DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/29/2020

CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVEI OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185039	B. WING				05/2	: 1/2020	
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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 COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ADDEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs .	F 0	00					
	KY#00031523, Con COVID-19 Focused initiated on 05/20/20	rvey investigating Complaint nplaint KY#00031725 and a I Infection Control Survey was 020 and concluded on	S						
	substantiated with r Complaint KY#0003	laint KY#00031523 was no deficient practice identified 31625 was not substantiated	•						
	determined the faci and Centers for Dis	ictice was identified. It was lity had implemented the CMS ease Control and Prevention ed practices to prepare for	5		51 51				
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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.

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

TITLE

(X6) DATE

PRINTED: 05/29/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C 185039 B. WING 05/21/2020 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 ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) E 000 Initial Comments E 000 A COVID-19 Focused Emergency Preparedness Survey was initiated on 05/20/2020 and concluded on 05/21/2020. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b)(6).

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.

PRINTED: 05/29/2020 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. WING 100218 05/21/2020 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 ΙD (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031523, Complaint KY#00031725 and a COVID-19 Focused Infection Control Survey was initiated on 05/20/2020 and concluded on 05/21/2020. Complaint KY#00031523 was substantiated with no deficient practice identified. Complaint KY#00031625 was not substantiated and no deficient practice was identified. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.

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

TITLE

(X6) DATE