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

PRINTED: 12/02/2020 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. WING_			11/10/2020		
NAME OF PROVIDER OR SUPPLIER  TUG VALLEY ARH SKILLED NURSING 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 000	conducted on 11/10/ to be in compliance of Control and has impl Medicare & Medicard Centers for Disease	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for 3 Services (CMS) and Control and Prevention d practices to prepare for	F 00	00				
LABORATORY	DIRECTOR'S OR PROVIDE	VSUPPLIER REPRESENTATIVE'S SIGNATUR	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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		185172	B. WING		11/10/2020		
	ROVIDER OR SUPPLIER  LEY ARH SKILLED NURS	SING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
E 000		d Emergency Preparedness	E 000				
	survey was conducte was found to be in co 483.73 Emergency F	ed on 11/10/2020. The facility ompliance with 42 CFR Preparedness related to practice was identified.			1		
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		20					
		47	:				
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LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	₹E	TITLE	(X6) DATE		

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FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 100714 11/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **260 HOSPITAL DRIVE** TUG VALLEY ARH SKILLED NURSING FACILITY **SOUTH WILLIAMSON, KY 41503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 11/10/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 2.

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

TITLE

(X6) DATE