DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/22/2020 FORM APPROVED OMB NO 0938-0391

STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185169	B. WNG		09/08/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SIGNATU	RE HEALTHCARE AT JE	FFERSON MANOR REHAB & WE		1801 LYNN WAY LOUISVILLE, KY 40222	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(2(5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	and a second sec
				Preparation and execution of this	
F 000	INITIAL COMMENTS		F 000		
	_			constitute an admission or	
}		d Infection Control Survey		agreement by the provider of the	
-		cluded on 09/08/2020 with a Scope and severity of a "D".		truth of the facts alleged	
1		to be in compliance with 42		or conclusions set forth in alleged	
		control regulations and has		deficiencies. This allegation of compliance is prepared and/or	
	implemented the Cen	_		executed solely because it is require	he
	Medicaid Services (C			by the provisions of Federal	
	Disease Control and			and State law.	
	recommended practic COVID-19.	es to prepare for			
F 842 SS≖D	Resident Records - Io CFR(s): 483.20(f)(5),		F 842		
	 (i) A facility may not no resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or co- except to the extent the to do so. §483.70(i) Medical re- §483.70(i) (1) In accor- professional standard must maintain medicat that are- (i) Complete; (ii) Accurately documed (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The faci- all information contain 	lease information that is on a agent only in intract under which the agent disclose the information the facility itself is permitted cords. dance with accepted s and practices, the facility if records on each resident ented; a; and panized lity must keep confidential red in the resident's records, or storage method of the		How corrective action will be accomplished for those residents for to have been affected by the deficien- practice; Physician orders for Resident #1, #2 and # 3 were updated to include documentation in the medical record of oxygen saturation (BID) tw on a day on 9/8/20 by the Director of Nursing. How the facility will identify other res having the potential to be affected b same deficient practice; Director of Nursing completed 100% audit of all residents to verify order for oxygen saturation that included documentation of those results in th medical record on 9/23/20.	nt ice F sidents y the
LABORATORY	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE	N	TITLE	(X6) DATE
	$C \Pi D$		12An	votateun	9-76-20

Any deficiency statement ending with an asiensk (*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100533

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If continuation artest Page	1 of 6
SEP 28 2023	
OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES	

		ID HUMAN SERVICES MEDICAID SERVICES				APPROVE 0. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185169	B. WING		09/	08/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1801 LYNN WAY		
SIGNATU	KE HEALTHCAKE AT JE	FFERSON MANOR REHAB & WE		LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(CS) COMPLETIO DATE
			1	What measures will be put in	to place or	1
F 842	Continued From page	1	F 842	systemic changes made, to e		
	(i) To the individual, o	r their resident		deficient practice will not rec		
		permitted by applicable law;		dencient practice win not ret	.01;	
	(ii) Required by Law;			Director of Nursing and/or U	nit Managers	
	(iii) For treatment, pay			will audit all new admissions		
		ed by and in compliance		saturation orders to include		
	with 45 CFR 164.506; (iv) For public health (activities, reporting of abuse,		of the resident's oxygen satu		
		iolence, health oversight		medical record five days a	a diotrint the	
		administrative proceedings,		week during clinical meeting.		
	law enforcement purp	•		freek burnig einiegt meening.	,	
		urposes, or to coroners,		Education started on 9/8 with	licensed	
		neral directors, and to avert		Staff and was completed on S		
		alth or safety as permitted		and 9/30 by the Staff Develo		
	by and in compliance	with 45 CFR 164.512.		Coordinator regarding the op		
	0 400 70/0/0) The feet			Saturation orders have been		
		lity must safeguard medical alnst loss, destruction, or		updated to include document		
	unauthorized use.	anst loss, destruction, of		resident's oxygen saturation i		
				record which occurs (BID) twi		
	§483.70(i)(4) Medical	records must be retained		record which occurs (BiD) (Wi	ce a day.	
	for-			How the facility will		
- 1		required by State law; or		How the facility will monitor i	ts	
		a date of discharge when		Corrective actions to ensure	that the	
	there is no requirement			Deficient practice is being co	rrected	
	legal age under State	rs after a resident reaches iaw.		and will not recur; and		
	§483.70(i)(5) The med	lical record must contain-				
	• • • • •	on to identify the resident;				
	(ii) A record of the resi	dent's assessments;				
		e plan of care and services		DEC		-
	provided;				EIVED	
	(IV) The results of any and resident review ev	preadmission screening				
	determinations conduct			SEP	28	
	(v) Physician's, nurse's	•				
	professional's progres			DIVISION OF HEALTHIC	SPECTOR GENE ARE FACILITIES AND SER	LAL
		gy and other diagnostic	1		THE PROJUTILES AND SER	ICES

FORM CMS-2567(02-99) Previous Versions Obsolete -

Event ID W113411

Family ID-100523

If continuation sheet Page 2 of 6

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.1.1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			Survey Leted
		185169	8 WING			09/	08/2020
	ROVIDER OR SUPPLIER	FFERSON MANOR REHAB & WE		11	IREET ADDRESS, CITY, STATE, ZIP CODE 101 LYNN WAY DUISVILLE, KY 40222		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIJ TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(245) COMPLETION DATE
F 842	services reports as re This REQUIREMENT by: Based on interview, policy, it was determi an effective system to were accurately docu resident's assessmer sampled residents (R Review of documenta respiratory assessment include the residents' parameters. Intervier assessments for COV residents' oxygen sat status. However, the document it on the re under vital signs nor specific respiratory in	is not met as evidenced record review and review of ned the facility failed to have o ensure clinical records imented to reflect the at for three (3) of three (3) resident #1, #2 and #3). ation of the residents' ent for COVID-19 did not oxygen saturation	F	342	Director of Nursing and/or Unit M will audit all new admissions for saturation orders to include docu of the resident oxygen saturation medical record. These audits beg 9/28/20 and will continue for 3 months and then re-evaluated by committee. Any issued identifie be corrected immediately. Reedu and/or counseling will be initiated necessary for noncompliance. Re from audit will be reviewed by th committee monthly for further re and recommendations.	oxygen mentation in the gan on the QAPI d will ication d as esults e QAPI	
	(COVID-19), revised facility made routine symptoms of COVID respiratory symptoms	s policy, Novel Coronavirus 08/31/2020, revealed the observations for respiratory -19. The facility reviewed s of all residents in the on clinical meetings. In			RECEIVE		
	addition, the facility w to ensure to monitor	rould review the symptoms for respiratory illness. It #1 clinical record revealed			RECEIVE SEP 28	1	

PRINTED: 09/22/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 09/08/2020 185169 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1801 LYNN WAY SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE LOUISVILLE, KY 40222 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ۱D. (X4) ID EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 842 F 842 **Continued From page 3** Respiratory Infection, and Dysphagia. Review of the resident's Physician's Orders revealed orders that included to monitor for change of condition. which included new/worse cough, fever, Shortness of Breath (SOB), sore throat, and difficulty breathing. Review of the resident's Treatment Administration Record (TAR) for August and September 2020 revealed the order included documentation of cough. However, review of the SOB record and the vital sign record revealed staff did not document the resident's oxygen saturation twice a day. Interview with Resident #1, on 09/08/2020 at 6:00 PM, revealed staff obtained oxygen saturation levels twice a day. The resident stated staff monitored the levels for COVID-19. 2. Review of Resident #2 clinical record revealed the facility admitted the resident on 06/04/2020, with the diagnoses of Pneumonia, Cognitive Communication Deficit, Dysphagia. Review of the resident's Physician's Orders included to monitor for change of condition, which included new/worse cough, fever, Shortness of Breath (SOB), sore throat, and difficulty breathing. Review of the resident's Treatment Administration Record (TAR) for August and September 2020 revealed the order included documentation of cough. However, record review revealed the TAR, vital sign records and the SOB record did not include documentation of oxygen saturation. twice a day, related to COVID-19 monitoring, Interview with Resident #2, on 09/08/2020 at 5:00 PM, revealed the staff obtained oxygen saturations levels twice a day. 3. Review of Resident #3's clinical record

FURM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WU3411 Facility ID: 100533

If continuation sheet Page-4-of 8-

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 185169 B. WING 09/08/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1801 LYNN WAY SIGNATURE HEALTHCARE AT JEFFERSON MANOR REHAB & WE LOUISVILLE, KY 40222 PROVIDER'S PLAN OF CORRECTION (75) SUMMARY STATEMENT OF DEFICIENCIES **ID** (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 842 F 842 Continued From page 4 revealed the facility admitted the resident on 05/07/18, with the diagnoses of Parkinson's disease, Sepsis Shock, and Dysphagia. Review of the resident's Physician's Orders included to monitor for change of condition, which included new/worse cough, fever, Shortness of Breath (SOB), sore throat, and difficulty breathing. Review of the resident's Treatment Administration Record (TAR) for August and September 2020 revealed the order included documentation of cough. However, the SOB record, revealed staff did not document oxygen saturation twice a day. Review of the resident's vital sign record revealed the facility staff did not document oxygen saturations twice a day daily. Interview with Licensed Practical Nurse (LPN) #1. on 09/08/2020 at 4:15 PM, revealed staff assessed a resident's status twice a day for respiratory symptoms related to COVID-19. She stated this included oxygen saturation levels. She stated the TAR did not have an area to document respiratory vital signs, including oxygen and respiratory rate. LPN #1 stated she did not put vital signs for the assessment in the resident's clinical record. She stated the facility would not be able to monitor for respiratory changes, and this piece of clinical information needed to be included for the clinical staff to review. Interview with Licensed Practical Nurse #2, on 09/08/2020 at 5:22 PM, revealed staff assessed a resident's status twice a day for respiratory RECEIVED symptoms related to COVID-19 as ordered by the physician. She stated an assessment included oxygen saturation levels. She stated resident the TAR's did not have an area to document respiratory vital signs, which included oxygen and OFFICE OF INSPECTOR GENER respiratory rate. LPN #2 stated the facility staff DIVISION OF HEALTH CARE I H contin alliget rage 5 of 8 FORM CMS-2557(02-99) Previous Versions Obsciele Facility ID: 100533 Event ID. WU3411

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S COMPL	
	CORRECTION	RRECTION IDENTIFICATION NUMBER:		A BUILDING		
		185169	8. WNG		09/0	8/2020
NAME OF PR	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	E HEALTHCARE AT	JEFFERSON MANOR REHAB & WE		1 LYNN WAY UISVILLE, KY 40222		
(X4) (D	SUMMAR	STATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORP		(745)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AU DEFICIENCY)		DATE
F 842		-	F 842			
		iratory changes twice a day ocument all respiratory related				
	09/08/2020 at 6:31	Director of Nursing (DON), on DPM, revealed her				
	She stated resider	cluded Infection Preventionist. Int respiratory assessments or oxygen levels. She stated				
	staff assessed res COVID-19 which i	idents twice a day for ncluded a full respiratory DON stated staff were to				
	document vital sig saturation levels.	ns, which included oxygen She stated if the resident's				
	as they were part then the facility co levels. Further int oxygen level trend	s levels were not documented, of the respiratory assessment, uld not review for abnormal erview revealed if the resident's led lower without other				
	exposed to the vir	ident's and staff could be us.				
	However, the DOI	was not available for interview. N stated she assumed the ties when he/she was not in the				
				RF	CEIVE	
					P 28 2020	
				OFFICE OF I DRASION OF HEALT	NSPECTOR GEN H CARE FACILITIES AND	ERAL

FORM CMS-2567(02:99) Previous Versions Obsolato Event ID: WU3111 Facility ID=100533

PRINTED: 09/22/2020 FORM APPROVED

		AND HUMAN SERVICES				FORM): 10/29/202 / APPROVE). 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		185169	B. WING			10	R /01/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		/01/2020
SIGNATU	JRE HEALTHCARE A	T JEFFERSON MANOR REHAB	& WE		01 LYNN WAY DUISVILLE, KY 40222		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	TS	{F 0	00}		8	
		mentation of the acceptable the facility was deemed to be 01/2020 as alleged.					
							3
BORATORY		ER/SUPPLIER REPRESENTATIVE'S SIG			7171 2		
		- CONTREMESENTATIVES SIC	JANURE		TITLE		(X6) DATE 09/26/2020

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.

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		PLETED
		185169	B. WING			R / 01/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE AT JE	FFERSON MANOR REHAB & WE		1801 LYNN WAY LOUISVILLE, KY 40222		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	6		
		entation of the acceptable he facility was deemed to be /2020 as alleged.				
_ABORATORY	UIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	(E	TITLE		(X6) DATE 09/26/2020

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: 12/02/2020

PRINTED: 10/29/2020 FORM APPROVED

INTERNATION OF DEFICIENCIES (N1) PROVIDERSUPPLIERCURAL (P2) MULTIPLE CONSTRUCTION (N3) DATE SUPPCY: COMMETED INDEXTOR OF CORRECTION INDEXTOR INFORMATION (P2) MULTIPLE CONSTRUCTION (N3) DATE SUPPCY: COMMETED INDEXTOR OF REVUICER OR SUPPLIER INDEXTOR INFORMATION INTEGET ADDRESS. CTV, STATE, ZIP CODE INDEXTOR HEALTHCARE AT JEFFERSON INTEGET ADDRESS. CTV, STATE, ZIP CODE INDEXTOR OF CORRECTION (N0) INDEXTOR OF USE OF DEFICIENCY OF THE SERVICE INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) (N0) INDEXTOR HEALTHCARE AT JEFFERSON INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) (N0) INDEXTOR OF USE OF DEFICIENCY OF THE SERVICE INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) INDEXTOR OF USE OF DEPICIENCY OF THE SERVICE INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) INDEXTOR OF USE OF DEPICIENCY OF THE SERVICE INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) INDEXTOR OF USE OF THE SERVICE OF THE SERVICE INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) INDEXTOR OF USE OF THE SERVICE OF THE SERVICE INTEGET ADDRESS. CTV, STATE, ZIP CODE (N0) INDEXTOR OF USE OF THE SERVICE OF THE SERVICE INTEGET ADDRESS (N0) INDEXTOR OF USE OF THE SERVICE OF THE SERVICE INTEGET ADDRESS (N0) INDEXTOR OF USE OF THE SERVICE OF THE SERVICE INTEGET ADDRESS (N0) DATE <	Office of	Inspector General				FURI	APPROVE
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MAKE OF FRONUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IGUATURE HEALTHCARE AT JEFFERSOM Idia LYNN WAY ICUISULE, KY 4022 IDIA CMUDON SUMMARY STATEMENT OF DEFICIENCIES IDIA PREX EXCLOSEVELLE, KY 4022 IDIA TAG ERCUATIONY OR LSC DEMINIPHING INFORMATION) IDIA PREVIX IDIA CROSS-REFERENCED TO THE APPROPRIATE IDIA (N 000) Initial Comments (N 000) Initial Comments (N 000) IDIA IDI			100533	B. WING			
INSTRUCT HEALTHCARE AT JEFFERSOM Boil LYNN Way UDUSVILLE, KY 40222 (K) 10 PREFIX Record Deficiency MUST EE PRECODED & FILLU Record Deficiency MUST EE PRECODED &	NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY.	STATE, ZIP CODE		
(X4) ID PREFX ISJUMARY STATEMENT OF DEFICIENCES ID PROVIDERS FLAND CORRECTION 0000 (RACH DEFICIENCY MOST BE PRECEDED &F JULI REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX ID PROVIDERS FLAND CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 0000 (RACH DEFICIENCY) (N 000) Initial Comments (N 000) Initial Comments (N 000) Based upon implementation of the acceptable Plan of Correction, the facility was deemed to be in compliance, 10/01/2020 as alleged. (N 000)	SIGNATU	IRE HEALTHCARE A	LIFEFERSON MI 1801 LYN	IN WAY			
Based upon implementation of the acceptable Plan of Correction, the facility was deemed to be in compliance, 10/01/2020 as alleged.	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF	ULD BE	(X5) COMPLET DATE
09/26/2		Plan of Correction,	the facility was deemed to be				
	BORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	3	
							09/26/20