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

PRINTED: 11/25/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185076	B. WING			11/25/2020	
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 PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 11/24 11/25/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 4/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention If practices to prepare for		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		(XX	(X3) DATE SURVEY COMPLETED	
	185076		B. WING			11/25/2020	
NAME OF PROVIDER OR SUPPLIER BRADFORD HEIGHTS NURSING & REHABILITATION				STREET ADDRESS, CITY, STATE, Z 950 HIGHPOINT DRIVE HOPKINSVILLE, KY 42240	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION DATE	
E 000	A COVID-19 Focuse Survey was initiated concluded on 11/25/2	d Emergency Preparedness on 11/24/2020 and 2020. The facility was found vith 42 CFR 483.73 related	E	000			
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

(X6) DATE TITLE

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.

Facility ID: 100070

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	100070			B. WING			11/25/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS 950 HIGHPOINT					RESS, CITY, STATE, ZIP CODE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ILLE, KY 4224 ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE			
	Initial Comments	Infection Control Surve 20 and concluded on ity was found to be in		TAG N 000		APPROPRIATE	DATE		

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

TITLE (X6) DATE