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

PRINTED: 01/04/2021 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	
		185302	B. WING			12/29/2020	
	PROVIDER OR SUPPLIER SBURG NURSING AN	D REHABILITATION CENTER		101 FAII	ADDRESS, CITY, STATE, ZIP CODE RGROUNDS ROAD NSBURG, KY 40143		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	A COVID-19 Focus was concluded on found to be in compinfection control regithe Centers for Med (CMS) and Centers Prevention (CDC) reprepare for COVID-	sed Infection Control Survey 12/29/2020. The facility was pliance with 42 CFR 483.80 gulations and has implemented dicare & Medicaid Services is for Disease Control and recommended practices to -19. Total census 59.		000			

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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E 000 Initial Comments A COVID-19 Focused Emergency Preparedness Survey was concluded on 12/29/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA1	(X3) DATE SURVEY COMPLETED	
HARDINSBURG NURSING AND REHABILITATION CENTER HARDINSBURG, KY 40143 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED by FULL TAGG (EACH DEFICIENCY MUST BE PRECEDED by FULL TAGG REGULATORY OR LSC IDENTIFYING INFORMATION) FOR 1000 Initial Comments A COVID-19 Focused Emergency Preparedness Survey was concluded on 12/28/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).			185302	B. WING		12	12/20/2020	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROPER TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROPER TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROPER TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY					101 FAIRGROUNDS ROAD	1 12	20,2020	
A COVID-19 Focused Emergency Preparedness Survey was concluded on 12/29/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRI		COMPLETION	
	E 000	A COVID-19 Focus Survey was conclud was found to be in	ded on 12/29/2020. The facility compliance with 42 CFR	EO				
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	ABORATORY	DIRECTOR'S OR REQUID	ED/CLIDDLIED REDOSCENTATIVES CO.					

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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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ 100041 B. WING 12/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG NURSING AND REHABILITATIC HARDINSBURG, KY 40143 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was concluded on 12/29/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80

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

TITLE

(X6) DATE