DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FO	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		185167	B. WING		C	5/08/2020
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HOPKINS	CENTER			460 SOUTH COLLEGE STREET		
TIOP KING	CENTER			WOODBURN, KY 42170		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
	was initiated on 05/08 05/08/2020. The facil compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	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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		ID HUMAN SERVICES				FOR	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185167	B. WING _	B. WING			/08/2020
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HOPKINS	CENTED			460	0 SOUTH COLLEGE STREET		
HOFKING	CENTER			W	OODBURN, KY 42170		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000			
	Survey was initiated of concluded on 05/08/2	d Emergency Preparedness on 05/08/2020 and 020. The facility was found ith 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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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Office of Inspector General           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:           100408			(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		05/08/2020			
IAME OF PF	ROVIDER OR SUPPLIER	STREET	I ADDRESS, CITY, STATE, ZIP CODE				
OPKINS	CENTER		JTH COLLEGE STR SURN, KY 42170	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	OVIDER'S PLAN OF CORRECTION (X5 I CORRECTIVE ACTION SHOULD BE COMPL REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)		
N 000	Initial Comments		N 000				
	was initiated 05/08/20	d Infection Control Survey 020 and concluded on ility was found to be in to 42 CFR 483.80.					

H8P811