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

PRINTED: 11/16/2021 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A, BUILDING				R
		185175	75 B. WING			11/05/2021	
	ROVIDER OR SUPPLIER			211	REET ADDRESS, CITY, STATE, ZIP CODE I WEST OAK STREET DUISVILLE, KY 40203		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{E 000}	Survey was condu	used Emergency Preparedness locted on 11/03/2021. The facility a compliance with 42 CFR E-0024 (b)(6).	{E 0	000}			
		OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATUR		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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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			R	
	185175		B. WING		11/05/2021			
	PROVIDER OR SUPPLIER			211 W	ET ADDRESS, CITY, STATE, ZIP CODE WEST OAK STREET ISVILLE, KY 40203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{E 000}	Initial Comments		{E 0	000}				
	Survey was condu	ised Emergency Preparedness octed on 11/03/2021. The facility compliance with 42 CFR E-0024 (b)(6).						
				2				
							- 40	
		OVIDER/SUPPLIER REPRÉSENTATIVE'S S			TITLE		(X6) DATE	

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			R-C		
	185175			B. WING 11/05/20				
NAME OF P	ROVIDER OR SUPPLIER				WEST OAK STREET			
TREYTON	NOAK TOWERS	•		LC	OUISVILLE, KY 40203	~	17(5)	
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			שש טוע.	COMPLETION DATE	
{F 000}	INITIAL COMMEN	ITS	{F 0	(00)				
	concluded on 11/0 completed on 06/2 determined the fa	was initiated on 11/02/2021 and 05/2021, for the survey 24/2021. This revisit cility had achieved substantial /2021, as alleged.						
	was also conduct in compliance wit Control regulation Centers for Medicand the Centers for Prevention (CDC)	used Infection Control Survey ed. The facility was found to be h 42 CFR 483.80 Infection hs and had implemented the care & Medicaid Services (CMS) for Disease Control and) recommended practices to ID-19. Total census was 42.						
,								
		OVIDER/SUPPLIER REPRESENTATIVE'S			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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Office of	Inspector General	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100548		A. BUILDING:		R-C 11/05/2021	
			B. WING			
			DRESS, CITY, ST	ATE, ZIP CODE		
	PROVIDER OR SUPPLIER		OAK STREE			
TREYTO	N OAK TOWERS	LOUISVIL	LE, KY 40203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{N 000}	and concluded on completed on 06/2 implemented the F with a compliance COVID-19 Focuse also conducted an compliance with 4 regulations and ha Medicare & Medic Centers for Disease	Survey, initiated on 11/02/2021 11/05/2021, for the survey 14/2021 determined the facility Plan of Correction as alleged date of 08/12/2021. A ad Infection Control Survey was d the facility was found to be in 2 CFR 483.80 infection control as implemented the Centers for aid Services (CMS) and se Control and Prevention ded practices to prepare for sensus 42.	{N 000}			

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

TITLE

(X6) DATE