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

PRINTED: 01/06/2021 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	
		185346	B. WING	B. WING		12/23/2020	
NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE 1614 WEST PARRISH AVENUE OWENSBORO, KY 42301	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 12/2: 12/23/2020. The facil compliance with 42 C regulations and has i Medicare and Medica Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 1/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for aid Services (CMS) and Control and Prevention If practices to prepare for		DOOD			(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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	185346		B. WING			12/23/2020	
NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, Z 1614 WEST PARRISH AVENUE OWENSBORO, KY 42301	IP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			(X5) COMPLETION DATE	
E 000	Survey was initiated of concluded on 12/23/2	d Emergency Preparedness on 12/21/2020 and 2020. The facility was found vith 42 CFR 483.73 related	E	000			
		SUPPLIER REPRESENTATIVE'S SIGNATURE		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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE : COMPI	(X3) DATE SURVEY COMPLETED	
				B. WING 12/23/2020			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1614 WEST PARRISH AVENUE							
HERMITAGE CARE AND REHABILITATION CENTER OWENSBORO, KY 42301							
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000				
N 000	A COVID-19 Focuse was initiated on 12/2	d Infection Control Survey 1/2020 and concluded on lity was found to be in to 42 CFR 483.80.	N 000				

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

TITLE (X6) DATE