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

PRINTED: 06/25/2020 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	
		185456	B. WING				C 04/03/2020	
NAME OF PROVIDER OR SUPPLIER SENECA PLACE				352	REET ADDRESS, CITY, STATE, ZIP 6 DUTCHMANS LANE UISVILLE, KY 40205	CODE	04/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		
F 000	INITIAL COMMENT	rs .	F	000				
	Focused Infection 0 03/31/2020 and cor Complaint KY#0003 both unsubstantiate The facility was four CFR 483.80 infection implemented the Complemented the Complemented the Complemented practice of the complemented practic	control Survey was initiated on included on 04/03/2020. B1224 and KY#00031272 were and with no deficiencies cited. Indicate to be in compliance with 42 on control regulations and has enters for Medicare & CMS) and Centers for deficient to prepare for insus 97.						
ABORATORY	DIRECTOR'S OR PROVIDE	ER/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.

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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	
185456			B. WING			C 04/03/2020	
NAME OF PROVIDER OR SUPPLIER SENECA PLACE				STREET ADDRESS, CITY, ST 3526 DUTCHMANS LANE LOUISVILLE, KY 4020	·	04/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPR ICIENCY)	BE COMPLÉTION	
E 000	Survey was initiated concluded on 04/03	sed Emergency Preparedness d on 03/31/2020 and 3/2020. The facility was found with 42 CFR 483.73 related	EC	000	(a)		
					ं •		
ABORATORY	DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

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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: _____ 100256 B. WING 04/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3526 DUTCHMANS LANE SENECA PLACE** LOUISVILLE, KY 40205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031224, Complaint KY#00031272 and a COVID-19 Focused Infection Control Survey was initiated on 03/31/2020 and concluded on 04/03/2020. Complaint KY#00031224 and KY#00031272 were both unsubstantiated with no deficiencies cited. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE