DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/14/2020 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			OWN DATE OUTSIEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE COI	(X3) DATE SURVEY COMPLETED		
		185213	B. WING		08/05/2020
	OUNTY HEALTH AND R	EHABILITATION CENTER	850 H	ET ADDRESS, CITY, STATE, ZIP CODE IWY 191 IPTON, KY 41301	
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ILD BE COMPLETION
F 000	INITIAL COMMENTS	5	F 000	ii-	
	to be in compliance Control and has imp Medicare & Medicai	d infection control survey was /2020. The facility was found with 42 CFR 483.80 Infection demented the Centrol d Services (CMS) and			iii
	(CDC) recommende	Control and Prevention and practices to prepare for cient practice was identified. as 94.			
22					
n e					
				177	
	N DIRECTOR'S OR BROWN	ER/SUPPLIER REPRESENTATIVE'S SIGNAT	URE	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.

Facility ID 100636

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	8.8	185213	B. WNG				08/0	05/2020
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				ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)			(XS) COMPLETION DATE
E 000	A COVID-19 focused survey was conducte facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 08/05/2020. The se in compliance with 42 ncy Preparedness related to practice was identified.	E	000			• 5	
								W.

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 I	nspector General							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED			
		100636	B, WING		08/05/2020			
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE				
WOLFE CO	DUNTY HEALTH AND R	EHABILITATION CEN 850 HWY CAMPTON	91 , KY 41301					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	HOULD BE COMPLETE			
N 000	Initial Comments		N 000					
	conducted on 08/05/	l infection control survey was 2020. The facility was found oursuant to 42 CFR 483.80. was identified.		÷.				
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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