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

PRINTED: 07/17/2020 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		
		185178	B. WING			07/46/2020		
NAME OF PROVIDER OR SUPPLIER  LOUISVILLE EAST POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220				
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD FIXED TO THE APPRICATION OF CROSS-REFERENCED TO THE APPRICATION OF CORRECT OF CROSS-REFERENCED TO THE APPRICATION OF CROSS-REFERENCED TO THE APPRI		O ILIOHS	D RE COMPLETION		
F 000	was conducted on of found to be in compinfection control regithe Centers for Med (CMS) and Centers Prevention (CDC) reprepare for COVID-	sed Infection Control Survey 07/16/2020. The facility was bliance with 42 CFR 483.80 gulations and has implemented dicare and Medicaid Services of for Disease Control and ecommended practices to		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) DATE SURVEY COMPLETED			
		185178	B. WING			07/46/2000			
NAME OF PROVIDER OR SUPPLIER  LOUISVILLE EAST POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERÊNCED TO THE APPROPI DEFICIENCY)	LD RE COMPLETION			
E 000	Initial Comments		Ε¢	000					
	Survey was conduc	sed Emergency Preparedness sted on 07/16/2020. The be in compliance with 42 to E-0024(b)(6).		ļ					
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	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 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

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(X6) DATE

If continuation sheet 1 of 1

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 100201 B. WING 07/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4200 BROWNS LANE** LOUISVILLE EAST POST ACUTE LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE 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 COVID-19 Focused Infection Control Survey was conducted on 07/16/2020. 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.

TITLE

H7W511

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

STATE FORM