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

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER		B. WING	à				
NAME OF PROVIDER OR SUPPLIER				l 12.	12/17/2020		
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203				
PREFIX (EACH DEFICIENC			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)		(X5) COMPLETION DATE		
was initiated on 12 12/17/2020. The facompliance with 42 regulations and ha Medicare & Medica Centers for Diseas	sed Infection Control Survey /16/2020 and concluded on acility was found to be in 2 CFR 483.80 infection control s implemented the Centers for aid Services (CMS) and se Control and Prevention ded practices to prepare for	F	DEFICIENC	Y)			
AROGANON	DER/SUPPLIER BEPBESENTATIVE'S SIGN		TITLE		(Ve) 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	185029		B. WING	i	12	12/17/2020	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER				920	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH FOURTH STREET JISVILLE, KY 40203	_   _  2	1772020
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 000	Survey was initiated concluded on 12/17	sed Emergency Preparedness d on 12/16/2020 and 1/2020. The facility was found with 42 CFR 483.73 related	E	000	DEFICIENCY)		
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	,	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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING 100200 12/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET **CHRISTIAN HEALTH CENTER** LOUISVILLE, KY 40203 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION in (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 12/16/2020 and concluded on 12/17/2020. 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