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

PRINTED: 09/03/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185122	B. WING					
NAME OF PROVIDER OR SUPPLIER  LANDMARK OF LOUISVILLE REHABILITATION AND NURSING				115	REET ADDRESS, CITY, STATE, ZIP CODE 5 EASTERN PARKWAY UISVILLE, KY 40217	_ 08	/18/2020	
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	BE COMPLETION	
F 000	An Abbreviated Surand a COVID-19 Fo Survey was initiated concluded on 08/18 KY#00032218 was deficiencies cited. Compliance with 42 regulations and has Medicare & Medicai Centers for Disease (CDC) recommende COVID-19. Total ce	rvey investigating KY 32218 ocused Infection Control I on 08/17/2020 and I/2020. Complaint unsubstantiated with no The facility was found to be in CFR 483.80 infection control implemented the Centers for d Services (CMS) and a Control and Prevention and practices to prepare for	F (		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

(X6) DATE

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

PRINTED: 09/03/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185122	B. WING					
NAME OF PROVIDER OR SUPPLIER  LANDMARK OF LOUISVILLE REHABILITATION AND NURSING				1155 EASTE	RESS, CITY, STATE, ZIP RN PARKWAY E, KY 40217	CODE	108/	18/2020
(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 CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIES.			LD BE COMPLETION	
E 000	concluded on 08/18	sed Emergency Preparedness d on 08/17/2020 and 5/2020. The facility was found for 42 CFR 483.73 related to	Ε	000				
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE		TITLE		9 10 10 10 10 10 10 10 10 10 10 10 10 10	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: 09/03/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED 100239 B. WING 08/18/2020 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 (X5) COMPLETE DATE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating KY 32218 and a COVID-19 Focused Infection Control Survey was initiated on 08/17/2020 and concluded on 08/18/2020. Complaint KY 32218 was unsubstantiated with no deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 189.

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

TITLE

(X6) DATE