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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		185297				
NAME OF PROVIDER OR SUPPLIER SANSBURY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2625 BARDSTOWN ROAD SAINT CATHARINE, KY 40061			113/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 000	was initiated on 08 08/13/2020. The facompliance with 42 regulations and ha Medicare & Medicare for Disease	ised Infection Control Survey 8/12/2020 and concluded on acility was found to be in 2 CFR 483.80 infection control is implemented the Centers for aid Services (CMS) and se Control and Prevention ded practices to prepare for	F 000			
ABORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	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.

PRINTED: 09/01/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 185297 B. WING 08/13/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2625 BARDSTOWN ROAD **SANSBURY CARE CENTER** SAINT CATHARINE, KY 40061 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PRFFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 000 Initial Comments E 000 A COVID-19 Focused Emergency Preparedness Survey was initiated on 08/12/2020 and concluded on 08/13/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).

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

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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FORM APPROVED 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: ____ B. WING_ 100505 08/13/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2625 BARDSTOWN ROAD SANSBURY CARE CENTER** SAINT CATHARINE, KY 40061 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 08/12/2020 and concluded on 08/13/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total census 41.

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

TITLE

(X6) DATE