	TMENT OF HEALT RS FOR MEDICAR	FOR	PRINTED: 05/06/202 FORM APPROVEI OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		185039	B. WING		04/29/2020		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATI	E, ZIP CODE	1/29/2020	
HIGHLA	NDS NURSING AND		16	1705 STEVENS AVENUE LOUISVILLE, KY 40205			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMME	NTS	F 00	00			
	was initiated on 0- 04/29/2020. It was implemented the Medicaid Services Disease Control a	used Infection Control Survey 4/28/2020 and concluded on s determined the facility had Centers for Medicare & s (CMS) and Centers for and Prevention (CDC) actices to prepare for census 141.			22		
30.0		×					
ORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	MATURE	TITLE		(YA) 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

TITLE

(X6) DATE

DEPAR CENTE	PRINTED: 05/06/202 FORM APPROVE OMB NO. 0938-039						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		185039	B. WING		04/29/2020		
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP C 1705 STEVENS AVENUE LOUISVILLE, KY 40205	ODE	1 04/29/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD RE	(X5) COMPLETIO DATE	
E 000	Initial Comments		E 00	0			
	Survey was initiate concluded on 04/2	used Emergency Preparedness ed on 04/28/2020 and 29/2020. It was determined ocerns with 42 CFR §483.73 (b)(6).					
		Š					
ODATORY.	NIDEOTODIA AS ===	DER/SUPPLIER REPRESENTATIVE'S SIGNA					

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.

TITLE

(X6) DATE

PRINTED: 05/06/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED 100218 B. WING 04/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE HIGHLANDS NURSING AND REHABILITATION LOUISVILLE, KY 40205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 04/28/2020 and concluded on 04/29/2020. It was determined the facility had implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 141

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

TITLE

(X6) DATE