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

PRINTED: 01/20/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185282	B. WING	B. WING		12/15/2020	
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)		ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	was initiated on 12/19 12/15/2020. The facil compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	d Infection Control Survey 5/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention It practices to prepare for	F	000			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	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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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	A COVID-19 Focused Emergency Preparedness		E	000			
		on 12/15/2020 and 2020. The facility was found vith 42 CFR 483.73 related					
LAPODATORY	DIDECTOR'S OR BROVINED!	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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Office of Inspector General

AND PLAN OF CORRECTION IDENTIFICATION NU	ER/CLIA MBER:				3) DATE SURVEY COMPLETED			
100156		B. WING			12/15/2020			
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SOUTH SHORE NURSING & REHABILITATION JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175								
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE 0	(X5) COMPLETE DATE			
N 000 Initial Comments		N 000						
A COVID-19 Focused Infection Control Su was initiated 12/15/2020 and concluded or	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments A COVID-19 Focused Infection Control Survey was initiated 12/15/2020 and concluded on 12/15/2020. The facility was found to be in							

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

TITLE (X6) DATE