DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2020 FORM APPROVED

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185433	B. WING		C 07/30/2020	
	ROVIDER OR SUPPLIER S NURSING AND REHAL	III ITATION CENTER	1 -	TREET ADDRESS, CITY, STATE, ZIP CODE 9101 US HIGHWAY 119 NORTH		
TRIFOTTIES	S HOKSING AND KENAL	SELIZION CENTEN	<u> </u>	CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION	
F 000	a COVID-19 focused conducted on 07/30/ unsubstantiated and identified. The facilit compliance with 42 (and has implemente	dard survey (KY31554) and linfection control survey was 2020. The complaint was no deficient practice was y was found to be in CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for Prevention (CDC) ices to prepare for	F 000			
LABORATORY	DIRECTOR'S OR PROVIDE	ZSUPPLIER REPRESENTATIVE'S SIGNATU	JRE	TITLE	(X5) 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.

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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED
		185433	B. WNG			07/	
-	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		30/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
€ 000	survey was conducte facility was found to t CFR 483.73 Emerge	d Emergency Preparedness of on 07/30/2020. The pe in compliance with 42 may preparedness related to practice was identified.	E	000			
LABORATORY	DIDECTOR'S OF PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(XA) 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.

Office of Inspector General (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ C B. WNG_ 100767 07/30/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

N 000 Initial Comments A complaint investigation (KY31554) and a COVID-19 focused infection control survey was conducted on 07/30/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.	 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X4) ID PREFIX TAG
		N 000	A complaint investigation (KY31554) and a COVID-19 focused infection control survey was conducted on 07/30/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in	N 000
	V. ***		1X 25	

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

TITLE

(X6) DATE