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

PRINTED: 09/04/2020 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 _			08/	04/2020
NAME OF PROVIDER OR SUPPLIER HARDINSBURG NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP (101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143	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 CORRECTIVE AC' CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	#KY30610 and a CO Control Survey was in concluded on 08/04/2 unsubstantiated with was no deficient pract 483.80 infection control facility has implement & Medicaid Services Disease Control and recommended practic COVID-19. Total cens	ey investigating Complaint VID-19 Focused Infection nitiated on 08/04/2020 and 2020. #KY30610 was no deficiencies cited. There tice identified with 42 CFR rol regulations and the ted the Centers for Medicare (CMS) and Centers for Prevention (CDC) ces to prepare for		DOO			(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.

Facility ID: 100041

CENTE	KS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB_NO. 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY
- The state of the		A. BUILDIN	IG	COMPLETED	
		185302	B WING_		00/04/0000
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/04/2020
HARDINSBURG NURSING AND REHABILITATION CENTER				101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D. P.E. COMPLETION
E 000	Initial Comments		E 00	0	
	concluded on 08/04	ed Emergency Preparedness on 08/04/2020 and /2020. The facility was found for 42 CFR 483.73 related to			
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hy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ogram participation.

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

TITLE

(X8) DATE

PRINTED: 09/04/2020 FORM APPROVED

Office of Inspector General

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:	(X3) DATE SURVEY COMPLETED		
100041	3. WING	08/04/2020		
HARDINSBURG NURSING AND REHABILITATION CEN	DRESS, CITY, STATE, ZIP CODE GROUNDS ROAD BURG, KY 40143			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COMPARED TO THE PROPERTY PROVIDER'S PLAN OF COMPARED TO THE PROV	ON SHOULD BE COMPLETE BE APPROPRIATE DATE		
A Complaint Survey (#KY30610) and a COVID-19 Focused Infection Control Survey was initiated 08/04/2020 and concluded on 08/04/2020. #KY30610 was unsubstantiated with no deficiencies cited. There was no deficient practice identified pursuant to 42 CFR 483.80.	N 000			

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

TITLE (X6) DATE