

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

PRINTED: 01/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2012
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Plan Approval:</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (111) Unprotected</p> <p>Smoke Compartment: Four (4)</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Dry)</p> <p>Generator: Type II Diesel and Type II Natural Gas</p> <p>A standard Life Safety Code survey was conducted on 01/04/12. Bluegrass Care and Rehabilitation Center was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	K 000		
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 01/03/12 and concluded on 01/06/12 with no deficiencies cited.</p>	F 000		
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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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100492	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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) COMPLETE DATE
N 000	<p>INITIAL COMMENTS</p> <p>A Relicensure Survey was initiated on 01/03/12 and concluded on 01/06/12 with no deficiencies cited.</p>	N 000		

TITLE

(X6) DATE

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