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

PRINTED: 04/23/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING				(X3) DATE SURVEY COMPLETED	
	185333					0	4/08/2020	
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  3802 KLONDIKE LANE  LOUISVILLE, KY 40218				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 000	An Abbreviated Su	rvey investigating Complaint a COVID-19 Focused	F O	00				
	Infection Control St 04/07/2020 and con Complaint KY#0003 with no deficiencies to be in compliance infection control reg the CMS and Cente Prevention (CDC) r	a COVID-19 Focused urvey was initiated on included on 04/08/2020. 31211 was unsubstantiated is cited. The facility was found with 42 CFR §483.80 gulations and has implemented ers for Disease Control and ecommended practices to 19. Total census 57.						
	·				81			
ADOD : 70-71	(DIRECTORIC OF TOTAL	ER/SUPPLIER REPRESENTATIVE'S SIG			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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185333		B. WING _	· .	04	C <b>04/08/2020</b>			
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  3802 KLONDIKE LANE  LOUISVILLE, KY 40218				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
E 000	Initial Comments		E 0	00	i j			
	Survey was initiated concluded on 04/08	sed Emergency Preparedness d on 04/07/2020 and 8/2020. The facility was found with 42 CFR §483.73 related						
				a				
				N. N				
				j.				
		47	153					
L	V DIDECTORIO OD POOVII	DED/SUIDDUIED DEDDESENTATIVE'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.

Office of Inspector General

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100424			(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		04/0	04/08/2020		
NAME OF 8	PROVIDER OR SUPPLIER			TATE, ZIP CODE		-	
KLONDII	KE CENTER		ONDIKE LANE LLE, KY 4021				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000		· ·		
	A Complaint Survey investigating Complaint KY#00031211 and a COVID-19 Focused Infection Control Survey was initiated on 04/07/2020 and concluded on 04/08/2020. Complaint KY#00031211 was unsubstantiated with no deficiencies cited. The facility was found to be in compliance pursuant to 42 CFR §483.80						
	the CMS and Center Prevention (CDC) re	pulations and has implemented ers for Disease Control and ecommended practices to 19. Total census 57.					
				8			
	æ						
127							

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

TITLE

(X6) DATE