DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 11/24/2020		
		185445 B. V						
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODCR	EST NURSING AND REF	ABILITATION CENTER		38	376 TURKEYFOOT ROAD			
neebon				E				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ULD BE COMPLETION		
F 000		d Infection Control Survey 3/2020 and concluded on	F	000				
	compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	Control and Prevention						
LABORATORY	DIRECTOR'S OR PROVIDER/	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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							APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185445	B. WING _			11/24/2020		
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODCB				3876 TURKEYFOOT ROAD				
WOODCK	WOODCREST NURSING AND REHABILITATION CENTER			ELSMERE, KY 41018				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE	
IAG					DEFICIENCY)			
E 000	Survey was initiated of concluded on 11/24/2	d Emergency Preparedness on 11/23/2020 and 020. The facility was found ith 42 CFR 483.73 related	E	0000	DEFICIENCY)			
	DIRECTOR'S OR PROVIDER/S	SUPPLIER 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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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		B. WING		11/24/2020		
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
OODCR	EST NURSING AND RE	HABILITATION CENT	RKEYFOOT ROAD RE, KY 41018			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTION ION SHOULD BE 'HE APPROPRIATE 'Y)	(X5) COMPLET DATE	
N 000	Initial Comments		N 000			
	was initiated on 11/2 11/24/2020. The fac compliance with 42 0 regulations and has Medicare & Medicaio Centers for Disease	d Infection Control Survey 3/2020 and concluded on ility was found to be in CFR 483.80 infection control implemented the Centers for d Services (CMS) and Control and Prevention d practices to prepare for sus 67				

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

TITLE

(X6) DATE

3RUK11