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

PRINTED: 05/22/2020 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	
		185132	B. WING	B. WING		04/08/2020	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP (3625 FERN VALLEY ROAD LOUISVILLE, KY 40219	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		-	(X5) COMPLETION DATE
F 000	was initiated on 04/00 04/08/2020. The facil compliance with 42 C regulations and has i Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cent	d Infection Control Survey 6/2020 and concluded on ity was found to be in EFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention		TITLE) 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.

Facility ID: 100196

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E 000	Initial Comments A COVID-19 Focuse Survey was initiated of concluded on 04/08/2	d Emergency Preparedness					
I ABORATORY	DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE			(X6) DATE

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Office of Inspector General

In wind CF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### STATE, ZIP CODE ### STREET ADDRESS, CITY, STATE, ZIP CODE ### STATE, ZIP CODE ##	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FRANCISCAN HEALTH CARE CENTER 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments A COVID-19 Focused Infection Control Survey was initiated 04/06/2020 and concluded on 04/08/2020. The facility was found to be in			100196	B. WING		04	08/2020
CAU ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 04/06/2020 and concluded on 04/08/2020. The facility was found to be in OUISVILLE, KY 40219 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION S	NAME OF PF	ROVIDER OR SUPPLIER					
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	N 000	A COVID-19 Focused was initiated 04/06/20 04/08/2020. The facil	20 and concluded on lity was found to be in	N 000	DEFICIENCY)		

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

TITLE (X6) DATE