DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/24/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING_ COMPLETED 185335 B. WING NAME OF PROVIDER OR SUPPLIER 07/23/2020 STREET ADDRESS, CITY, STATE, ZIP CODE SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214 SUMMARY STATEMENT OF DEFICIENCIES ΙĐ PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 A COVID-19 Focused Infection Control Survey was initiated on 07/23/2020 and concluded on 07/23/2020. 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 85.

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.

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

TITLE

(X6) DATE

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

PRINTED: 07/24/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING		COMPLETED		
		185335	B. WING			07/23/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214				44444
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments A COVID-19 Focus	sed Emergency Preparedness	E	000			
	Survey was initiated concluded on 07/23	d on 07/23/2020 and 3/2020. The facility was found with 42 CFR 483.73 related					
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							¥.,
LABORATORY	A DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	MATURE		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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If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING; COMPLETED B. WING 100452 07/23/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD SIGNATURE HEALTHCARE OF SOUTH LOUIS\ LOUISVILLE, KY 40214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **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 initiated 07/23/2020 and concluded on 07/23/2020. 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

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Office of Inspector General

STATE FORM