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

PRINTED: 09/28/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185244	B. WING		0	C 09/15/2020	
NAME OF PROVIDER OR SUPPLIER  STANFORD CARE AND REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP ( 105 HARMON HEIGHTS STANFORD, KY 40484	<u>-</u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 000		tandard survey (KY32352) and	F	000			
	a COVID-19 focu initiated on 09/14 09/15/2020. The and no deficient pfacility was found CFR 483.80 Infectimplemented the Medicaid Service Disease Control arecommended pr	sed infection control survey was /2020 and concluded on complaint was unsubstantiated bractice was identified. The to be in compliance with 42 ction Control and has Centers for Medicare & s (CMS) and Centers for and Prevention (CDC) actices to prepare for total census was 73.					
:							
					22		
LABORATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGNAT	'URE	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.

Event ID: NFGL11

## 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 COMP	(X3) DATE SURVEY COMPLETED	
		185244	B. WNG		ı	C	
	ROVIDER OR SUPPLIER  D CARE AND REHAB, L		STREET ADDRESS, CITY, STATE, ZIP CODE  105 HARMON HEIGHTS  STANFORD, KY 40484				
(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 CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	survey was initiated of concluded on 09/15/2 to be in compliance v	2020. The facility was found with 42 CFR 483.73 dness related to E0024. No	ΕO	000			
	- File				₹4		
	>>			¥			
_		1					
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X8) 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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING\_ 09/15/2020 100290 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **105 HARMON HEIGHTS** STANFORD CARE AND REHAB, LLC STANFORD, KY 40484 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 **Initial Comments** A complaint investigation (KY32352) and a COVID-19 focused infection control survey was initiated on 09/14/2020 and concluded on 09/15/2020. The complaint was unsubstantiated and no deficient practice was identified. 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