DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185228	B. WING _			09/	/09/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WESTEDN	I STATE NURSING FACI	ITY		24	00 RUSSELLVILLE ROAD		
WESTERN				н	OPKINSVILLE, KY 42240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was initiated on 09/09 09/09/2021. There widentified at 42 CFR 4 regulations and the fa Centers for Medicare and Centers for Disea	d Infection Control Survey 0/2021and 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 72.					
LABORATORY I	DIRECTOR'S OR PROVIDER/	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: 09/14/2021

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185228	B. WING			09/	09/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTERN		ITY		2	400 RUSSELLVILLE ROAD		
	WESTERN STATE NURSING FACILITY			HOPKINSVILLE, KY 42240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 09/09/2	d Emergency Preparedness on 09/09/2021 and 021. The facility was found ith 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	25		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: 09/14/2021

## PRINTED: 09/14/2021 FORM APPROVED

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
100490		B. WING		09/09/2021	
OVIDER OR SUPPLIER	I			00/00/2021	
STATE NURSING FACI	LITY		)		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
was initiated 09/09/20 09/09/2021. There w	021 and concluded on vas no deficient practice	N 000			
	F CORRECTION OVIDER OR SUPPLIER STATE NURSING FAC SUMMARY S' (EACH DEFICIENC REGULATORY OR Initial Comments A COVID-19 Focuse was initiated 09/09/2 09/09/2021. There v	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100490 OVIDER OR SUPPLIER STREET A 2400 RU HOPKIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CC         F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:       (X3) DATE COM         100490       B. WING       00         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         STATE NURSING FACILITY       2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240       00         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Initial Comments       N 000       N 000       N 000         A COVID-19 Focused Infection Control Survey was initiated 09/09/2021 and concluded on 09/09/2021. There was no deficient practice       N 000

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