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

PRINTED: 01/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185354	B. WING			12/2	23/2020
	ROVIDER OR SUPPLIER LLE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, 313 MAIN STREET FORDSVILLE, KY 42343	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	X (EACH CORRECTIVI 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 12/23 12/23/2020. The faci compliance with 42 C regulations and has i Medicare & Medicaid for Disease Control a recommended practic COVID-19. Total cen	d Infection Control Survey 2/2020 and concluded on ility was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Center and Prevention (CDC) ces 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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		185354	B. WING		12/	12/23/2020	
NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343	-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE	
E 000	Survey was initiated of concluded on 12/23/2	d Emergency Preparedness on 12/22/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	DEFICIENCY)			

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

(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: 100351

PRINTED: 01/06/2021 FORM APPROVED

Office of Inspector General

NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTI (A4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compiliance pursuant to 42 CFR 483.80 B. WING. STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ON 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 12/22/2020 and concluded on 12/23/2020. The facility was found to be in compiliance pursuant to 42 CFR 483.80	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTI (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 12/22/2020 and concluded on 12/23/2020. The facility was found to be in					A. BUILDING:					
FORDSVILLE NURSING AND REHABILITATION CENTI (X4) ID PREFIX TAG N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 12/22/2020 and concluded on 12/23/2020. The facility was found to be in			100351		B. WING		12	23/2020		
FORDSVILLE, KY 42343 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 12/22/2020 and concluded on 12/23/2020. The facility was found to be in	NAME OF P									
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was initiated 12/22/2020 and concluded on 12/23/2020. The facility was found to be in	N 000	Initial Comments			N 000					
	N 000	A COVID-19 Focused was initiated 12/22/20 12/23/2020. The faci	020 and concluded on lity was found to be in	vey	N 000					

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

TITLE (X6) DATE