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

PRINTED: 07/07/2020 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		
		185232	B. WING		07.	07/07/2020	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER				116 5	ET ADDRESS, CITY, STATE, ZIP CODE OUTH COMMONWEALTH AVENUE BIN, KY 40701		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE	
F 000	A COVID-19 focused initiated on 07/06/2020 07/07/2020. The fact compliance with 42 cand has implemented Medicaid Services (C Disease Control and recommended practi	d infection control survey was 20 and concluded on ility was found to be in CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for ient practice was identified.	F	000			
					3		
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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.

PRINTED: 07/07/2020 **FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ B. WING 100540 07/07/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE **CHRISTIAN HEALTH CENTER CORBIN, KY 40701** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was initiated on 07/06/2020 and concluded on 07/07/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE

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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	
185232			B. WING_		07	07/07/2020	
	N HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40701				
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€ 000	Initial Comments		E	000		2	
	survey was initiated of concluded on 07/07/2 to be in compliance was	2020. The facility was found with 42 CFR 483.73 clased to E0024. No					
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:			7.1	•		27	
						A	
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE		(X6) DATE	

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