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

PRINTED: 05/22/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER  SUBMARY STATEMENT OF DEPICIENCES (SE2 PARKWAY DRIVE SALYERSVILLE, KY 41466)  PREDIX RECOLATORY OR US: DEPITTIVING INFORMATION)  F 000 INITIAL COMMENTS  A COVID-19 facused infection control survey was initiated on 04/13/2020 and concluded on 04/13/2020 and concluded on 04/13/2020 and concluded on 10 compliance with 42 CFR 483 80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for COVID-19. No deficient practice was identified. The total census was 122.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
SALYERSVILLE NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  A COVID-19 focused infection control survey was initiated on 04/13/2020 and concluded on 04/14/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.		185221	B. WING			04/14/2020		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  A COVID-19 focused infection control survey was initiated on 04/13/2020 and concluded on 04/14/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.					6	62 PARKWAY DRIVE		
A COVID-19 focused infection control survey was initiated on 04/13/2020 and concluded on 04/14/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			COMPLETION
	F 000	A COVID-19 focused initiated on 04/13/202 04/14/2020. The faci compliance with 42 C and has implemented Medicaid Services (C Disease Control and recommended practic COVID-19. No deficie	I infection control survey was 20 and concluded on lity was found to be in EFR 483.80 Infection Control I the Centers for Medicare & MS) and Centers for Prevention (CDC) ces to prepare for ent practice was identified.	F	0000	DEFICIENCY)		

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

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: 100519

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

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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	
185221			B. WING _			04/14/2020	
NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 662 PARKWAY DRIVE SALYERSVILLE, KY 41465	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA		
E 000	Initial Comments  A COVID-19 focused Emergency Preparedness survey was initiated on 04/13/2020 and concluded on 04/14/2020. The facility was found		E	000			
	to be in compliance w	rith 42 CFR 483.73 related nt practice was identified.					

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

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100519		ı		04/	14/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  662 PARKWAY DRIVE								
SALYERS	VILLE NURSING AND R	EHABILITATION CEN		ILLE, KY 414	65			
(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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
N 000	Initial Comments			N 000				
N 000	A COVID-19 focused initiated on 04/13/20:04/14/2020. The fac	l infection control survey 20 and concluded on ility was found to be in to 42 CFR 483.80. No s identified.		N 000				

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

TITLE (X6) DATE