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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185175	A. BUILDING _____ B. WING _____	R 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYTON OAK TOWERS	211 WEST OAK STREET LOUISVILLE, KY 40203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on 11/03/2021. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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	A. BUILDING _____ B. WING _____	R-C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYTON OAK TOWERS	211 WEST OAK STREET LOUISVILLE, KY 40203

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{F 000}	INITIAL COMMENTS An on-site revisit was initiated on 11/02/2021 and concluded on 11/05/2021, for the survey completed on 06/24/2021. This revisit determined the facility had achieved substantial compliance 08/12/2021, as alleged. A COVID-19 Focused Infection Control Survey was also conducted. The facility was found to be in compliance with 42 CFR 483.80 Infection Control regulations and had implemented the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census was 42.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100548	A. BUILDING: _____ B. WING _____	R-C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYTON OAK TOWERS	211 WEST OAK STREET LOUISVILLE, KY 40203

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{N 000}	Initial Comments An on-site Revisit Survey, initiated on 11/02/2021 and concluded on 11/05/2021, for the survey completed on 06/24/2021 determined the facility implemented the Plan of Correction as alleged with a compliance date of 08/12/2021. A COVID-19 Focused Infection Control Survey was also conducted and 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 42.	{N 000}		

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