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

PRINTED: 01/03/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 185336		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185336	B. WING	12			
	PROVIDER OR SUPPLIE	R ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMME	NTS	F 000				
	was initiated on 1 12/08/2020. The compliance with a regulations and h Medicare & Medic Centers for Disea	cused Infection Control Survey 2/08/2020 and concluded on facility was found to be in 42 CFR 483.80 infection control as implemented the Centers for caid Services (CMS) and ase Control and Prevention and practices to prepare for census 54.					
*	*						
					H	-	
ABODATON	ODECTORIC OR COOK	/IDER/SUPPLIER REPRESENTATIVE'S SIG	MATURE	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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185336			B. WING	12/	12/08/2020		
	PROVIDER OR SUPPLIEF	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069				
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E 000	Survey was initiate concluded on 12/0	used Emergency Preparedness ed on 12/08/2020 and 08/2020. The facility was found se with 42 CFR 483.73 related	E 000				
					N.		
			×				

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PRINTED: 01/03/2021 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: 100412 B. WING 12/08/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 EAST GRUNDY AVENUE** SPRINGFIELD NURSING AND REHABILITATION SPRINGFIELD, KY 40069 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG** DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 12/08/2020 and concluded on 12/08/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total census 54.

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

TITLE

(X6) DATE