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

PRINTED: 07/02/2020 **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			C 05/29/2020	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				23/2020
LOUISVILLE EAST POST ACUTE			4200 BROWNS LANE LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey initiated, on 05/19/2020 and concluded on		F	000			
	05/29/2020. The fa with 42 CFR 483.80 and has implement Medicaid Services (cility was found in compliance of infection control regulations ed the Centers for Medicare & (CMS) and Centers for d Prevention (CDC) etices to prepare for					
	on 05/19/2020 throu complaint KY 31717	eviated survey was conducted ugh 05/29/2020, to investigate 7. The Division of Health the allegation with no	38				
							s
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

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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Office of Inspector General

AND PLAN OF CORRECTION (X1) PHOVIDEH/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		B. WING		C 05/29/2020				
NAME OF	PROVIDER OR SUPPLIER	STREET AF	ADDECC CITY	STATE ZIR CORE	31			
I NAME OF	PHOVIDEN ON SUPPLIEN			STATE, ZIP CODE				
LOUISVILLE EAST POST ACUTE 4200 BROWNS LANE LOUISVILLE, KY 40220								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
N 000	A COVID-19 Focused Infection Control Survey was initiated 05/19/2020 and concluded on 05/29/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. In addition, a complaint survey to investigate KY 31717 was conducted on 05/19/2020 through 05/29/2020. The complaint was substantiated.		N 000					
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			W.					
					8			

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

TITLE

(X6) DATE

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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				C .05/29/2020
	PROVIDER OR SUPPLIER	JTE		STREET ADDRESS, CITY, STAT 4200 BROWNS LANE LOUISVILLE, KY 40220	E, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
E 000	Survey was initiated concluded on 05/29	sed Emergency Preparedness d on 05/19/2020 and 9/2020. The facility was found with 42 CFR 483.73 related	EO	000			
					IJ.		
		63 .9					
		:8					
ABODATORY	DIRECTOR'S OR BROWN	ER/SUPPLIER REPRESENTATIVE'S SIGN	1ATLIDE	TITLE	20.		X6) DATE

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