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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		An Abbreviated Survey investigating KY#31930 and a COVID-19 Focused Infection Control Survey was initiated on 07/08/2020 and concluded on 07/16/2020. Complaint KY#31930 was substantiated with deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for			F 000				
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ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED: 09/25/2020

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.

		& MEDICAID SERVICES			0		APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		185364	B. WING			07/	16/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OWENT					005 HWY 127 NORTH DWENTON, KY 40359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Survey was initiated concluded on 07/16	sed Emergency Preparedness d on 07/08/2020 and 6/2020. The facility was found e with 42 CFR 483.73 related					
ABURATOR	T DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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: 07/30/2020

PRINTED: 09/25/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 100508			(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION		(X3) DATE SURVEY COMPLETED		
		B. WING		07	07/16/2020			
IAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,					
WENTO	N CENTER		Y 127 NORTH ON, KY 40359					
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N 000	Initial Comments		N 000					
	a COVID-19 Focused was initiated on 07/08 07/16/2020. Complai substantiated with de	ficiencies cited. The facility population of the second second second second second second second second second						

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

TITLE

(X6) DATE