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

PRINTED: 12/03/2020 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		
185		185268	B. WING			12/02/2020		
NAME OF PROVIDER OR SUPPLIER  JEFFERSONTOWN REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 000	was initiated, on 12 12/02/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommend COVID-19. Total co	sed Infection Control Survey 1/01/2020 and concluded on acility was found in 2 CFR 483.80 infection control as implemented the Centers for aid Services (CMS) and a Control and Prevention and practices to prepare for		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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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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		
		185268	B. WING			12/02/2020	
NAME OF PROVIDER OR SUPPLIER  JEFFERSONTOWN REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299				
(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 CORRECT (EACH CORRECTIVE ACTION SHOUT AGE CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)			BE	(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 Focus Survey was initiated concluded on 12/02	sed Emergency Preparedness d on 12/01/2020 and 2/2020. The facility was found with 42 CFR 483.73 related		000			
			- minute de distribuir de				
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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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Office of Inspector General

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
	100222		B. WING		12/02/2020		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		_	
JEFFERSONTOWN REHABILITATION  3500 GOOD SAMARITAN WAY  JEFFERSONTOWN, KY 40299							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	D BE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000				
	was initiated, on 12 12/02/2020. The factorial compliance with 42 regulations and has Medicare & Medica Centers for Disease	CFR 483.80 infection control implemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for					

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

TITLE

(X6) DATE