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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		185147	B. WING _		10	10/21/2020	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  200 STERLING DRIVE  HOPKINSVILLE, KY 42240	•		
(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 CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 000	A COVID-19 Focuser was initiated on 10/20 10/21/2020. The facil compliance with 42 Coregulations and has in Medicare & Medicaid Centers for Disease (CDC) recommended COVID-19. Total cens	d Infection Control Survey 0/2020 and concluded on ity was found to be in IFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for	FC	TITLE		(X6) DATE	

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

(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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185147	B. WING _	NG		10/21/2020	
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CODE  200 STERLING DRIVE  HOPKINSVILLE, KY 42240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG				(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 10/21/2	d Emergency Preparedness on 10/20/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	DEFICIE	ENCY)		
	DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATUI	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.

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Office of Inspector General

	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3		COMPLETED	X3) DATE SURVEY COMPLETED	
	100486	B. WING		10/21/2020		
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE			
CHRISTIAN HEALTH CENTER		RLING DRIVE SVILLE, KY 4224	10			
PREFIX (EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	Έ	
N 000 Initial Comments		N 000				
A COVID-19 Focused Imwas initiated 10/20/2020 10/21/2020. The facility compliance pursuant to 4	and concluded on was found to be in					

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

TITLE (X6) DATE