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

PRINTED: 01/05/2021 FORM APPROVED

STATEMENT	T OF DEFICIENCIES	(X1) PROMPTE OF THE COLOR				OMB NO. 0938-0391		
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185190	B. WING	s				
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH LA GRANGE				10:	REET ADDRESS, CITY, STATE, ZIP CODE 25 NEW MOODY LANE A GRANGE, KY 40031	1 <u>2</u>	2/18/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	II D BE	(X5) COMPLETION DATE	
F 000	A COVID-19 Focus was conducted by the Medicaid Services (facility was found to CFR 483.80 infection implemented the CI Control and Prevented to Control and Prevented to Control and Prevented to Control and Cont	sed Infection Control Survey the Centers for Medicare & (CMS) on 12/18/2020. The set in compliance with 42 on control regulations and has MS and Centers for Disease tion (CDC) recommended for COVID-19. Total census	F	000	DEFICIENCY)			
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE		TITLE		(XR) 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

(X6) DATE

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

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STATEMEN'	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB NO. 0938-039	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185190	B. WING				
	PROVIDER OR SUPPLIER THEALTH LA GRANG	E	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NEW MOODY LANE LA GRANGE, KY 40031			12/18/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JI D BE	(X5) COMPLETION DATE
E 000	Medicare & Medicare 12/18/2020. The fa	sed Emergency Preparedness ted by the Centers for id Services (CMS) State on cility was found to be in CFR 483.73 related to	E	000	DEPICIENCY		
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE		TITLE		(YE) 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

(X6) DATE

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 100763 B. WING _ 12/18/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1025 NEW MOODY LANE BAPTIST HEALTH LA GRANGE** LA GRANGE, KY 40031 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG ROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was completed on 12/18/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE