DEPART CENTER	PRINTED: 09/08/2020 FORM APPROVED							
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
NAME OF	200/2050 00 00 00 00	185194	B. WING			C 08/20/2020		
NAME OF PROVIDER OR SUPPLIER  THE FORUM AT BROOKSIDE					TREET ADDRESS, CITY, STATE, ZIP CODE 00 BROOKSIDE DRIVE OUISVILLE, KY 40243	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000				
	Focused Infection C 08/19/2020 and cor Complaint KY#0003 unsubstantiated wit facility was found to CFR 483.80 infection implemented the Co	KY00032329 and a COVID-19 Control Survey was initiated on necluded on 08/20/2020. 30553 and KY00032329 was h no deficiencies cited. The be in compliance with 42 on control regulations and has enters for Medicare & (CMS) and Centers for d Prevention (CDC) etices to prepare for						

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.

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

TITLE

(X6) DATE

DEPART CENTER	PRINTED: 09/08/2020 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185194	B. WING		C		
NAME OF PROVIDER OR SUPPLIER  THE FORUM AT BROOKSIDE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243	_ 1 _ 08/	20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		II D RE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00			
	Survey was initiated concluded on 08/20	sed Emergency Preparedness d on 08/19/2020 and 0/2020. The facility was found with 42 CFR 483.73 related					

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.

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

TITLE

(X6) DATE

PRINTED: 09/08/2020 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: \_\_ C B. WING 100551 08/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE THE FORUM AT BROOKSIDE LOUISVILLE, KY 40243 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating KY#00030553 and KY0032329 and a COVID-19 Focused Infection Control Survey was initiated on 08/19/2020 and concluded on 08/20/2020. Complaint KY#00030553 and KY00032329 was unsubstantiated with no deficiencies cited. 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 COVID-19, Total census 36,

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TITLE

(X6) DATE