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

PRINTED: 12/18/2020 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 | | |
|---|---|--|--|--|----------------------------------|------------|----------------------------|
| | | 185213 | B. WING | | | 12/16/2020 | |
| NAME OF PROVIDER OR SUPPLIER WOLFE COUNTY HEALTH AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP 850 HWY 191 CAMPTON, KY 41301 | CODE | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | CTION SHOULD BE THE APPROPRIA | | (X5) COMPLETION DATE |
| F 000 | conducted on 12/16/2 to be in compliance we Control and has imple Medicare & Medicaid Centers for Disease (CDC) recommended | I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention I practices to prepare for ent practice was identified. | F | 000 | | | |
| I ABORATORY | DIRECTOR'S OR PROVIDER/S | 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.

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

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| | | 185213 | B. WING | | | 12/16/2020 | |
| NAME OF PROVIDER OR SUPPLIER WOLFE COUNTY HEALTH AND REHABILITATION CENTER | | | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE 150 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) | | PREFIX (EACH CORRECTIVE ACTION SHOU | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | Initial Comments A COVID-19 focused survey was conducted facility was found to b CFR 483.73 Emerger | | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| | | | | | | | |

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

(X6) DATE TITLE

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Facility ID: 100636

PRINTED: 01/07/2021 FORM APPROVED

Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION IG: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-----------------------|--|--------------------------------------|--------------------------|--|
| 100636 | | | B. WING _ | B. WING | | | |
| NAME OF PI | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12/16/2020 | | | | | | |
| WOLFE COUNTY HEALTH AND REHABILITATION CEN 850 HWY 191 CAMPTON, KY | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE | |
| N 000 | N 000 Initial Comments | | | | | | |
| N 000 | A COVID-19 focused conducted on 12/16/2 | infection control survey was 2020. The facility was found ursuant to 42 CFR 483.80. was identified. | d | | | | |
| | | | | | | | |

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

TITLE (X6) DATE