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

PRINTED: 12/16/2020 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) DATE SURVEY COMPLETED			
		185455	B. WING		12	19/14/9999		
NAME OF PROVIDER OR SUPPLIER VALHALLA POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245				
(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 CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)		LD BE COMPLETION			
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey		F	000				
	found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re	2/14/2020. The facility was liance with 42 CFR 483.80 ulations and has implemented licare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 113.						
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						7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		
Day and And A								
				JA:				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185455	B. WING			40/44/2000	
NAME OF PROVIDER OR SUPPLIER VALHALLA POST ACUTE				300	REET ADDRESS, CITY, STATE, ZIP CODE SHELBY STATION DRIVE UISVILLE, KY 40245	_112	/14/2020
(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 SHOUT AGE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE O			(X5) COMPLETION DATE
E 000	Survey was conduc	ted Emergency Preparedness ted on 12/14/2020. The facility compliance with 42 CFR 0024 (b)(6).	E	000			
					67/		
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE		TITLE		(X6) DATE

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(X6) DATE

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING 101018 12/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 SHELBY STATION DRIVE VALHALLA POST ACUTE** LOUISVILLE, KY 40245 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated and concluded on 12/14/2020. 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