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

PRINTED: 07/07/2020 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				
		185039	B. WING			C 07/02/2020				
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING AND REHABILITATION				170	REET ADDRESS, CITY, STATE, ZIP CODE D5 STEVENS AVENUE DUISVILLE, KY 40205					
(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 CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		LD BE COMPLETION				
F 000	and a COVID-19 For Survey was initiated concluded on 07/02 was unsubstantiated. The facility was fou CFR 483.80 infection implemented the Complemented the Complemented practices and the complemented practices. Total celebrates are commended practices and the covid of the covid	rvey investigating KY#31905 bocused Infection Control d on 06/29/2020 and 2/2020. Complaint KY#31905 ed with no deficiencies cited. Ind to be in compliance with 42 on control regulations and has enters for Medicare & (CMS) and Centers for d Prevention (CDC) citices to prepare for ensus 137.		000						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		407000	-R1			C				
		185039	B. WING			07/02/2020				
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
HIGHLAN	NDS NURSING AND F	REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		BE	(X5) COMPLETION DATE			
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/29/2020 and		E	000						
	concluded on 07/02	2/2020. The facility was found with 42 CFR 483.73 related								
	Þ									
							7%			
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE			

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING_ 07/02/2020 100218 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1705 STEVENS AVENUE** HIGHLANDS NURSING AND REHABILITATION LOUISVILLE, KY 40205 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A Complaint Survey investigating KY31905 and a COVID-19 Focused Infection Control Survey was initiated on 06/29/2020 and concluded on 07/02/2020. Complaint KY31905 was unsubstantiated with no deficiencies cited. 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