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

PRINTED: 01/14/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DA	(X3) DATE SURVEY COMPLETED		
185090			B. WING			12/23/2020	
	PROVIDER OR SUPPLIEF POINT CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042			12/23/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
F 000	Survey was initiate concluded on 12/2	used Emergency Preparedness ed on 12/23/2020 and 3/2020. The facility was found e with 42 CFR 483.73 related	F 000				
	was initiated and of facility was found to CFR 483.80 infection implemented the Computer Medicaid Services Disease Control are	sed Infection Control Survey oncluded on 12/23/2020. The obe in compliance with 42 ion control regulations and has centers for Medicare & (CMS) and the Centers for nd Prevention (CDC) ctices to prepare for lensus 131.		To the second se			
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BORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATUDE	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.

(X6) DATE

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
100022			B. WING		12/23/2020		
	PROVIDER OR SUPPLIER POINT CENTER	7300 WO	ODRESS, CITY, ODSPOINT I			Utts	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULID BE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000	· .	a		
	A COVID-19 Focused Infection Control Survey was initiated and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare &						
		(CMS) and the Centers for d Prevention (CDC) etices to prepare for ensus 131.					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE