DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED	
		185472	B. WING			12/	/08/2020	
NAME OF PROVIDER OR SUPPLIER JOSEPH EDDIE BALLARD WESTERN KENTUCKY VETERANS CEN				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				926 VETERANS DRIVE				
JUGELITE	JUSEPH EDDIE BALLARD WESTERN RENTUCKT VETERANS CEN			HANSON, KY 42413				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG				COMPLETION DATE	
		,			DEFICIENCY)			
F 000	INITIAL COMMENTS A COVID-19 Focused was initiated on 12/07 12/08/2020. The faci compliance with 42 C regulations and has in	d Infection Control Survey 7/2020 and concluded on lity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Center nd Prevention (CDC) ces to prepare for		000				
LABORATORY [DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	E		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.

PRINTED: 12/11/2020

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		
		185472	B. WING _			12/	08/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		RN KENTUCKY VETERANS CEN		920	6 VETERANS DRIVE		
JUSEFIL		AN RENTOCKT VETERANS CEN		HA	ANSON, KY 42413		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
					DEFICIENCY)		
E 000	Initial Comments	d Emergency Preparedness	EC	000			
	Survey was initiated on 12/07/2020 and concluded on 12/08/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	=		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.

PRINTED: 12/11/2020

PRINTED: 12/11/2020 FORM APPROVED

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
100978		B. WING		12/08/2020		
ROVIDER OR SUPPLIER	IERN KENTUCKY VE	ERANS DRIVE	, ZIP CODE			
(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLE DATE	
was initiated 12/07/2 12/08/2020. The fac	2020 and concluded on cility was found to be in	N 000				
	DF CORRECTION ROVIDER OR SUPPLIER EDDIE BALLARD WEST SUMMARY S (EACH DEFICIEN REGULATORY OF Initial Comments A COVID-19 Focuse was initiated 12/07/2 12/08/2020. The fac	TOP CORRECTION IDENTIFICATION NUMBER: 100978 ROVIDER OR SUPPLIER STREET A PODIE BALLARD WESTERN KENTUCKY VET EDDIE BALLARD WESTERN KENTUCKY VET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	

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