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

PRINTED: 01/13/2021 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			
		185028	B. WING				C 01/07/2021			
100	PROVIDER OR SUPPLIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311					1 0110112021			
(X4) ID PREFIX TAG	(EACH DEFICIEN	IDENTIFICATION NUMBER: 185028 JPPLIER NURSING HOME MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL JRY OR LSC IDENTIFYING INFORMATION)		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	NTS	F 0	00		*		ļ		
	KY#00032870 and Infection Control S 01/05/2021 and complaint KY#000 with no deficiencie to be in compliant control regulations Centers for Medicand Centers for D (CDC) recommen	d a COVID-19 Focused Survey was initiated on oncluded on 01/07/2021. 032870 was unsubstantiated es cited. The facility was found ce with 42 CFR 483.80 infection s and has implemented the care & Medicaid Services (CMS) bisease Control and Prevention aded practices to prepare for								
	OGVID-13. Total	census 91.								
									181	
						, x				
								*		
ABORATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		Ti	TLE			(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

PRINTED: 01/13/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		185028	B. WING_			C 01/07/2021		
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
E 000	Initial Comments		E 00	00				
	Survey and Abbre ARO #KY000328 and concluded or #KY00032870 wa deficient practice	used Emergency Preparedness eviated Survey investigating 70 was initiated on 01/05/2021 o 01/07/2021. ARO as unsubstantiated with no cited. The facility was found to with 42 CFR 483.73 related to ensus 91						
	L-0024 (b)(0). Co	alisus 91.	:					
			-					
		IDER/SUPPLIER REPRESENTATIVE'S SIGI		TITLE				

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.

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 100349 01/07/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD JOHNSON MATHERS NURSING HOME CARLISLE, KY 40311 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A Complaint Investigation of ARO #KY00032870 and a COVID-19 Focused Infection Control Survey was initiated 01/05/2021 and concluded on 01/07/2021. ARO #KY00032870 was unsubstantiated with no deficient practice identified. The facility was found to be in compliance pursuant to 42 CFR 483.80. Census 91.

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

TITLE

(X6) DATE