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

PRINTED: 06/26/2020 FORM APPROVED OMB NO. 0938-0391

F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey initiated on 08/12/2020 and concluded on 08/12/2020. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicard Services (CMS)and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census was 118.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
SIGNATURE HEALTHCARE AT SUMMERFIELD REHAB & WELLNE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (X4) ID PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) FOUND INITIAL COMMENTS A COVID-19 Focused Infection Control Survey initiated on 06/1/2/2020 and concluded on 06/1/2/2020 and concluded on 06/1/2/2020 and concluded on 06/1/2/2020 and concluded on 06/1/2/2020 the facility was found 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 was 118.			185300	B. WING				
(A4) ID SUMMARY STATEGEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFEX TAG FOOD INITIAL COMMENTS A COVID-19 Focused Infection Control Survey initiated on 06/12/2020 and concluded on 06/17/2020. The facility was found 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 was 118.	ŀ		SUMMERFIELD REHAB & WEL		S1 18	377 FARNSLEY ROAD	_ _06	<u> 5/17/2020</u>
A COVID-19 Focused Infection Control Survey initiated on 06/12/2020 and concluded on 06/17/2020. The facility was found 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 was 118.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT AG CROSS-REFERENCED TO THE APPRO		DRE	COMPLETION	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE	F 000	A COVID-19 Focus initiated on 06/12/20 06/17/2020. The fa with 42 CFR 483.80 and has implemented Medicaid Services (Control and Preven practices to prepare	sed Infection Control Survey D20 and concluded on cility was found in compliance infection control regulations ed the Centers for Medicare & CMS)and Centers for Disease tion (CDC) recommended	F	000	DEFICIENCY		
TITLE (X6) DATE	ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE		TITLE		

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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STATEMENI	OF DEFICIENCIES	(VA) PROVIDED SERVICES			OMB_NC	0.0938-039	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
185300			B. WING				
	PROVIDER OR SUPPLIER JRE HEALTHCARE A	T SUMMERFIELD REHAB & WE		STREET ADDRESS, CITY, STATE, 1877 FARNSLEY ROAD LOUISVILLE, KY 40216	ZIP CODE	/17/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	00			
	concluded on 06/17	sed Emergency Preparedness d on 06/12/2020 and 7/2020. The facility was found with 42 CFR 483.73 related					
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN		TITLE			

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

TITLE

(X6) DATE

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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 IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED 100517 B. WING _ 06/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIGNATURE HEALTHCARE AT SUMMERFIELD **1877 FARNSLEY ROAD** LOUISVILLE, KY 40216 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 06/12/2020 and concluded on 06/17/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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STATE FORM