## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/11/2020 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	
		40	1				
		185003	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	06/0	08/2020
NAME OF PE	ROVIDER OR SUPPLIER			ı	8 WEST TWELFTH STREET		
LAUREL H	EIGHTS HOME FOR TH	IE ELDERLY		LC			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	5	F	000			
	conducted on 06/08/ to be in compliance of Control and has impl Medicare & Medicaid Centers for Disease (CDC) recommender	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection lemented the Centers for d Services (CMS) and Control and Prevention d practices to prepare for cient practice was identified. s 125.					
LABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE.		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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CENTER	S FOR WEDICARE &	VIEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185003	B, WNG			06/08/2020	
NAME OF PR	ROVIDER OR SUPPLIER	·		Ş	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	08 WEST TWELFTH STREET		
LAUREL H	EIGHTS HOME FOR TH	E ELDERLY					
			i	_	ONDON, KY 40743		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	-	(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)	_	
	<del> </del>	·	1				
E 000	Initial Comments		_	000			
E 000	initial Comments		=	000			
			1				
	A COVID-19 focused	Emergency Preparedness					
		d on 06/08/2020. The					
		e in compliance with 42					
		ncy Preparedness related to					
		practice was identified.					
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	59						
			1				
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		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.

PRINTED: 06/11/2020 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 \_\_\_\_ B. WNG\_ 100280 06/08/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **208 WEST TWELFTH STREET** LAUREL HEIGHTS HOME FOR THE ELDERLY **LONDON, KY 40743** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 06/08/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X5) DATE