DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/01/2020 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		185149	B WING	08/27/2020		
	ROVIDER OR SUPPLIER	REHABILITATION AND NURSING	STRE 120 L BAR			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	TION (X5) JLD BE COMPLETION OPRIATE DATE		
F 000			F 000			
	initiated on 08/26/ 08/27/2020. The compliance with 4 and has implement Medicaid Service: Disease Control a recommended pro-	sed infection control survey was (2020 and concluded on facility was found to be in 12 CFR 483.80 Infection Control inted the Centers for Medicare & (CMS) and Centers for and Prevention (CDC) actices to prepare for efficient practice was identified, was 79.				
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	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.

Facility ID 100489

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	185149			B, WING				08/27/2020		
NAME OF PROVIDER OR SUPPLIER LANDMARK OF BARDSTOWN REHABILITATION AND NURSING					120	EET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE WAY RDSTOWN, KY 40004		N		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE		(X5) COMPLETION DATE	
E 000	survey was initiated of concluded on 08/27/2 to be in compliance v	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No		E	000	4) a				
AROPATORY	OURFCTOR'S OR PROVIDES	VSUPPLIER REPRESENTATIVE'S SIGN	VATURF			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 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ B. WING_ 100489 08/27/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 LIFE CARE WAY LANDMARK OF BARDSTOWN REHABILITATION AND BARDSTOWN, KY 40004 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was initiated on 08/26/2020 and concluded on 08/27/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE