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

PRINTED: 05/07/2021 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES					0. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185484	B. WING		2	02	2/05/2021	
NAME OF PROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
THE SEASONS AT ALEXANDRIA				7341 E ALEXANDRIA PIKE ALEXANDRIA, KY 41001				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	S = ±	F 0	00				

A COVID-19 Focused Infection Control Survey was initiated on 02/04/2020 and concluded on 02/05/2020. It was determined there were no concerns with 42 CFR §483.80 infection control regulations and the facility 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 105.

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.

DEDARTMENT OF HEALTH AND HUMANI CED 4050

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		185484	B. WING_			1.	02/05/2021
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E 000	Initial Comments		E 00	00			
	Survey was initiated concluded on 02/05	sed Emergency Preparedness d on 02/04/2021 and s/2021. It was determined erns with 42 CFR §483.73 b)(6).					
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	v _a						

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PRINTED: 05/07/2021 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: ____ 100055 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7341 E ALEXANDRIA PIKE THE SEASONS AT ALEXANDRIA **ALEXANDRIA, KY 41001** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 02/04/2020 and concluded on 02/05/2020. It was determined there were no concerns with 42 CFR §483.80 infection control regulations and the facility 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 105.

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