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

PRINTED: 12/11/2020 FORM APPROVED OMB NO. 0938-0391

STATEMEN'	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			<u>OMB NO. 0938-039</u>		
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185236	B. WING				
	PROVIDER OR SUPPLIER  BORO CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD ROAD OWENSBORO, KY 42303			12/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE	(X5) COMPLETION DATE	
F 000	12/10/2020. The fa with 42 CFR 483.80 and has implemented	sed Infection Control Survey 1020 and concluded on cility was found in compliance infection control regulations ed the Centers for Medicare & CMS) and Centers for d Prevention (CDC) tices to prepare for	F 000	DEFICIENCY)			
BORATORY	DIRECTORIO CE CONTRA						
DORATORY L	PINECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	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 program participation.

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

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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	
		185236	B. WING			
	PROVIDER OR SUPPLIER		STF 120	REET ADDRESS, CITY, STATE, ZIP CODE DE LEITCHFIELD ROAD VENSBORO, KY 42303	<u>  12</u>	/10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION : TAG CROSS-REFERENCED TO THE A DEFICIENCY)		HOULD BE COMPLETIC	
E 000	Survey was initiated concluded on 12/10	eed Emergency Preparedness d on 12/09/2020 and /2020. The facility was found with 42 CFR 483.73 related	E 000			
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	IATHE	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.

(X6) DATE

PRINTED: 12/11/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_ COMPLETED B. WING 100093 12/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD ROAD **OWENSBORO CENTER** OWENSBORO, KY 42303 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 12/09/2020 and concluded on 12/10/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE