PRINTED: 04/29/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ B. WING 185322 04/14/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3057 NORTH CLEVELAND ROAD **ROSE MANOR HEALTH CARE LEXINGTON, KY 40516** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 A COVID-19 Focused Infection Control Survey was initiated on 04/13/2020 and concluded on 04/14/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 27.

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.

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

PRINTED: 04/29/2020 FORM APPROVEI OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DA	(X3) DATE SURVEY COMPLETED 04/14/2020 ODE	
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NAME OF PROVIDER OR SUPPLIER ROSE MANOR HEALTH CARE				STREET ADDRESS, CITY, STATE 3057 NORTH CLEVELAND RO LEXINGTON, KY 40516	, ZIP CODE		
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E 000	Initial Comments		E 0	000			
	Survey was initiate concluded on 04/14	sed Emergency Preparedness d on 04/13/2020 and 4/2020. The facility was found e with 42 CFR 483.73 related					
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		IDER/SLIPPLIER REPRESENTATIVE'S SI	CNATURE	TITLE		(X6) DATE	

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If continuation sheet 1 of

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 100115 04/14/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3057 NORTH CLEVELAND ROAD ROSE MANOR HEALTH CARE** LEXINGTON, KY 40516 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 04/13/2020 and concluded on 04/14/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

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STATE FORM