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

PRINTED: 05/22/2020 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
185440		B. WING			05/14/2020	
PROVIDER OR SUPPLIER E CARE CENTER			STREET ADDRESS, CITY, STA 2990 RIGGS AVENUE ERLANGER, KY 41018		03/14/2020	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
A COVID-19 Focus was initiated on 05/05/14/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommended	sed Infection Control Survey 13/2020 and concluded on acility was found to be in CFR 483.80 infection control s implemented the Centers for id Services (CMS) and c Control and Prevention ed practices to prepare for					
	x					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT A COVID-19 Focus was initiated on 05/ 05/14/2020. The fa compliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommend	TRESULATORY OR LSC IDENTIFICATION NUMBER: 185440 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 05/13/2020 and concluded on 05/14/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control	TRESTORMENTS A. BUILD 185440 B. WING PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 05/13/2020 and concluded on 05/14/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for	TREST ADDRESS, CITY, STATE AND	TRESTANDER OF SUPPLIER TRESTANDER OR SUPPLIER TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TINITIAL COMMENTS A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was initiated on 05/13/2020 and concluded on 05/14/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for	

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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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185440	B. WING			05/14/2020	
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018				1412020
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		LD BE COMPLETION	
E 000	Initial Comments		Ε¢	000			
	Survey was initiated concluded on 05/14	sed Emergency Preparedness d on 05/13/2020 and 1/2020. The facility was found with 42 CFR 483.73 related					
							nen -
	27						
	*						
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITI F		(YR) 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.

Office of Inspector General

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:			COMP			
		100429	B. WING		05/1	05/14/2020		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
VILLAGE CARE CENTER 2990 RIGGS AVENUE								
VILLAGI	- OAKE OERTEK	ERLANG	ER, KY 410	18				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
	A COVID-19 Focus was initiated 05/13/ 05/14/2020. The fa	ed Infection Control Survey 2020 and concluded on cility was found to be in nt to 42 CFR 483.80.						
	*							
						75		

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

TITLE

(X6) DATE