

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

PRINTED: 08/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2013
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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(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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000

INITIAL COMMENTS

F 000

A Standard Recertification Survey was initiated on 07/30/13 and concluded on 08/01/13 with no deficient practice 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CEDAR RIDGE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2013
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2004 Addition 6/16/2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211) Protected</p> <p>SMOKE COMPARTMENTS: Fourteen (14) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (Original Installation)</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) (Original Installation)</p> <p>EMERGENCY POWER: Type II Diesel Generator. (Original Installation)</p> <p>A life safety code survey was initiated and concluded on 07/31/13. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).</p>	K 000		
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