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

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
185348			B. WING			11/13/2020	
	PROVIDER OR SUPPLIER PRE HEIGHTS HEALT	H AND REHABILITATION		21	TREET ADDRESS, CITY, STATE, ZIP CODE 141 SYCAMORE AVENUE OUISVILLE, KY 40206	, ,,,	10/200
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	was conducted on found to be in compinfection control reg the Centers for Mer (CMS) and Centers Prevention (CDC) r	sed Infection Control Survey 11/13/2020. The facility was pliance with 42 CFR 483.80 gulations and has implemented dicare & Medicaid Services of for Disease Control and recommended practices to -19. Total census 62.		0000			
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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) DA	(X3) DATE SURVEY COMPLETED	
		185348	B. WING		11	11/13/2020	
	PROVIDER OR SUPPLIER PRE HEIGHTS HEALT	H AND REHABILITATION		STREET ADDRESS, CITY, STATE, 2 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	ZIP CODE	13/2020	
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTT AG CROSS-REFERENCED TO THE APPLICATION CROSS-REFERENCED TO THE APPLICAT		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		ΕC	000			
	Survey was conduct	sed Emergency Preparedness sted on 11/13/2020. The be in compliance with 42 d to E-0024 (b)(6).					
						:	
						:	
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IDE	TITLE		(X6) DATE	

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PRINTED: 12/01/2020 **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: ____ 100197 B. WING 11/13/2020 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 PROVIDER'S PLAN OF CORRECTION (X4) 1D (X5) COMPLETE DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** 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 11/13/2020. 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