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

PRINTED: 08/26/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------|--|---|-------------------------------|----------------------------|--|
| W | | 185358 | B. WING | | **Valuation and \$10.00 femoments in the second seco | C | | |
| NAME OF PROVIDER OR SUPPLIER | | | | _ | STREET ADDRESS, CITY, STATE, ZIP CODE | 08/12/2020 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | 50 SHEPHERD LANE | | | |
| BEDFORD SPRINGS HEALTH AND REHABILITATION | | | | BEDFORD, KY 40006 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | | | (X5) COMPLETION DATE | |
| F 000 | INITIAL COMMENTS | | | 000 | | | 7,5 | |
| 25 | 08/11/2020 and cor investigate KY 3117 Care unsubstantiate deficiencies cited. Focused Infection C 08/11/2020 through found to be in compinfectioin control region the Centers for Mediand the Centers for Prevention (CDC) regions investigated and the Centers for Prevention (CDC) regions investigated and the Centers for Prevention (CDC) regions investigated and the Centers for Prevention (CDC) regions in the Center (CDC) regions in t | rvey was initiated on acluded on 08/12/2020 to 73. The Division of Health ed the allegation with no In addition, a COVID-19 Control Survey was conducted 08/12/2020 The facility was obliance with 42 CFR 483.80 guations and has implemented dicaid and Medicare (CMS) Disease Control and ecommended practices to 19. Total census 39. | 2 | | | 2 | | |
| | prepare for COVID | TO. TOTAL CENSUS CO. | | | 3 | | | |
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| ASSOCIATION | CONTROL OF THE CONTRO | NED/CLIDDI IED DEDDESENTATIVE'S SIG | MATURE | | 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: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|-----------------|---|----|---|----------------------------------|------------------------------|-------------------------------|----------------------------|
| | | 185358 | | B. WING | | 0 yr | 5.5 | | 0 1 2/2020 | |
| NAME OF PROVIDER OR SUPPLIER BEDFORD SPRINGS HEALTH AND REHABILITATION | | | | 4. | 50 | REET ADDRESS, CITY, S SHEPHERD LANE DFORD, KY 40006 | | <u> </u> | 001 | 12/2020 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY) | | | FIVE ACTION SH CED TO THE APP | N SHOULD BE E APPROPRIATE | | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | ΕŒ | 000 | | | | | | |
| | A COVID-19 Focused Infection Control Survey was initiated on 08/11/2020 and concluded on 08/12/2020. The facility were found to be in compliance pursuant to 42 CFR 483.80. | | | | | | | | | 0 |
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| ARODATOD | / DIRECTOR'S OR PROVID | EDIOLIDALISA DEDDECENI | 7.711.1710.010. | 1171105 | ļ | TIT1 C | | 10 | | YE) DATE |

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING_ 100506 08/12/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **50 SHEPHERD LANE** BEDFORD SPRINGS HEALTH AND REHABILITA BEDFORD, KY 40006 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey was initiated on 08/11/2020 and concluded on 08/12/2020 to investigate Complaint KY 31173. The Division of Health Care unsubstantiated the allegation with no deficiencies cited. In addition a COVID-19 Focused Infection Control survey was conducted 08/11/2020 through 08/12/2020 and found the facility complaint with 42 CFR 483.80 infection control regulations.

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

TITLE

(X6) DATE