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

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
185330		B. WING		09/17/2020	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	1980	ET ADDRESS, CITY, STATE, ZIP CODE OLD GREENSBURG ROAD IPBELLSVILLE, KY 42718	130
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 000	A COVID-19 focus conducted on 09/1 to be in compliance Control and has im Medicare & Medicare Centers for Diseas (CDC) recommend	ed infection control survey was 7/2020. The facility was found e with 42 CFR 483.80 Infection plemented the Centers for aid Services (CMS) and e Control and Prevention led practices to prepare for ficient practice was identified.	F 000		
		RED/SLIDDI IED REDRESENTATIVE'S SIGNATI	105	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.

Facility ID 100392

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

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185330	B. WING		09/17/2020	
NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODI 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
E 000	survey was conduct facility was found to CFR 483.73 Emerg	ed Emergency Preparedness ted on 09/17/2020. The be in compliance with 42 gency Preparedness related to an arctice was identified.	EO	00		
AROPATORY	DIDECTOR'S OR DPAVIO	ER/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.

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING_ 09/17/2020 100392 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE NURSING AND REHABILITATION (CAMPBELLSVILLE, KY 42718 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 09/17/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X8) DATE