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

PRINTED: 11/24/2020 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	
		185167	B. WING _			11/24/2020	
NAME OF PROVIDER OR SUPPLIER  HOPKINS CENTER				STREET ADDRESS, CITY, STATE, ZI 460 SOUTH COLLEGE STREET WOODBURN, KY 42170	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIA		
F 000	was initiated on 11/23 11/24/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 8/2020 and concluded on ity was found to be in FR 483.80 infection control implemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for sus 41.				(VC) DATE	
I ABORATORY I	DIRECTOR'S OR PROVIDER/S	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.

Facility ID: 100408

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 Focused Emergency Preparedness		E	000			
	Survey was initiated of concluded on 11/24/2						
I ABORATORY	 	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER  HOPKINS CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  460 SOUTH COLLEGE STREET  WOODBURN, KY 42170   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 11/23/2020 and concluded on 11/24/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED			
HOPKINS CENTER  ### WOODBURN, KY 42170    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   N 000   Initial Comments   N 000   A COVID-19 Focused Infection Control Survey was initiated 11/23/2020 and concluded on 11/24/2020. The facility was found to be in   10   PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)      N 000   N 000   N 000   N 000   N 000   N 000	100408			B. WING			11/24/2020			
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
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A COVID-19 Focused Infection Control Survey was initiated 11/23/2020 and concluded on 11/24/2020. The facility was found to be in	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE			
was initiated 11/23/2020 and concluded on 11/24/2020. The facility was found to be in	N 000	Initial Comments		N 000						
		A COVID-19 Focused was initiated 11/23/20 11/24/2020. The faci	020 and concluded on lity was found to be in							

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

TITLE (X6) DATE