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

PRINTED: 10/30/2020 FORM APPROVED OMB 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	
		185436	B. WING			10/20/2020	
NAME OF PROVIDER OR SUPPLIER  WELLINGTON PARC OF OWENSBORO				2	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD ROAD DWENSBORO, KY 42303	•	
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTAGE CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIE		D BE COMPLETION	
F 000	A COVID-19 Focus was initiated on 10/10/20/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommend COVID-19. Total co	sed Infection Control Survey 20/2020 and concluded on acility was found to be in CFR 483.80 infection control is implemented the Centers for id Services (CMS) and a Control and Prevention ed practices to prepare for ensus 42.		000			
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATLINE		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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185436	B. WING		<u> </u>	10/20/2020	
NAME OF PROVIDER OR SUPPLIER  WELLINGTON PARC OF OWENSBORO				288	REET ADDRESS, CITY, STATE, ZIP CODE 5 NEW HARTFORD ROAD /ENSBORO, KY 42303		NO.2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 10/20/2020 and		E	000			
	concluded on 10/20/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).						127
							41
		*					
ABORATORY	DIRECTOR'S OR PROVIDE	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\_ 100648 10/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD ROAD **WELLINGTON PARC OF OWENSBORO** OWENSBORO, KY 42303 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 10/20/2020 through 10/20/2020. 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