CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185133	B. WING	3		04/07/2020	
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
				100 WEST RAMSEY			
				DAWSON SPRINGS, KY 42408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 000	was initiated and con facility was found to b CFR 483.80 Infection	d Infection Control Survey cluded on 04/08/2020. The be in compliance with 42 control regulations and Centers for Medicare and MS) and Centers for Prevention (CDC) ctices to prepare for	F	000			
		SUPPLIER REPRESENTATIVE'S SIGNATU	RF		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

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AND PLAN OF PR TRADEWA (X4) ID PREFIX TAG E 000	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
TRADEWA	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
TRADEWA		185133	B. WING			04	/07/2020
(X4) ID PREFIX TAG E 000	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG E 000	ATER POINTE				WEST RAMSEY VSON SPRINGS, KY 42408		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD		D BE	(X5) COMPLETION DATE
	Initial Comments A COVID-19 Focuse Survey was initiated concluded on 04/07/2	d Emergency Preparedness		000		PRIATE	
LABORATORY D							

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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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
100436		B. WING	04/07/2020		
OVIDER OR SUPPLIER	STREET	•		•	
TER POINTE			408		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
was conducted on 04	4/08/2020. The facility was	N 000			
	F CORRECTION OVIDER OR SUPPLIER TER POINTE SUMMARY S (EACH DEFICIENC REGULATORY OR Initial Comments A COVID-19 Focuse was conducted on 0- found to be in compl	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         100436         OVIDER OR SUPPLIER       STREET /         TER POINTE       100 WEI DAWSO         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Initial Comments         A COVID-19 Focused Infection Control Survey was conducted on 04/08/2020. The facility was found to be in compliance pursuant to 42 CFR	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         100436       B. WING         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE,         TER POINTE       100 WEST RAMSEY         DAWSON SPRINGS, KY       42         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Initial Comments       N 000       N 000         A COVID-19 Focused Infection Control Survey was conducted on 04/08/2020. The facility was found to be in compliance pursuant to 42 CFR       N 000	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         100436       B. WING         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         100 WEST RAMSEY       DAWSON SPRINGS, KY         100 WEST RAMSEY       ID       PREFIX         100 KEST RAMSEY       N 000       PREFIX       CROSS-REFERENCED TO DEFICIENCIEN         101 Initial Comments       N 000       N 000       A COVID-19 Focused Infection Control Survey       N 000         101 A COVID-19 Focused Infection Control Survey       M	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:

OIH611