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

PRINTED: 02/09/2021 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) DATE SURVEY COMPLETED 10/28/2020	
		185197				
	PROVIDER OR SUPPLIER POINT/LEXINGTON H	EALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	# §	E 000			
	Survey was initiate concluded on 10/28	sed Emergency Preparedness d on 10/27/2020 and 3/2020. The facility was found with 42 CFR 483.73 related			•	
F 000	INITIAL COMMEN	ΓS	F 000			
	was initiated on 10/ 10/28/2020. The facompliance with 42 regulations and has Centers for Disease (CDC) recommend	sed Infection Control Survey 127/2020 and concluded on acility was found to be in CFR 483.80 infection control is implemented the CMS and a Control and Prevention ed practices to prepare for all census was 110.				
				g =		
						*
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 100110 10/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD NORTHPOINT/LEXINGTON HEALTHCARE CEN **LEXINGTON, KY 40515** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 10/27/2020 and concluded on 10/28/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 110.

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

TITLE

(X6) DATE