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

PRINTED: 12/04/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE X D SUMMARY STATEMENT OF DEFICIENCIES LOUISVILLE, KY 40220 (X/) ID PREFIX EACH DEPRICENCY MUST BE PRISCRED BY MULTIPATE LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCIES LOUISVILLE, KY 40220 (X/) ID PREFIX EACH DEPRICENCE BY A LOUISVILLE, KY 40220 (X/) ID PREFIX EACH DEPRICENCE BY A LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCIES LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCIES LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCIES LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRISCRED BY MULTIPATE LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRISCRED BY MUST BE PRISCRED BY MUST BE LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRISCRED BY MUST BE LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCE STATEMENT OF LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCE STATEMENT OF LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCE STATEMENT OF LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF DEFICIENCE STATEMENT OF LOUISVILLE, KY 40220 (X/) ID SUMMARY STATEMENT OF LOUISVILLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE (X4) ID PREFIX (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 conducted on 11/17/2020. 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			185350				4414	17/2020	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focus was initiated conducted facility was found to CFR 483.80 infection implemented the C Medicaid Services Disease Control and recommended practical COVID-19. Total complements of the Covid-19 covided the Covi	sed Infection Control Survey acted on 11/17/2020. The obe in compliance with 42 on control regulations and has enters for Medicare & (CMS) and Centers for ad Prevention (CDC) ctices to prepare for ensus 83.		000	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.

Event ID:06GB11

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

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CENTERS FOR MEDICARE & MEDICARD SERVICES							-
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185350	B. WING	-		11/1	7/2020
	PROVIDER OR SUPPLIER	F EAST LOUISVILLE		25	FREET ADDRESS, CITY, STATE, ZIP CODE 529 SIX MILE LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF COP PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		HOULD BE COMPLETION	
E 000	Initial Comments	sed Emergency Preparedness	E	000			
	Survey was conduct	oted on 11/17/2020. The be in compliance with 42					
			1 0 0				
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LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING _ 11/17/2020 100428 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2529 SIX MILE LANE SIGNATURE HEALTHCARE OF EAST LOUISVII LOUISVILLE, KY 40220 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 Focused Infection Control Survey was conducted on 11/17/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE