

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

PRINTED: 05/15/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>LANDMARK OF IROQUOIS PARK REHAB AND NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 GAGEL AVENUE LOUISVILLE, KY 40216</b>		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A COVID-19 Focused Infection Control Survey was initiated on 04/27/2020 and concluded on 04/28/2020. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 91.	F 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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NAME OF PROVIDER OR SUPPLIER  <b>LANDMARK OF IROQUOIS PARK REHAB AND NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 GAGEL AVENUE LOUISVILLE, KY 40216</b>		
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E 000	Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 04/27/2020 and concluded on 04/28/2020. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b)(6).	E 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>100208</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/28/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LANDMARK OF IROQUOIS PARK REHAB AND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>900 GAGEL AVENUE LOUISVILLE, KY 40216</b>
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N 000	Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 04/27/2020 and concluded on 04/28/2020. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19	N 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_