DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		185312	B. WING _			11/12/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
STONECR				4747 ALBEN BARKLEY D	ORIVE		
OTONEON	STONECREEK HEALTH AND REHABILITATION			PADUCAH, KY 42001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		
F 000	INITIAL COMMENTS		FC	00			
	was initiated on 11/10 11/12/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for					
LABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

CTOR'S OR

PRINTED: 11/13/2020

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.

		ID HUMAN SERVICES			FOR	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		O. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		185312	B. WING		11	/12/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
STONECR	EEK HEALTH AND REH	ABILITATION		4747 ALBEN BARKLEY DRIVE		
				PADUCAH, KY 42001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E O	00		
	Survey was initiated of concluded on 11/12/2	d Emergency Preparedness on 11/10/2020 and 2020. The facility was found with 42 CFR 483.73 related				
		SUPPLIER REPRESENTATIVE'S SIGNATU	RE	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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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		100309	B. WING	B. WING		11/12/2020
AME OF PR	OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
TONECR	EEK HEALTH AND REH	IABILITATION	BEN BARKLEY DR AH, KY 42001	VE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments		N 000			
	was initiated 11/10/2	d Infection Control Survey 020 and concluded on ility was found to be in t to 42 CFR 483.80.				

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