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

PRINTED: 05/21/2020 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) DA1	(X3) DATE SURVEY COMPLETED	
	· · · · · · · · · · · · · · · · · · ·	185175	B. WING				04/17/2020		
NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS				STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRÉCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)			LD BE COMPLETION	
F 000	INITIAL COMMENTS		F 000						
	was initiated on 04/ 04/17/2020. The far compliance with 42 regulations and has Medicare & Medica Centers for Disease	sed Infection Control Survey 16/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and e Control and Prevention							
	COVID-19. Total ce	ed practices to prepare for nsus 18.							
			nes						
10 - 1000 III A									
6									
								SI	
ABORATORY	DIRECTOR'S OR PROVIDE	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.

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		185175		<u> </u>				0.4/47/0.000			
NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS				STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203					04/17/2020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)				(X5) COMPLETION DATE		
E 000	Initial Comments  A COVID-19 Focused Infection Control Survey was initiated on 04/16/2020 and concluded on 04/17/2020. 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		EC	000							
	(CDC) recommende COVID-19. Total ce	ed practices to prepare for									
. 76											
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE				(X6) DATE		

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