NAME OF PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) D/		
LANDMAR (X4) ID PREFIX		185122		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
LANDMAR (X4) ID PREFIX					04/29/2020		
(X4) ID PREFIX		NAME OF PROVIDER OR SUPPLIER			IP CODE	VIZ SIZ OZO	
PREFIX		REHABILITATION AND NURSI	N(4	55 EASTERN PARKWAY DUISVILLE, KY 40217			
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 000 II	NITIAL COMMENT	'S	F 000				
w 0 ir C p	vas initiated on 04/2 04/29/2020. It was mplemented the CN Control and Prevent	ed Infection Control Survey 28/2020 and concluded on determined the facility had MS and Centers for Disease tion (CDC) recommended for COVID-19. The total					
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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

		AND HUMAN SERVICES  MEDICAID SERVICES			FOR	D: 05/15/2020 M APPROVED	
STATEMENT OF DEFICIENCIES (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		185122	B. WING		0.4/00/0000		
	PROVIDER OR SUPPLIER  ARK OF LOUISVILLE	REHABILITATION AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE				
(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 CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPROPRIES OF THE APP	ULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
	Survey was initiated concluded on 04/29	sed Emergency Preparedness d on 04/28/2020 and 0/2020. It was determined erns with 42 CFR §483.73 o)(6).					
	© C	,					
BORATORY [	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	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.

(X6) DATE

PRINTED: 05/15/2020 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: A. BUILDING: \_ COMPLETED 100239 B. WING 04/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LANDMARK OF LOUISVILLE REHABILITATION LOUISVILLE, KY 40217 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE 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 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