DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			0	MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		()	(X3) DATE SURVEY COMPLETED		
		185120	B. WING			05/29/2020		
NAME OF PE	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE			
SIGNATURE HEALTHCARE AT HILLCREST				3740 OLD HARTFORD ROAD				
UCNAIO				OWENSBORO, KY 42303				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE	N SHOULD BE COMPLETION		
F 000		d Infection Control Survey 3/2020 and concluded on	F 0	000				
	05/29/2020. The fac compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	ility was found to be in FR 483.80 infection control nplemented the Centers for						
	COVID-19. Total cens							
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: 06/16/2020

DEPARTM	ENT OF HEALTH AN	D HUMAN SERVICES					APPROVED		
CENTERS	FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		185120	B. WING	3. WING		05/29/2020			
NAME OF PRO	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
SIGNATURE HEALTHCARE AT HILLCREST				3	740 OLD HARTFORD ROAD				
	SIGNATURE REALTINGARE AT HILLOREST			OWENSBORO, KY 42303					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE			
E 000	Initial Comments		E	000					
	Survey was initiated c concluded on 05/29/2	d Emergency Preparedness in 05/28/2020 and 020. The facility was found ith 42 CFR 483.73 related							
		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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100090			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 05/29/2020		
		B. WING					
		3740 OL	ADDRESS, CITY, STATE,				
		OWENS	BORO, KY 42303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	BE COMPLE	
N 000	Initial Comments		N 000				
	was conducted on 05	ility was found to be in					

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