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

PRINTED: 01/04/2021 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	
		185350	B. WING			12/08/2020	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE  2529 SIX MILE LANE  LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 000	was conducted on found to be in compinfection control reg the Centers for Med (CMS) and Centers Prevention (CDC) reprepare for COVID-	sed Infection Control Survey 12/08/2020. The facility was oliance with 42 CFR 483.80 qulations and has implemented dicare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 87.					
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATLIDE	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.

TITLE

(X6) DATE

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

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0301

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					
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE				25	TREET ADDRESS, CITY, STATE, ZIP CODE 529 SIX MILE LANE OUISVILLE, KY 40220	_( 12	2/08/2020	
(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 CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			I D BE COMPLETION	
E 000	Initial Comments		ΕŒ	000				
	Survey was conduc	ed Emergency Preparedness ted on 12/08/2020. The be in compliance with 42 to E-0024 (b)(6).						
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	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 program participation.

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(X6) DATE

If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 100428 B. WING \_ 12/08/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE SIGNATURE HEALTHCARE OF EAST LOUISVIL LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 12/08/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

XH3211

TITLE

Office of Inspector General

STATE FORM