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

PRINTED: 11/09/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE CONSTRUCTION				<u> MB NO. 0938-0391</u>	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		185348	B. WING	;		10	122/2020	
NAME OF PROVIDER OR SUPPLIER SYCAMORE HEIGHTS HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 000	A COVID-19 Focus was conducted on a found to be in compinifection control regithe Centers for Med (CMS) and Centers Prevention (CDC) reprepare for COVID-	sed Infection Control Survey 10/23/2020. The facility was bliance with 42 CFR 483.80 gulations and has implemented dicare & Medicaid Services for Disease Control and ecommended practices to		000				
		-NOUPPLIER 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

(X6) DATE

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

PRINTED: 11/09/2020 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	·		10	/23/2020
NAME OF PROVIDER OR SUPPLIER SYCAMORE HEIGHTS HEALTH AND REHABILITATION				2	TREET ADDRESS, CITY, STATE, ZIP CODE 141 SYCAMORE AVENUE OUISVILLE, KY 40206	1 10	23/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
E 000	A COVID-19 Focused Emergency Preparedness Survey was conducted on 10/23/2020. The		E	000			
	CFR 483.73 related	be in compliance with 42 to E-0024 (b)(6).					
				10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -			
ABORATORY	DIRECTOR'S OR PROVIDI	ER/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.

PRINTED: 11/09/2020

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: ___ B. WING 100197 10/23/2020 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 (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 DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted 10/23/2020 and 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