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

PRINTED: 05/22/2020 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	
		185286	B. WING	B. WING		04/21/2020	
NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH AND REHABILITATION			•	STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	initiated on 04/20/202 04/21/2020. The faci compliance with 42 C and has implemented Medicaid Services (C Disease Control and recommended practic COVID-19. No defici The total census was	d infection control survey was 20 and concluded on lity was found to be in CFR 483.80 Infection Control of the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for ent practice was identified.		DOO			(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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E 000	survey was initiated of concluded on 04/21/2 to be in compliance w	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	EO		

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

TITLE (X6) DATE

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE JAMESTOWN, KY 42629 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 focused infection control survey was initiated on 04/20/2020 and concluded on 04/21/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			3) DATE SURVEY COMPLETED			
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