DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185244	B. WING	B. WING			/07/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
STANEOD	D CARE AND REHAB, L			10	05 HARMON HEIGHTS			
	D CARE AND REHAD, E		STANFORD, KY 40484					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	OULD BE COMPLETION		
F 000	INITIAL COMMENTS			000				
	INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 04/07/2020. 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. The total census was 102.			F 000				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	) 		TITLE		(X6) DATE	
LADURAIURY	DIRECTORS OR PROVIDER/S	JUFFLIER REFREJEN IAHVE J JIGNALUK			IIILE		(AU) 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.

PRINTED: 05/22/2020

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
185244		B. WING	B. WING			04/07/2020		
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
STANFOR	STANFORD CARE AND REHAB, LLC				05 HARMON HEIGHTS			
				STANFORD, KY 40484				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
E 000	Initial Comments		E 000					
	survey was conducted facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 04/07/2020. The be in compliance with 42 hcy Preparedness related to practice was identified.						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		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.

PRINTED: 05/22/2020

## PRINTED: 05/22/2020 FORM APPROVED

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		100290	B. WING		04/07/2022		
			DDRESS, CITY, STATE,	04	04/07/2020		
		105 HAR	MON HEIGHTS				
TANFOR	D CARE AND REHAB,		RD, KY 40484				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	CTION SHOULD BE COMPLE THE APPROPRIATE DATE		
N 000	Initial Comments		N 000				
	conducted on 04/07/	d infection control survey was /2020. The facility was found pursuant to 42 CFR 483.80. a was identified.					