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 BEREA HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD BEREA, KY 40403	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BEREA HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD BEREA, KY 40403	185384		B. WING _		04	04/10/2020		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				STREET ADDRESS, CITY, STATE, ZIP CODE 601 RICHMOND ROAD				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM					(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE		
F 000 INITIAL COMMENTS A COVID-19 focused infection control survey was initiated on 04/09/2020 and concluded on 04/10/2020. 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. The total census was 80.		A COVID-19 focused initiated on 04/09/202 04/10/2020. The faci compliance with 42 C and has implemented Medicaid Services (C Disease Control and recommended practic COVID-19. The total	I infection control survey was 20 and concluded on lity was found to be in EFR 483.80 Infection Control the Centers for Medicare & MS) and Centers for Prevention (CDC) ces to prepare for census was 80.	FO			(X6) DATE	

(X6) DATE 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.

Facility ID: 100319

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) DA	(X3) DATE SURVEY COMPLETED	
	185461		B. WING			04/15/2020	
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299				
(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 CORRE ((EACH CORRECTIVE ACTION SHOOT) CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
E 000	Survey was initiated of concluded on 04/15/2	d Emergency Preparedness on 04/14/2020 and 020. The facility was found vith 42 CFR 483.73 related	E 0				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

(X6) DATE 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.

Facility ID: 100729A

PRINTED: 05/22/2020 FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING:					
		100700	B. WING		04/1	3/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
EDGEWOOD ESTATES 195 BERRYMAN ROAD EDENCHBURG KV. 40222								
()(1) ID	FRENCHBURG, KY 40322 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 000	A COVID-19 focused conducted on 04/13/2	infection control survey was 2020. The facility was found ursuant to 42 CFR 483.80. was identified.	N 000					

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

TITLE (X6) DATE