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

PRINTED: 10/15/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER BEDROCK HC AT GREEN MEADOWS, LLC SITREET ADDRESS, CITY, STATE, ZIP CODE 319 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047 (PACH) D. SUMMARY STATEMENT OF DESICIENCIES (EACH DESIGNERY MUST BE PRECEDED BY FILL REGULATORY OR IS: IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 10/06/2020. 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 73.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
BEDROCK HC AT GREEN MEADOWS, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 10/06/2020 and concluded on 10/06/2020. 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			185464	B. WING			10/06/2020	
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focus was initiated on 10/10/06/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommend COVID-19. Total co	sed Infection Control Survey 06/2020 and concluded on acility was found to be in CFR 483.80 infection control implemented the Centers for iid Services (CMS) and a Control and Prevention ed practices to prepare for ensus 73.					

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.

(X6) DATE

If continuation sheet 1 of 1

Office of Inspector General
STATEMENT OF DEFICIENCIES

STATE FORM

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100637	B. WING			10/06/2020	
	ROVIDER OR SUPPLIER	ADOWS, LLC 310 BOX	DDRESS, CITY, S (WOOD RUN F WASHINGTON	ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
N 000	was initiated 10/06/. 10/06/2020. The fa	ed Infection Control Survey 2020 and concluded on icility was found to be in int to 42 CFR 483.80.	N 000				
BORATORY	DIRECTOR'S OR PROVING	ER/SUPPLIER REPRESENTATIVE'S SIG		TITLE			

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