DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 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		1	1/30/2020		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
		OREHABILITATION CENTER		1980 OLD GREENSBURG ROAD				
		REHABILITATION CENTER		CAMPBELLSVILLE, KY 42718				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	D BE COMPLETION		
F 000	INITIAL COMMENTS		F 00	00				
	conducted on 11/30/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	Control and Prevention I practices to prepare for ent practice was identified.						
LABUKATURY	JIKEUTUKS UK PKUVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR		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.

PRINTED: 12/03/2020

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		185330	B. WING _			11/	30/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				1980 OLD GREENSBURG ROAD			
	IPBELLSVILLE NURSING AND REHABILITATION CENTER			CAMPBELLSVILLE, KY 42718			
(X4) ID		ATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX TAG			PREFIX	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG	REGULATORT ORT		IAG		DEFICIENCY)		
E 000	survey was conducted was found to be in co 483.73 Emergency Pl	Emergency Preparedness d on 11/30/2020. The facility mpliance with 42 CFR reparedness related to bractice was identified.	EC	000	DEFICIENCY)		
		SUPPLIER REPRESENTATIVE'S SIGNATUR	2E		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.

PRINTED: 12/08/2020

PRINTED: 12/08/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 100392 B. WING 11/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE NURSING AND REHABILITATION 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL NB ID (EACH OEFICIENCY COMPLETE N 000 Initial Comments N 000 N 000 N 000 INITIAL COMPLETE ID ID ID N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 11/30/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified. IIIII IIIIIIIIIIIIIII	Office of	Inspector General				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CAMPBELLSVILLE NURSING AND REHABILITATION (1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 (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 N 000 N 000 A COVID-19 focused infection control survey was conducted on 11/30/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. N 000						
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conducted on 11/30/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	N 000	Initial Comments		N 000		
		A COVID-19 focused conducted on 11/30/2 to be in compliance p	020. The facility was found ursuant to 42 CFR 483.80.			

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

TITLE

(X6) DATE