ID PRESTIX TITLE LICADI DEFICIENCY MUST OR PRECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 11/17/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.			185168	B. WING			11/17/2020	
PREFIX (EACH DEPICIENCY MUST BE PRECOCED BY FULL TAG CROSS REPERENCED TO THE APPROPRIATE DIAGRAM (CROSS REPERENCED TO THE APPROPRIATE DIAGRAM) E 000 Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 11/17/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.					706 NORTH MAGNOLIA STREET	DE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Initial Comments A COVID-19 focused survey was conducte was found to be in code 483.73 Emergency P	d Emergency Preparedness d on 11/17/2020. The facility ompliance with 42 CFR reparedness related to	1	DEFICIENCY		AI E	

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Facility ID: 100337

PRINTED: 12/08/2020 FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(3) DATE SURVEY COMPLETED		
		100337		B. WING		11/	17/2020	
NAME OF PROVIDER OR SUPPLIER STREET AD 706 NORT				DDRESS, CITY, STATE, ZIP CODE TH MAGNOLIA STREET ISVILLE, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
	TOMPKINS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		N 000					

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

TITLE (X6) DATE