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

PRINTED: 01/25/2021 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				MB NO. 0938-0391	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		195240	B. WING				С	
NAME OF PROVIDER OR SUPPLIER		B. WING				01/	20/2021	
SYCAMORE HEIGHTS HEALTH AND REHABILITATION				2141 SYC	ODRESS, CITY, STATE, ZIP COD AMORE AVENUE LLE, KY 40206	Œ		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (E	PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH OSS-REFERENCED TO THE API DEFICIENCY)	HOULD	BE	COMPLETION DATE
F 000	was conducted on C found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re	ed Infection Control Survey 01/20/2020. The facility was diance with 42 CFR 483.80 ulations and has implemented licare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 70.	F	000				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE		TITLE		F	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.

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

PRINTED: 01/25/2021 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					
		185348	B. WING		***************************************	C				
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	01/20/2021				
SYCAMORE HEIGHTS HEALTH AND REHABILITATION					2141 SYCAMORE AVENUE LOUISVILLE, KY 40206					
(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 APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(XS) COMPLETION DATE			
E 000	Initial Comments		E 00							
	Survey was conduc	ted Emergency Preparedness ted on 01/20/2021. The be in compliance with 42 to E-0024 (b)(6).								
ã.										
_ABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	_	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.

PRINTED: 01/25/2021 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: _ C 100197 B. WING _ 01/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE SYCAMORE HEIGHTS HEALTH AND REHABILI LOUISVILLE, KY 40206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (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 TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 01/20/2021. 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