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

PRINTED: 04/24/2020 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			
		185225	B. WING		<u> </u>		03/2	27/2020		
NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN				STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE		
F 000	INITIAL COMMEN	тѕ	F	000						
	was initiated on 03, 03/27/2020. The facompliance with 42 regulations and had Medicare & Medica Centers for Diseas	sed Infection Control Survey /26/2020 and concluded on cility was found to be in 2 CFR §483.80 infection control is implemented the Centers for aid Services (CMS) and the Control and Prevention led practices to prepare for ensus 167.	i an							
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LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	!	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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185225			B. WING				03/27/2020		
NAME OF PROVIDER OR SUPPLIER ROSEDALE GREEN				STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015					
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E 000	Initial Comments		E 000						
	Survey was initiated concluded on 03/27	sed Emergency Preparedness d on 03/26/2020 and 7/2020. The facility was found with 42 CFR §483.73 related							
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LABORATOR	V DIDECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURF		TITLE			(X6) DATE	

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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:** COMPLETED A. BUILDING: ___ B. WING 100269 03/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4250 GLENN AVENUE ROSEDALE GREEN** COVINGTON, KY 41015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 03/26/2020 and concluded on 03/27/2020. The facility was found to be in compliance pursuant to 42 CFR §483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 167.

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

TITLE

(X6) DATE