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

PRINTED: 05/20/2020 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		
	185382		B. WING		04/	04/22/2020	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CENTER FOR REHABILITATION AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 47 MARGO AVENUE BARDWELL, KY 42023			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OULD BE COMPLETIC		
F 000	was initiated on 04/21 04/22/2020. The facili compliance with 42 C regulations and has ir Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 1/2020 and concluded on ity was found to be in EFR 483.80 infection control implemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for sus 44.	F 000				
ADODATODY	DIDECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	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/CI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		100663		B. WING			04/22/2	020
	ROVIDER OR SUPPLIER	AARII ITATION AND	47 MARGO		TE, ZIP CODE			
	ODE GENTER FOR REI	IABIEITATION AND	BARDWELI	L, KY 42023				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD E	BE C	(X5) OMPLETE DATE
N 000	Initial Comments			N 000				
	A COVID-19 Focused was initiated 04/21/20	d Infection Control Survey 220 and concluded on lity was found to be in to 42 CFR 483.80.	y					

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

TITLE (X6) DATE

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		185382	B. WING _			04/22/2020	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CENTER FOR REHABILITATION AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CO 47 MARGO AVENUE BARDWELL, KY 42023			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Survey was initiated concluded on 04/22	ed Emergency Preparedness on 04/21/2020 and /2020. The facility was found with 42 CFR 483.73 related	EO				

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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