CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391   STATISHING CONDENCIONES AND PLAY OF CONSTRUCTION INFORMATION AND ALL STATUS INFORMATION CONSTRUCTION INFORMATION CONSTRUCTION INFORMATION AND ALL STATUS INFORMATION CONSTRUCTION CONSTRUCTION INFOR	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED   185149 b.WMG STREET ADDRESS, CITY, STATE, ZIP CODE 123/26/201   IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY 120 LIFE CARE WAY   LANDMARK OF BARDSTOWN REHABILITATION AND NURSING If the CARE WAY 120 LIFE CARE WAY 120 LIFE CARE WAY   PROVIDER OR SUPPLIER SUMMARY STATUMENT OF DEFORMORIES If the CARE WAY ISRAED COMRECTIVE ACTION SHOULD BE CROSS REFINEMENT OF CONFECTION COMPLETED   PROVIDER OR SUPPLIER SUMMARY STATUMENT OF DEFORMORIES IF ROUD CONFECTIVE ACTION SHOULD BE ISRAED CONFECTIVE ACTION SHOULD BE <t< td=""><td>CENTER</td><td>S FOR MEDICARE &amp;</td><td>MEDICAID SERVICES</td><td></td><td></td><td></td><td>OM</td><td>B NO. 0938-0391</td></t<>	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OM	B NO. 0938-0391	
NAME OF PROVIDER OR BUPPLER DIAL STREET ADDRESS, CITY, STATE, ZP CODE   LANDMARK OF BARDSTOWN REHABILITATION AND NURSING BITREET ADDRESS, CITY, STATE, ZP CODE 120 LIFE CARE WAY   MARK OF BARDSTOWN, RY 40004 PREVIX PROVIDERS PLANO CONSECTION CONSECTION   MARK OF BARDSTOWN, RY 40004 PREVIX PROVIDERS PLANO CONSECTION CONSECTION   MARK OF BARDSTOWN, RY 40004 PREVIX PROVIDERS PLANO CONSECTION CONSECTION   MARK OF DARDSTOWN, RY 40004 PREVIX PROVIDERS PLANO CONSECTION CONSECTION   YAG SUMMARY STATEMENT OF DESCED BY TILL PREVIX PROVIDERS PLANO CONSECTION STATE REPRESENCE TO TON BIOLID BE CONSECTION   F 000 INITIAL COMMENTS F 000 F 000 F 000 F 000   A COVID-19 Focused Infection Control Survey was conducted on 01/25/21. The facility was found to be in compliance with 42 CFR 483.80 F 000 <t< td=""><td colspan="2"></td><td></td><td></td><td colspan="3"></td><td colspan="2"></td></t<>									
LADDMARK OF BARDSTOWN REHABILITATION AND NURSION 129 LIFE CARE WAY BARDSTOWN, KV 40004   PRETRX Txc SUMMARY STATEMENT OF DEFICIENCIES INCOMENTATION OF LAD DEFICIENCY WAS BE PRECEDED BY FULL Txc IPROVIDENTS AN OF CORRECTION (EACH CORRECTIVE OF LAD DEFICIENCY WAS LAD DEFICIENCY OF LAD DEFICIENCY) IDEFICIENCY (EACH CORRECTIVE OF LAD DEFICIENCY WAS LAD DEFICIENCY) IDEFICIENCY   F 000 INITIAL COMMENTS F 000   A COVID-19 Focused Infection Control Survey was conducted on 01/25/21. The facility was as found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaide Services (CMS) and Centers for Disease Control and Prevention (CDC) centor and Centers to for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 68. F 000			185149	B. WING				01/25/2021	
LANDWARK OF BARDSTOWN REHABILITATION AND NURSING BARDSTOWN, KY 40004   (%1) D PREEK TAG ISUMMARY STATEMENT OF DEPOISINGES (EACH DEPOISINGED VIAIL REGULATIONY ON LSC DERITIPING INFORMATION) D PREEK TAG PROVIDERS HAN OF CORRECTION (EACH DEPOISINGED VIAIL REGULATIONY ON LSC DERITIPING INFORMATION) D PREEK TAG PROVIDERS HAN OF CORRECTION (CASS-REFIREREDDI TO THE APPROPRIME DEFICIENCY) CMULTING CAGSS-REFIRERED TO THE APPROPRIME DEFICIENCY) CMULTING CAGSS-REFIRERED TO THE APPROPRIME DEFICIENCY) CMULTING CAGSS-REFIRERED TO ACH OF CORRECTION (CASS) and Conters of the Compliance with 42 CFR 483.80 (Infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CAS) and Conters for Disease Control and (Prevention (CDC) recommended practices to prepare for COVID-19. Total census 66. F 000	NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE			
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Pretrix TxG (EACH CORFECTION VISITE EPRECEDED BY FULL REGULTIONY OR LSC IDENTIFYING INFORMATION) PRETRX TxG CEACH CORFERENCE ATION SHOULD BE CROSS-REFERENCE DT IN HEAPROPHIATE COMULA   F 000 INITIAL COMMENTS F 000					BARDSTO	VN, KY 40004			
A COVID-19 Focused Infection Control Survey was conducted on 01/25/21. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare &	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A	HOULD BE	COMPLETION	
was conducted on 01/28/21. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 60.	F 000	INITIAL COMMENTS	3	F 0	00				
		was conducted on 01 found to be in compli- infection control regu the Centers for Medic (CMS) and Centers for Prevention (CDC) rec	/25/21. The facility was ance with 42 CFR 483.80 lations and has implemented care & Medicaid Services or Disease Control and commended practices to						

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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DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185149	B. WING _			01/	25/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	K OF BARDSTOWN RE	HABILITATION AND NURSING		12	0 LIFE CARE WAY		
LANDINAN				B/	ARDSTOWN, KY 40004		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
1/10		,			DEFICIENCY)		
E 000	Survey was conducte was found to be in co	d Emergency Preparedness d on 01/25/21. The facility mpliance with 42 CFR	E	000			
	483.73 related to E-0	024 (D)(O).					
		SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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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## PRINTED: 02/01/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COM A. BUILDING:	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		100489	B. WING		01/25/2021	
ME OF PR	OVIDER OR SUPPLIER	STREET A	L DDRESS, CITY, STATE, 2	ZIP CODE		
ANDMAR	K OF BARDSTOWN R	FHARII ΙΤΑΤΙΟΝ ΔΝΠ	E CARE WAY FOWN, KY 40004			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	Initial Comments A COVID-19 Focused Infection Control Survey was initiated and concluded on 01/25/21. The facility was found to be in compliance pursuant to		N 000			
	42 CFR 483.80. Tota	al census 66.				

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