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

PRINTED: 11/02/2021 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			10/25/2021	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  116 SOUTH COMMONWEALTH AVENUE  CORBIN, KY 40702			
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH APPROVIDER'S PLAN OF CORRECT PROVIDER'S PLAN OF CORRECT PROVI		BE	(X5) COMPLETION DATE
F 000	conducted on 10/2s was identified with Control and the factor Centers for Medical and Centers for District (CDC) recommend COVID-19. The to	ed infection control survey was 5/2021. No deficient practice 42 CFR 483.80 Infection illity has implemented the are & Medicaid Services (CMS) sease Control and Prevention ded practices to prepare for tal census was 86.		0000			
LABUKATUK	T DIKECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	INATURE		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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		185232	B. WING			10/25/2021	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE CORBIN, KY 40702			
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E 000	Initial Comments  A COVID-19 focus survey was conduct deficient practice w	ed Emergency Preparedness sted on 10/25/2021. No vas identified with 42 CFR Preparedness related to		000			
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

TITLE

(X6) DATE

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Office of Inspector General STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING 100540 10/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 116 SOUTH COMMONWEALTH AVENUE **CHRISTIAN HEALTH CENTER CORBIN, KY 40702** SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 10/25/2021. No deficient practice was identified pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE