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

PRINTED: 05/14/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185318	B. WING	B. WING		04/16/2020	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE  1253 LAKE BARKLEY DRIVE  KUTTAWA, KY 42055			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	A COVID-19 Focuse was initiated on 04/1 04/16/2020. There widentified at 42 CFR regulations and the facenters for Medicare and Centers for Dise (CDC) recommended COVID-19. Total cen	d Infection Control Survey 5/2020 and concluded on as no deficient practice 483.80 infection control acility has implemented the a Medicaid Services (CMS) ase Control and Prevention d practices to prepare for		000	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: 05/14/2020 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	
		185318	B. WING_	B. WING		04/16/2020	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE  1253 LAKE BARKLEY DRIVE  KUTTAWA, KY 42055			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 04/16/2	2020. There was no ntified at 42 CFR 483.73	E	000			
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	 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.

PRINTED: 05/14/2020 FORM APPROVED

Office of Inspector General

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE S COMPLI	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 04/15/2020 and concluded on 04/16/2020. There was no deficient practice  STREET ADDRESS, CITY, STATE, ZIP CODE  1253 LAKE BARKLEY DRIVE  KUTTAWA, KY 42055  ID PROVIDER'S PLAN OF CORRECTION (SA)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  N 000  N 000  N 000  A COVID-19 Focused Infection Control Survey was initiated 04/15/2020 and concluded on 04/16/2020. There was no deficient practice									
CHRISTIAN CARE CENTER OF KUTTAWA, LLC    1253 LAKE BARKLEY DRIVE   KUTTAWA, KY   42055	NAME OF PE	ROVIDER OR SUPPLIER		VH/10/2020					
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 04/15/2020 and concluded on 04/16/2020. There was no deficient practice	1253 I AKE BARKI FY DRIVE								
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 04/15/2020 and concluded on 04/16/2020. There was no deficient practice			KUTIAWA						
A COVID-19 Focused Infection Control Survey was initiated 04/15/2020 and concluded on 04/16/2020. There was no deficient practice	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERT	D BE	(X5) COMPLETE DATE		
was initiated 04/15/2020 and concluded on 04/16/2020. There was no deficient practice	N 000	Initial Comments		N 000					
	N 000	A COVID-19 Focused was initiated 04/15/20 04/16/2020. There w	020 and concluded on vas no deficient practice	N 000					

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

TITLE (X6) DATE