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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2020

NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HIGHPOINT DRIVE HOPKINSVILLE, KY 42240

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 11/18/2020 and concluded on 11/19/2020. The facility was 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 70.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER **BRADFORD HEIGHTS NURSING & REHABILITATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **950 HIGHPOINT DRIVE** **HOPKINSVILLE, KY 42240**

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 11/18/2020 and concluded on 11/19/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **100070**	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED **11/19/2020**

NAME OF PROVIDER OR SUPPLIER **BRADFORD HEIGHTS NURSING & REHABILITATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **950 HIGHPOINT DRIVE** **HOPKINSVILLE, KY 42240**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A COVID-19 Focused Infection Control Survey was conducted on 11/18/2020 through 11/19/2020. The facility was in compliance pursuant to 42 CFR 483.80.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE