DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2020 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ 185169 B. WING 10/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE LOUISVILLE, KY 40222 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 A COVID-19 Focused Infection Control Survey was initiated on 10/21/2020 and concluded on 10/21/2020. 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. Total census 64.

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.

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

TITLE

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X2) MULTIPLE CONSTRUCT (X2) MULTIPLE CONSTRUCT (X3) MULTIPLE CONSTRUCT (X4) MULTIPLE CONSTRUCT (X5) MULTIPLE CONSTRUCT (X6) MULTIPLE CONSTRUCT (X7) MULTIPLE CONSTRUCT (X8) MULTIPLE CONSTRUCT (X8) MULTIPLE CONSTRUCT (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X3) MULTIPLE CONSTRUCT (X4) MULTIPLE CONSTRUCT (X5) MULTIPLE CONSTRUCT (X6) MULTIPLE CONSTRUCT (X7) MULTIPLE CONSTRUCT (X8) MULTIPLE C

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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	
		185169	B. WING			40/04/0000	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB 8				WE STREET ADDRESS, CITY, STATE, ZIP CODE  1801 LYNN WAY  LOUISVILLE, KY 40222			
(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 SHOUTH APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH		IDAF	(X5) COMPLETION DATE
E 000	Initial Comments		E 000				
	10/21/2020, the fac	sed Emergency Preparedness d on 10/21/2020 concluded on ility was found to be in CFR 483.73 related to					
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	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

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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 B. WING 100533 10/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1801 LYNN WAY** SIGNATURE HEALTHCARE AT JEFFERSON MA LOUISVILLE, KY 40222 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX **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 initiated 10/21/2020 and concluded on 10/21/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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TITLE

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

STATE FORM