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

PRINTED: 05/27/2021 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	
		185447	B. WING			12/31/2020	
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER				STREET ADDRESS, CITY, STATE, ZIP CODE 4220 HOUSTON ROAD ERLANGER, KY 41018			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	sed Infection Control Survey	F 00	00			
	12/31/2020. The fa compliance with 42 regulations and has Medicare & Medica Centers for Disease	/30/2020 and concluded on cility was found to be in CFR 483.80 infection control is implemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for ensus 116.					
					n e		
		ER/SUPPLIER REPRESENTATIVE'S SIGN	<u>.</u>		TITLE	:1	

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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		B. WING_		12	12/31/2020		
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER				STREET ADDRESS, CITY, STATE, ZII 4220 HOUSTON ROAD ERLANGER, KY 41018	PCODE	CODE	
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E 000	Initial Comments		E 00	00			
	Survey was initiate concluded on 12/3	used Emergency Preparedness ed on 12/30/2020 and 31/2020. The facility was found the with 42 CFR 483.73 related					
		e z					
					TO:		
BORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATUDE	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: A. BUILDING: _ COMPLETED 100925 B. WING 12/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4220 HOUSTON ROAD** VILLASPRING OF ERLANGER **ERLANGER, KY 41018** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 12/30/2020 and concluded on 12/31/2020. 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