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

PRINTED: 05/20/2020 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	
	185401 B. WING			05/01/2020			
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 813 SOUTH MAIN STREET BROWNSVILLE, KY 42210	DDE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 000	was initiated on 04/28 05/01/2020. The facili compliance with 42 Cregulations and has in Medicare and Medicar Disease Control and recommended practic COVID-19. Total cens	d Infection Control Survey 8/2020 and concluded on ity was found to be in FR 483.80 infection control implemented the Centers for aid Services and Centers for Prevention (CDC) ces to prepare for	F	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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E 000	Initial Comments		E 00	0			
	Survey was initiated of concluded on 05/01/2	d Emergency Preparedness on 04/28/2020 and 020. The facility was found with 42 CFR 483.73 related					

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

TITLE (X6) DATE

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 813 SOUTH MAIN STREET BROWNSVILLE, KY 42210 (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 on 04/28/2020 and concluded on 05/01/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED		
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