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

PRINTED: 08/04/2021 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	
185176		B. WING			01/25/2021			
NAME OF PROVIDER OR SUPPLIER CLIFTON OAKS CARE AND REHAB CENTER, LLC				STI 446 LO		ILOILOL I		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETION		
F 000	A COVID-19 Focus was initiated on 01/2 01/25/2021. The fa compliance with 42 regulations and has Medicare & Medical Centers for Disease	red Infection Control Survey 21/2021 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and a Control and Prevention ed practices to prepare for	F	000				
ABOBATORY	DIRECTOR'S OR BROVIN	ED/SLIPPLIED DEPRESENTATIVE'S SIGN	ATUDE		TITI E		(VE) 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185176	B. WING		· · · · · · · · · · · · · · · · · · ·	01/25/2021	
NAME OF PROVIDER OR SUPPLIER CLIFTON OAKS CARE AND REHAB CENTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVENUE LOUISVILLE, KY 40206			
(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 COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)			(X5) COMPLETION DATE
E 000	Initial Comments		Ε¢	000			
	Survey was initiated concluded on 01/25	sed Emergency Preparedness d on 01/21/2021 and 5/2021. It was determined erns with 42 CFR §483.73 b)(6).					
	*		2				
			3				
AROBATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATUDE		TIT) F		(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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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING _ 100231 01/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVENUE CLIFTON OAKS CARE AND REHAB CENTER, I LOUISVILLE, KY 40206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 01/21/2021 and concluded on 01/25/2021. 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