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

PRINTED: 08/18/2020 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 | | | |
|---|--|---|--|--|---|-------|----------------------------|--|
| | | 185003 | | B. WNG | | | C 08/12/2020 | |
| NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY | | | | | RESS, CITY, STATE, ZIP CODE VELFTH STREET Y 40743 | 1 007 | 12/2020 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREF | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | |
| F 000 | a COVID-19 focused conducted on 08/12/2 unsubstantiated and identified. The facility compliance with 42 C | dard survey (KY32202) and infection control survey was 2020. The complaint was no deficient practice was y was found to be in CFR 483.80 Infection Control of the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for | F | 000 | DEFICIENCY) | 5 | | |
| | | | | | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATUR | i.e. | | 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: COMPLETED A. BUILDING: _ C B. WING 100280 08/12/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **208 WEST TWELFTH STREET** LAUREL HEIGHTS HOME FOR THE ELDERLY **LONDON, KY 40743** 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 REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY32202) and a COVID-19 focused infection control survey was conducted on 08/12/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

STATE FORM

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

5819

(X6) DATE

TITLE

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

PRINTED: 08/18/2020 FORM APPROVED OMB NO. 0938-0391

| OFILLFILL | OT OIL WILDIOMILE | MICDIOMID OFITAIOEO | | | | CIVID 140 | <u>7. 0930-039 I</u> |
|---|--|---|--|---|--------------------------------------|-------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 185003 | B. WING | | | C 08/12/2020 | |
| NAME OF DE | ROVIDER OR SUPPLIER | | 1 1 1 1 | 61 | FREET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | 12/2020 |
| NAME OF FR | KOVIDER OR SUPPLIER | | | | | | |
| LAUREL H | EIGHTS HOME FOR TH | E ELDERLY | | | 08 WEST TWELFTH STREET | | |
| | | | | L | ONDON, KY 40743 | | |
| (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 CORRECTIC EFIX (EACH CORRECTIVE ACTION SHOULI AG CROSS-REFERENCED TO THE APPROF DEFICIENCY) | | | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E | 000 | | | |
| | survey was conducte facility was found to b CFR 483.73 Emerger | I Emergency Preparedness d on 08/12/2020. The pe in compliance with 42 ncy Preparedness related to practice was identified. | | | × | | 3 |
| | | | | | 3 | | |
| | | | | | | | |
| | | | | | 8 | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | PURE TORING OR OTHER WATER | ISHIDDHED DEDDESENTATIVE'S SIGNATI | 105 | | TITLE | _ | (VE) 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.