

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

PRINTED: 04/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185394	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH FLORENCE SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 4900 HOUSTON ROAD FLORENCE, KY 41042
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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) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted 03/18/14 through 03/20/14 with no deficiencies cited.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

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

PRINTED: 03/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185394	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2014
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NAME OF PROVIDER OR SUPPLIER ST ELIZABETH FLORENCE SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 4900 HOUSTON ROAD FLORENCE, KY 41042
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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) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>Building: 01</p> <p>Plan Approval: 1977</p> <p>Survey Under: 2000 Existing</p> <p>Facility Type: Skilled Nursing Facility (SNF)</p> <p>Type of Structure: Type II (222) Protected</p> <p>Smoke Compartments: 2</p> <p>Fire Alarm: Complete fire alarm. Updates to the system in 2006 and 2008</p> <p>Sprinkler System: Complete system. Installed 1977</p> <p>Generator: Three (3) Type I Caterpillar Diesel (Two (2) upgraded in 12/2012.</p> <p>A Short Form Life Safety Code Survey was initiated and concluded on 03/19/14. The findings revealed St. Elizabeth Florence SNF meets the requirements for compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). No deficiencies cited.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ 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.