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

PRINTED: 12/17/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING _		12/14/2020		
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		SHOULD BE COMPLÉT	
F 000	INITIAL COMMEN	тѕ	F 00	0		
	was initiated and c facility was found to CFR 483.80 infecti implemented the C Medicaid Services Disease Control ar	sed Infection Control Survey oncluded on 12/14/2020. The obe in compliance with 42 on control regulations and has centers for Medicare & (CMS) and Centers for nd Prevention (CDC) ctices to prepare for tensus 96.				
			/			
ABORATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	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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		185174	B. WING		12/14/2020		
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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	
E 000	Initial Comments		E 00	00			
	Survey was initiated 12/14/2020. The fa	cility was found to be in CFR 483.73 related to					
					a a		
<u> </u>						a a	
	= x						
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	<u> </u>	(X6) DATE	

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FORM APPROVED 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 100547 12/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6975 BURLINGTON PIKE** FLORENCE PARK CARE CENTER FLORENCE, KY 41042 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated and concluded on 12/14/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total Census 96.

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

TITLE

(X6) DATE