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

PRINTED: 09/22/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) D/	(X3) DATE SURVEY COMPLETED	
		185093				C 09/17/2021		
	PROVIDER OR SUPPLIER			109	ET ADDRESS, CITY, STATE, ZIP CODE HOMEWOOD BLVD. SGOW, KY 42141		5/17/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
E 000	Survey was initiate concluded on 09/1	sed Emergency Preparedness d on 09/16/2021 and 7/2021. The facility was found e with 42 CFR 483.73 related		000				
AROPATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NIATUDE		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	
185093			B. WING			C 09/17/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 109 HOMEWOOD BLVD. GLASGOW, KY 42141	E, ZIP CODE	09/1//2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD E O THE APPROPRI	BE COMPLETION	
F 000	INITIAL COMMEN	тѕ	FO	000			
,	Infection Control Si 09/16/2021 and con Complaint KY#000 with no deficiencies	a COVID-19 Focused urvey was initiated on ncluded on 09/17/2021. 34545 was unsubstantiated scited. The facility was found					
	to be in compliance control regulations Centers for Medica and Centers for Dis	e with 42 CFR 483.80 infection and has implemented the re & Medicaid Services (CMS) sease Control and Prevention ed practices to prepare for			a.		
			*				
		**					
	-						
ARODATORY	DIDECTORIC OR COOK	ER/SUPPLIER REPRESENTATIVE'S SIC		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.

Office of Inspector General

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100015	100015		B. WING			
	PROVIDER OR SUPPLIER	ow -	109 HO	DDRESS, CITY, ST MEWOOD BLV DW, KY 42141		-	17/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	D BE COMPLETE	
N 000	A COVID-19 Focus was initiated 09/16/09/17/2021. The facompliance pursua	2021 and conclacility was found	uded on I to be in	N 000				
	n n							

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

TITLE

(X6) DATE