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

PRINTED: 09/09/2020 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY						
AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED						
		405400	B. WING		004	19/2020					
		185122		STREET ADDRESS, CITY, STATE, ZIP CODE	l <u>09/</u> (08/2020					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY											
LANDMARK OF LOUISVILLE REHABILITATION AND NURSING LOUISVILLE, KY 40217											
(VA) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)					
(X4) ID PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE RIATE	COMPLÉTION DATE					
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)							
	W -										
F 000	INITIAL COMMENTS			0							
	A COVID-19 Focus	sed Infection Control Survey									
		/08/2020 and concluded on cility was found to be in									
	compliance with 42	CFR 483.80 infection control									
	regulations and has	s implemented the Centers for									
		aid Services (CMS) and									
		e Control and Prevention led practices to prepare for									
	COVID-19. Total ce										
İ											
	T C										
				187							
				TITLE		(X6) DATE					
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		WOULDAIE					

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 & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		185122	B. WING			09/	08/2020	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF LOUISVILLE REHABILITATION AND NURSING				STREET AC 1155 EAST LOUISVII				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOUL OSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 000	Survey was initiated concluded on 09/08	sed Emergency Preparedness on 09/08/2020 and 3/2020. The facility was found with 42 CFR 483.73 related	E	00				

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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Office of Inspector General (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING _ 09/08/2020 100239 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1155 EASTERN PARKWAY LANDMARK OF LOUISVILLE REHABILITATION LOUISVILLE, KY 40217 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 09/08/2020 and concluded on 09/08/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE

6899