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

PRINTED: 06/15/2020 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	
		185213	B. WNG		06/	11/2020	
	OVIDER OR SUPPLIER	EHABILITATION CENTER	850	EET ADDRESS, CITY, STATE, ZIP CODE HWY 191 MPTON, KY 41301			
(X4) 1D PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	initiated on 06/10/20: 06/11/2020. The factompliance with 42 0 and has implemented. Medicaid Services (ODisease Control and recommended practi	d infection control survey was 20 and concluded on illity was found to be in CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for I Prevention (CDC) ices to prepare for ient practice was identified.	F 000				
LARORATORY	DIRECTOR'S OR PROVIDE	R/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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		185213	B, WING		06/11/2020			
NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  850 HWY 191  CAMPTON, KY 41301				
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE			
E 000	survey was initiated of concluded on 06/11/2 to be in compliance w	2020. The facility was found with 42 CFR 483,73 Iness related to E0024. No	E 00					
LABORATORY	DIDECTORIS OF PROMISER	SI IDDI IED DEDDESENTATIVE'S SIGNATI IDE		TITLE		(YE) DATE		

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FORM APPROVED Office of Inspector General (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL!A IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ B. WNG 100636 06/11/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 850 HWY 191 WOLFE COUNTY HEALTH AND REHABILITATION CEN CAMPTON, KY 41301 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was initiated on 06/10/2020 and concluded on 06/11/2020. 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

(X8) DATE