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

PRINTED: 06/04/2020 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
185342			B. WING				C 05/06/2020		
2		COLONIAL REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004				1 03	10012020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACI	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)			D BE COMPLÉTION	
F 000			F 00	00					
	An Abbreviated Survey investigating KY#31633 and a COVID-19 Focused Infection Control Survey was initiated on 05/05/2020 and concluded on 05/06/2020. Complaint KY#31633 was unsubstantiated. Total census 43.								
								+6	
							v .		
		E .							
								8	
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		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.

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

PRINTED: 06/04/2020 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			
185342			B. WING				С		
NAME OF PROVIDER OR SUPPLIER				STI	REET ADDRESS, CITY, STATE, ZIP CODE	<u> 05/</u>	06/2020		
SIGNATU	<u> </u>	COLONIAL REHAB & WELLNE	708 BARTLEY AVENUE BARDSTOWN, KY 40004						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE		
E 000	Initial Comments		ΕC	000					
	Survey was initiated concluded on 05/06	ted Emergency Preparedness on 05/05/2020 and ideas/2020. The facility was found with 42 CFR 483.73 related							
1									
3.									
						. 6			
						*			
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED 100347 B. WING 05/06/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **708 BARTLEY AVENUE** SIGNATURE HEALTHCARE AT COLONIAL REH BARDSTOWN, KY 40004 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating KY#31633 and a COVID-19 Focused Infection Control Survey was initiated 05/05/2020 and concluded on 05/06/2020. KY#31633 was unsubstantiated. 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

Office of Inspector General