		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVED IO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185364	B. WING		12/15/2020		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
OWENTO				905 HWY 127 NORTH OWENTON, KY 40359			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	was conducted on 12 found to be in complia infection control regul the Centers for Medic (CMS) and Centers for	d Infection Control Survey /15/2020. The facility was ance with 42 CFR 483.80 lations and has implemented care & Medicaid Services or Disease Control and commended practices to	F 00	0			
		SUPPLIER REPRESENTATIVE'S SIGNATUI		TITLE		(X6) DATE	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(X6)

PRINTED: 01/08/2021

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	185364		B. WING	B. WING		12/15/2020		
NAME OF PROVIDER OR SUPPLIER			<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
OWENTON CENTER					05 HWY 127 NORTH WENTON, KY 40359			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TH DEFICIENCY			(X5) COMPLETION DATE	
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on 12/15/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).		E	000				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		100508	B. WING		40/45/0000		
NAME OF PF	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE, ZIP CODE			12/15/2020	
OWENTON		905 HW	Y 127 NORTH ON, KY 40359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
N 000	Initial Comments		N 000				
	was conducted on 12	d Infection Control Survey 2/15/2020. The facility was iance pursuant to 42 CFR					

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

TITLE

(X6) DATE