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

PRINTED: 11/30/2020 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) DATE SURVEY COMPLETED	
185122		B. WING		11,	11/10/2020		
	PROVIDER OR SUPPLIER ARK OF LOUISVILLE	REHABILITATION AND NURSING		1155 EA	ADDRESS, CITY, STATE, ZIP CODE STERN PARKWAY VILLE, KY 40217		
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE
F 000	was conducted on found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) r	sed Infection Control Survey 11/10/2020. The facility was pliance with 42 CFR 483.80 gulations and has implemented dicare & Medicaid Services for Disease Control and recommended practices to -19. Total census 197.	F	000			
LABORATORY	OIRECTOR'S OR PROVIDE	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	The state of the s	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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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		11/	11/10/2020	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF LOUISVILLE REHABILITATION AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217			
(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 C PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TI DEFICIENCY		JLD BE	(X5) COMPLETION DATE	
E 000	Survey was conduct	sed Emergency Preparedness cted on 11/10/2020. The be in compliance with 42 d to E-0024 (b)(6).	E	000			
ABORATORY	DIRECTOR'S OR PROVIE	DER/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 AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100239	B. WING		11/10/2020		
	PROVIDER OR SUPPLIER	REHABILITATION 1155 EAS	DDRESS, CITY, S STERN PARKI LLE, KY 4021				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
N 000	A COVID-19 Focus was conducted on	ed Infection Control Survey 11/10/2020. The facility was oliance pursuant to 42 CFR	N 000				

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

TITLE

(X6) DATE