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

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		185122	B. WING				
NAME OF PROVIDER OR SUPPLIER  LANDMARK OF LOUISVILLE REHABILITATION AND NURSING				STREET ADDRESS, CITY, STATE, ZIP COE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217	12 )E	2/30/2020	
(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 CORRI X (EACH CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETION DATE	
F 000	was completed on found to be in compinfection control regithe Centers for Med (CMS) and Centers Prevention (CDC) reprepare for COVID-	sed Infection Control Survey 12/30/2020. The facility was oliance with 42 CFR 483.80 pulations and has implemented dicare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 199.	FO				
	LO . O. C.	AND OFFICER REPRESENTATIVE'S SIGNA	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 program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		185122	B. WING	i	4.	40,000	
NAME OF PROVIDER OR SUPPLIER  LANDMARK OF LOUISVILLE REHABILITATION AND NURSING			,	STREET ADDRESS, CITY, STATE, ZIF 1155 EASTERN PARKWAY LOUISVILLE, KY 40217	° CODE	2/30/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 000	Survey was conduct	sed Emergency Preparedness sted on 12/30/2020. The be in compliance with 42 if to E-0024 (b)(6).	EO	000			
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	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 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 100239 B. WING 12/30/2020 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 ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX 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 concluded on 12/30/2020. 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