DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>D. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		185227	B. WING			09/	/03/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	NCE POINTE HEALTHCA	ARE			0 MARSHALL COURT		
				PADUCAH, KY 42001			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION		
F 000	NITIAL COMMENTS		F	000			
	was initiated on 09/02 09/03/2021. There w identified at 42 CFR 4 regulations and the fa Centers for Medicare and Centers for Disea	d Infection Control Survey 2/2021and concluded on vas no deficient practice 483.80 Infection Control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention I practices to prepare for usus 79.					
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	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.

PRINTED: 09/15/2021

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		185227	B. WING			09/	03/2021	
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PROVIDE	ICE POINTE HEALTHCA	RE			00 MARSHALL COURT			
				Р	ADUCAH, KY 42001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
	Survey was initiated of concluded on 09/03/2	2021. There was no htified at 42 CFR 483.73						
		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.

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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100312			(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		09/03/2021		
AME OF PI	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE			
ROVIDE	NCE POINTE HEALTHO	CARF	RSHALL COURT AH, KY 42001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		CTION SHOULD BE COMPL D THE APPROPRIATE DAT	
N 000	was initiated 09/02/2	ed Infection Control Survey 2021 and concluded on was no deficient practice o 42 CFR 483.80.	N 000			