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

PRINTED: 01/06/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|--|-------------------------------|----------------------------|--|
| | | 185132 | B. WING | | | 12/22/2020 | | |
| NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219 | | | | |
| (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 | |
| F 000 | A COVID-19 Focus was initiated and cofacility was found in 483.80 infection cor implemented the Complemented Services (Disease Control and recommended practice). Total complemented the Covid-19. Total complemented the Covid-19. | sed Infection Control Survey concluded on 12/22/2020. The compliance with 42 CFR entrol regulations and has enters for Medicare & (CMS) and Centers for d Prevention (CDC) etices to prepare for | | 000 | 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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|---|--|---|--|-----|---|-------------------------------|----------------------------|
| | | 185132 | B. WING | | | 12/22/2020 | |
| NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER | | | | 362 | REET ADDRESS, CITY, STATE, ZIP CODE 25 FERN VALLEY ROAD DUISVILLE, KY 40219 | _ | 12212020 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | Ε¢ | 000 | | | |
| | Survey was initiated 12/22/2020. The fa | ed Emergency Preparedness I and concluded on cility was found to be in CFR 483.73 related to | | | | | |
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| ABORATORY | DIRECTOR'S OR PROVIDE | ER/SUPPLIER REPRESENTATIVE'S SIGN | ATURE | | 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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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 100196 B. WING 12/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3625 FERN VALLEY ROAD** FRANCISCAN HEALTH CARE CENTER LOUISVILLE, KY 40219 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated and concluded on 12/22/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE