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

PRINTED: 01/26/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED						
					R-C						
185456			B. WING			01/05/2021					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
SENECA	PLACE			3526 DUTCHMANS LANE							
OLINEOA	FLAGE			LOUISVILLE, KY 40205							
(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 SHOUT FAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE				
{E 000}	Initial Comments		{E 000}		}						
	Revisit Survey was facility was found to	sed Emergency Preparedness conducted on 01/05/21. The be in compliance as alleged ection with 42 CFR 483.73 b)(6).									
					21						
LABORATOR'	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		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	
						R-C	
185456			B. WING			01/05/2021	
SENECA	PROVIDER OR SUPPLIER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205				
	CULTURA BY STA	TENENT OF PERIORNOLES	10			1	nur.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	determined the faci alleged in the acce effective 12/19/202 11/17/2020. The facompliance with 42 regulations and has Medicare and Medi	as completed on 01/05/21 and ility to be in compliance as ptable Plan of Correction, 0 for the survey completed on cility was found to be in CFR 483.80 infection control is implemented the Centers for icaid Services (CMS) and	{F 0	00}			
		e Control and Prevention ed practices to prepare for ensus 89.					
	9.						
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

PRINTED: 01/26/2021 FORM APPROVED 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: _ R-C B. WING _ 100256 01/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE SENECA PLACE LOUISVILLE, KY 40205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {N 000} Initial Comments {N 000} A Revisit Survey was conducted on 01/05/21 and determined the facility to be in compliance on 12/19/2020 as alleged in the acceptable Plan of Correction. The facility was found to be in compliance with 42 CFR 483.80. Total census 89.

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

TITLE

(X6) DATE