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

PRINTED: 09/02/2021 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	
		185270	B. WING		08/	08/27/2021	
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR				301 SOUTH M	ESS, CITY, STATE, ZIP CODE IAIN STREET .LE, KY 42717	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACI	ROVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	initiated and conclu facility was found n identified with 42 C and the facility has Medicare & Medica Centers for Diseas	ed infection control survey was ided on 08/27/2021. The o deficient practice was FR 483.80 Infection Control implemented the Centers for id Services (CMS) and e Control and Prevention led practices to prepare for	FC	00			
	COVID-19. The to						
					TITLE		(VG) 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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		185270	B. WING			08/27/2021	
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	survey was initiated 08/27/2021. No de	ed Emergency Preparedness I and concluded on ficient practice was identified Emergency Preparedness	E	0000	DEFICIENCY		
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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
STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY			
AND FEAR OF CORRECTION		DENTIFICATION NOWIDER.	A. BUILDING:		COMPLETED			
	100471		B. WING		08/27/2021			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CUMBERLAND VALLEY MANOR 301 SOUTH MAIN STREET								
	BURKESVILLE, KY 42717							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 000	A COVID-19 focuse initiated and conclu	ed infection control survey was ded on 08/27/2021. No as identified pursuant to 42	N 000					

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

TITLE

(X6) DATE