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

PRINTED: 07/17/2020 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3)	(X3) DATE SURVEY COMPLETED	
185265			B. WING				C 06/09/2020	
NAME OF PROVIDER OR SUPPLIER  GRANT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		CODE	00/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	KY#00031814, Com COVID-19 Focused initiated on 06/08/20 06/09//2020. Comp Complaint KY #0003 with no deficiencies to be in compliance control regulations a Centers for Medicar and Centers for Dise	rvey investigating Complaint aplaint KY #00031817, and a Infection Control Survey was 220 and concluded on laints KY#00031814 and 31817 were unsubstantiated cited. The facility was found with 42 CFR 483.80 infection and has implemented the e & Medicaid Services (CMS) ease Control and Prevention and practices to prepare for	FC	000				
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATLIDE	_	TITLE	<del></del>	(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.

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR A SUMMARY STATEMENT OF DEFICIENCIES ID PROVENTY (EACH OF CROSS-RESERVED)  FOR A SUMMARY STATEMENT OF DEFICIENCIES OF A SUMMARY STATEMENT OF DEFICIENCIES	COMPLETED  C 06/09/2020 S, CITY, STATE, ZIP CODE  ANE VN, KY 41097
RANT CENTER  STREET ADDRESS  201 KIMBERLY L WILLIAMSTOW  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR CROSS-RE	S, CITY, STATE, ZIP CODE  ANE  VN, KY 41097
GRANT CENTER  201 KIMBERLY L WILLIAMSTOW  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROV PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) TAG CROSS-RE	S, CITY, STATE, ZIP CODE  ANE  VN, KY 41097
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVPREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) TAG CROSS-RE	VN, KY 41097
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH O TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-RE	IDER'S PLAN OF CORRECTION
E 000 Initial Community	CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETIO DATE
E 000 Initial Comments E 000	
A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/08/2020 and concluded on 06/09/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	
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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.

TITLE

(X6) DATE

(X6) DATE

If continuation sheet 1 of 1

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 100594 B. WING 06/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **201 KIMBERLY LANE GRANT CENTER** WILLIAMSTOWN, KY 41097 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX 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 Complaint Survey investigating Complaint KY#00031814, Complaint KY #00031817, and a COVID-19 Focused Infection Control Survey was initiated on 06/08/2020 and concluded on 06/09//2020. Complaints KY#00031814 and Complaint KY #00031817 were unsubstantiated with no deficiencies cited. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 87.

TITLE

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

STATE FORM