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

PRINTED: 06/18/2020 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	
		185172	B. WNG			06/16/2020	
NAME OF PROVIDER OR SUPPLIER TUG VALLEY ARH SKILLED NURSING FACILITY				STREET ADDRESS, C 260 HOSPITAL DRIV SOUTH WILLIAMS		× ×	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			
F 000	A COVID-19 focused initiated on 06/15/202 06/16/2020. The fact compliance with 42 0 and has implemented Medicaid Services (ODisease Control and recommended practices)	d infection control survey was 20 and concluded on lity was found to be in CFR 483.80 Infection Control of the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for lient practice was identified.	F	000	DEPICIENCY)		
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>		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.

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

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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			
		185172	B. WNG			06/16/2020			
	ROVIDER OR SUPPLIER	SING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)			(X5) COMPLETION DATE		
E 000	survey was initiated of concluded on 06/16/2 to be in compliance v	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	E	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.

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING_ 06/16/2020 100714 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **260 HOSPITAL DRIVE** TUG VALLEY ARH SKILLED NURSING FACILITY SOUTH WILLIAMSON, KY 41503 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was initiated on 06/15/2020 and concluded on 06/16/2020. 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