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

PRINTED: 01/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185349	B. WING			12/18/2020		
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	1 12	110/2020		
		T JEFFERSON PLACE REHAB &	WE LOUISVILLE, KY 40222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOLE TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		D.RE COMPLETION		
F 000	was concluded on 1 found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re	red Infection Control Survey 12/18/2020. The facility was oliance with 42 CFR 483.80 pulations and has implemented ficare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 55.	F	000	DEFICIENCY			
AROBATORY	DIDECTOR OF THE					82		
YPOUNI ORY	PINES TOR'S OR PHOVIDE	R/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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185349	B. WING		<u> </u>	12/18/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JEFFERSON PLACE REHAB &				170	REET ADDRESS, CITY, STATE, ZIP CODE 15 HERR LANE UISVILLE, KY 40222	1 12	710/2020
(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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focus Survey was comple	ed Emergency Preparedness ted on 12/18/2020. The facility compliance with 42 CFR		000	DEFICIENCY)	THIAIE	
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN.		- 10 - 0) - 0 0-	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 (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING _ 100644 12/18/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1705 HERR LANE SIGNATURE HEALTHCARE AT JEFFERSON PL LOUISVILLE, KY 40222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (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 DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was concluded on 12/18/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

TITLE

4UGX11

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

STATE FORM