DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	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		
		185334	B. WING			08/05/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
		CENTER INC		15	595 S US HIGHWAY 231			
	BEAVER DAM NURSING & REHAB CENTER, INC			BEAVER DAM, KY 42320				
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE COMPLE S-REFERENCED TO THE APPROPRIATE DATE		
F 000	INITIAL COMMENTS		F	000				
	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 08/04/2020 and concluded on 08/05/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations 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. Total census: 55			F 000				
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUI	RE		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: 08/06/2020

							APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
185334		B. WING	B. WING			08/05/2020			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
BEAVER	DAM NURSING & REHAE	CENTER. INC		1595 S US HIGHWAY 231					
				BEAVER DAM, KY 42320					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IOULD BE COMPLETION			
E 000	Initial Comments		E	000					
	Survey was initiated of concluded on 08/05/2	d Emergency Preparedness on 08/04/2020 and 0200. The facility was found vith 42 CFR 483.73 related							
		SUPPLIER REPRESENTATIVE'S SIGNATU			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: 08/06/2020

PRINTED: 08/06/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 100353			(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		08	08/05/2020		
IAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
EAVER D	AM NURSING & REHAE	3 CENTER, INC	IS HIGHWAY 231				
		BEAVER	2 DAM, KY 42320				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE CC EFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 000	Initial Comments		N 000				
	was initiated 08/04/20	d Infection Control Survey 020 and concluded on lity was found to be in to 42 CFR 483.80.					

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

TITLE

(X6) DATE