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

PRINTED: 09/03/2020 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE (X4) ID PRETRY TAG SUMMAY STATEMENT OF DEFICIENCIES (EACH DEPOSITION OF CORRECTION REGULATORY OR LSC DEPITIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused infection Control Survey was initiated on 08/31/2020 and concluded on 08/31/2020. The facility was found to be 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 69. | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|------|--|------------------------------|----------|
| SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 08/31/2020 and concluded on 08/31/2020. 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 | | | 185335 | B. WING | | | 08/31/2020 | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 08/31/2020 and concluded on 08/31/2020. 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 | | | | | 1120 | CRISTLAND ROAD | 1 00 | O ITESES |
| A COVID-19 Focused Infection Control Survey was initiated on 08/31/2020 and concluded on 08/31/2020. 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 | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | N SHOULD BE E APPROPRIATE | |
| ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE | | A COVID-19 Focus was initiated on 08/08/31//2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommende COVID-19. Total ce | sed Infection Control Survey 31/2020 and concluded on scility was found to be in CFR 483.80 infection control simplemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for nsus 69. | | 000 | | | |

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 | |
|--|--|---|--|---|---|-------------------------------|-----------|
| | | 185335 | B. WING | | | 08/31/2020 | |
| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE | | | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE 120 CRISTLAND ROAD OUISVILLE, KY 40214 | | |
| (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 CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY) | | JLD BE COMPLETION | |
| E 000 | Initial Comments | | Ε¢ | 000 | | | |
| | Survey was initiated concluded on 08/31 | ed Emergency Preparedness d on 08/31/2020 and /2020. The facility was found with 42 CFR 483.73 related | | | | | |
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| ABORATORY | DIRECTOR'S OR PROVIDE | ER/SUPPLIER REPRESENTATIVE'S SIGN | 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 program participation.

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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: _ B. WING_ 100452 08/31/2020 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 PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 08/31/2020 and concluded on 08/31/2020. 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