DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					0. 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/	24/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
SIGNATURE HEALTHCARE OF MONROE COUNTY REHAB & WELL				7	06 NORTH MAGNOLIA STREET			
U U U U U				Т	OMPKINSVILLE, KY 42167			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A COVID-19 focused infection control survey was initiated on 11/23/2020 and concluded on		F	000				
	11/24/2020. The facil compliance with 42 C	ity was found to be in FR 483.80 Infection Control the Centers for Medicare & MS) and Centers for						
	recommended practic	es to prepare for ent practice was identified.						
		SUPPLIER REPRESENTATIVE'S SIGNATUR			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.

PRINTED: 12/04/2020

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 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/	24/2020	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SIGNATUR		ONROE COUNTY REHAB & WELL		70	06 NORTH MAGNOLIA STREET			
SIGNATOR	THE HEALTHCARE OF MIC	NROE COUNTY REHAB & WELL		TOMPKINSVILLE, KY 42167				
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	PREFIZ TAG	K (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION CROSS-REFERENCED TO THE APPROPRIATION CONTINUES AND ADDRESS AND			COMPLETION DATE		
140			IAG		DEFICIENCY)			
E 000	Initial Comments A COVID-19 focused survey was initiated o on 11/24/2020. The f compliance with 42 C	Emergency Preparedness n 11/23/2020 and concluded acility was found to be in FR 483.73 Emergency to E0024. No deficient		000				
LABORATORY [DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	-		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.

PRINTED: 12/08/2020

PRINTED: 12/08/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100337			(X2) MULTIPLE CON A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		11/24/2020			
AME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, Z	ZIP CODE			
GNATUR	RE HEALTHCARE OF M	IONROE COUNTY RE	TH MAGNOLIA STR NSVILLE, KY 42167				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE		
N 000	Initial Comments		N 000				
	initiated on 11/23/20 11/24/2020. The fac	d infection control survey was 20 and concluded on cility was found to be in t to 42 CFR 483.80. No is identified.					

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

TITLE

(X6) DATE