

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100182	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2025
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NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 384 THOMPSON AVENUE MADISONVILLE, KY 42431
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(X4) ID PREFIX TAG	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)	(X5) COMPLETE DATE
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P 000	<p>Initial Comments</p> <p>A Complaint Survey investigating KY00046642, KY00046097, and KY00045704 was completed on 06/27/2025.</p> <p>There were no deficiencies issued related to KY00046642, KY00046097 and KY00045704.</p> <p>Survey Dates: 06/25/2025 through 06/27/2025 Facility Census: 49 Sample Size:10</p>	P 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____