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

PRINTED: 12/23/2020 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				
		185433	B. WING		_	12/21/2020				
NAME OF PROVIDER OR SUPPLIER  TRI-CITIES NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIV CROSS-REFERENCE		BE COMPLETION				
F 000	INITIAL COMMENTS		F0	000						
	conducted on 12/2 to be in complianc Control and has in Medicare & Medicare Centers for Diseas (CDC) recommend	sed infection control survey was 11/2020. The facility was found e with 42 CFR 483.80 Infection applemented the Centers for aid Services (CMS) and se Control and Prevention ded practices to prepare for ficient practice was identified. was 54.								
LARORATOR	A DIBECTUBIS UB BBON	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATI IRE	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185433	B. WING			12/21/2020	
	PROVIDER OR SUPPLIER ES NURSING AND RE	EHABILITATION CENTER		191	REET ADDRESS, CITY, STATE, ZIP CODE 101 US HIGHWAY 119 NORTH JMBERLAND, KY 40823	1 000	7
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	LD BE COMPLETION	
E 000	survey was conduct facility was found to CFR 483.73 Emerg	ted Emergency Preparedness sted on 12/21/2020. The be in compliance with 42 gency Preparedness related to nt practice was identified.	E	000			
		5.	<i>N</i>				
PADOKALOK,	T DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_ B. WING\_ 100767 12/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **19101 US HIGHWAY 119 NORTH** TRI-CITIES NURSING AND REHABILITATION C CUMBERLAND, KY 40823 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 12/21/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE