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

PRINTED: 01/15/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		185442					
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 2120 PAYNE STREET LOUISVILLE, KY 40206	CODE	<u>  U1/</u>	11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CO	A SHOULD	RE	(X5) COMPLETION DATE
F 000	was conducted on 0 found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re	red Infection Control Survey 01/11/2021. The facility was oliance with 42 CFR 483.80 ulations and has implemented licare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 83.	F	DEFICIENCY)			
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		(X	(6) 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.

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

PRINTED: 01/15/2021 FORM APPROVED OMB NO. 0938-0301

		(X1) PROVIDER/SUPPLIER/CLIA	(2002.24)		OMB NO	OMB NO. 0938-03	
		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED	
		185442					
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		01/11/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	HOLLD DE COMPLETA	
E 000	Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was conducted on 01/11/2021. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).		EC	000	·		
ATORY D	RECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE		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

(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 IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: \_\_\_ COMPLETED 100248 B. WING 01/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET NAZARETH HOME CLIFTON LOUISVILLE, KY 40206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE 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 conducted 01/11/2021. The facility was found to be in compliance pursuant to 42 CFR 483.80.

TITLE

F1V511

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

STATE FORM