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

PRINTED: 06/10/2020 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	
		185320	B. WING _	B. WING		05/27/2020	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LA CENTER				STREET ADDRESS, CITY, STATE, ZIP C 252 W. 5TH STREET LA CENTER, KY 42056	CODE		2 2
(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 ACT CROSS-REFERENCED TO 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	was initiated on 05/26 05/27/2020. The facil compliance with 42 C regulations and has i Medicare & Medicaid Centers for Disease 0	d Infection Control Survey 6/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention	F				
LABORATORY	DIRECTOR'S OR PROVIDER/S	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.

Facility ID: 100011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185320	B. WING	B. WING		05/27/2020	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LA CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH STREET LA CENTER, KY 42056			
(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 CORRECT CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Survey was initiated of concluded on 05/27/2	d Emergency Preparedness on 05/26/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	000	DEFICIENCY)		
L ARORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	PF	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:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND TENTO CONTROL	IDENTIFICATION	NDEI (.	A. BUILDING:		OOWII EETEB		
	100011		B. WING		05/2	05/27/2020	
NAME OF PROVIDER OR SUPPLI	ER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
LIFE CARE CENTER OF LA CENTER LA CENTER, KY 42056							
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY RY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
N 000 Initial Commen	000 Initial Comments						
A COVID-19 Fo was initiated 05 05/27/2020. Ti	cused Infection Control Sui /26/2020 and concluded on e facility was found to be in suant to 42 CFR 483.80.	1	N 000				

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

TITLE (X6) DATE