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

PRINTED: 09/20/2021 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		<u>.                                    </u>	09/0	02/2021
NAME OF PROVIDER OR SUPPLIER  CUMBERLAND VALLEY MANOR				30 <sup>-</sup>	REET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH MAIN STREET JRKESVILLE, KY 42717		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	conducted on 09/02 was identified with Control and has im Medicare & Medica Centers for Diseas	ed infection control survey was 2/2021. No deficient practice 42 CFR 483.80 Infection plemented the Centers for aid Services (CMS) and e Control and Prevention led practices to prepare for		000			
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	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.

**FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ B. WING 100471 09/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **301 SOUTH MAIN STREET CUMBERLAND VALLEY MANOR BURKESVILLE, KY 42717** (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted 09/02/2021. No deficient practice was identified pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MAN			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717		
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survey was conduct deficient practice v	sed Emergency Preparedness cted on 09/02/2021. No vas identified with 42 CFR y Preparedness related to	E 00	00		
E0024.	y reparedness related to	:			
	IDER/SUPPLIER REPRESENTATIVE'S SIG		TITLE	(X6) DATE	

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