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

PRINTED: 06/03/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PRÖVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED		
		185282	B. WING			05/29/2020		
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE NURSING & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 000	A COVID-19 Focus was initiated on 05/05/29/2020. The facompliance with 42 regulations and has medicare and Medi Centers for Disease	sed Infection Control Survey 26/2020 and concluded on acility was found to be in CFR 483.80 infection control simplemented the Centers for caid Services (CMS) and a Control and Prevention and practices to prepare for						
ABORATORY	A DIDECTOR'S OR DROVIN	ED/SLIDDI IED DEDRESENTATIVE'S SIGN	IATHOS	TITLE		YELDATE		

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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E 000	Initial Comments		E	000			The second secon	
	Survey was initiated concluded on 05/29	sed Emergency Preparedness d on 05/26/2020 and 9/2020. The facility was found with 42 CFR 483.73 related						
							*	
		्र ब						
L ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 100156 05/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **JAMES E. HANNAH DRIVE SOUTH SHORE NURSING & REHABILITATION** SOUTH SHORE, KY 41175 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID ID 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 05/26/2020 and concluded on 05/29/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

STATE FORM

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

6899

(X6) DATE

TITLE