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

PRINTED: 01/12/2021 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	
		185298	B. WING			12/3	28/2020
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME				1	TREET ADDRESS, CITY, STATE, ZIP CODE 901 WEST HIGHWAY 90 BYPASS NONTICELLO, KY 42633		K
(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 SHOUT FAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE	
F 000	A COVID-19 focus conducted on 12/20 to be in compliance Control and has im Medicare & Medica Centers for Diseas (CDC) recommend	ed infection control survey was 8/2020. The facility was found a with 42 CFR 483.80 Infection plemented the Centers for aid Services (CMS) and e Control and Prevention led practices to prepare for ficient practice was identified.	F	0000	DEFICIENCY)		
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185298	B. WING		!	12/2	8/2020
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP (1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633	CODE		:
(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 SHOU TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
E 000	survey was conduct facility was found to CFR 483.73 Emerg	sed Emergency Preparedness sted on 12/28/2020. The so be in compliance with 42 gency Preparedness related to nt practice was identified.	E	2000			
ABORATOR	DIV DIDECTOR'S OR REQUI	IDED/SLIDDI IER REDRESENTATIVE'S SIG	NATURE	TITLE			(XB) 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.

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 100485 12/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS HICKS GOLDEN YEARS NURSING HOME MONTICELLO, KY 42633 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 12/28/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

STATE FORM

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

Office of Inspector General

TITLE

(X6) DATE