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

PRINTED: 05/21/2020 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185264	B. WNG		n _z	C 04/16/2020	
NAME OF P	ROVIDER OR SUPPLIER		STOR	ET ADDRESS, CITY, STATE, ZIP COD		rr 1012020	
NAME OF F	NOVIDER OR SOFFEICK		l .	BRUCE COURT	-		
CHARLES	TON HEALTH CARE CE	NTER		VILLE, KY 40422			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	UMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION I DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE LATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		I SHOULD BE	(X5) COMPLETION DATE		
F 000	F 000 INITIAL COMMENTS An abbreviated standard survey (KY31543) and		F 000				
	a COVID-19 focused initiated on 04/15/2020. The cor and no deficient practicality was found to CFR 483.80 Infection implemented the Certain intercept of the control of the	l infection control survey was 20 and concluded on implaint was unsubstantiated citice was identified. The be in compliance with 42 in Control and has inters for Medicare &					
	Medicaid Services (Coisease Control and recommended practice) COVID-19. The total	ices to prepare for					
k							
	1		105			ING BATT	
LABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATU	JKE	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.

FORM APPROVED Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ____ C B. WNG_ 04/16/2020 100037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **203 BRUCE COURT CHARLESTON HEALTH CARE CENTER** DANVILLE, KY 40422 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY31543) and a COVID-19 focused infection control survey was initiated on 04/15/2020 and concluded on 04/16/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X5) DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
	ROVIDER OR SUPPLIER	185264 ENTER	B. WING 04/16/2020 STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40422				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION		
E 000	survey was initiated concluded on 04/16/ to be in compliance	2020. The facility was found with 42 CFR 483.73 dness related to E0024. No	E 000				
LABORATORY	DIRECTOR'S OR PROVINCE	VSUPPLIER REPRESENTATIVE'S SIGNATU	IDE	TITLE	(X6) DATE		

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