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

PRINTED: 01/25/2021 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	
		185136	B. WING			01/25/2021	
NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR				5	TREET ADDRESS, CITY, STATE, ZIP CODE 012 EAST MANSLICK RD OUISVILLE, KY 40219	1 011	ZUZUZI
(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 CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION	
F 000	was conducted on 0 found to be in comp infection control reg the Centers for Med (CMS) and Centers Prevention (CDC) re	red Infection Control Survey 01/25/2020. The facility was oliance with 42 CFR 483.80 relations and has implemented licare & Medicaid Services for Disease Control and ecommended practices to 19. Total census 52.	F		DEFICIENCY		
ABORATORY	( DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATLINE		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.

PRINTED: 01/25/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING\_ COMPLETED 185136 **B. WING** 01/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5012 EAST MANSLICK RD WESLEY MANOR** LOUISVILLE, KY 40219 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CAOSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 000 Initial Comments E 000 A COVID-19 Focused Emergency Preparedness Survey was conducted on 01/25/2021. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).

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.

PRINTED: 01/25/2021 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: \_ B. WING \_ 100230 01/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5012 EAST MANSLICK RD WESLEY MANOR** LOUISVILLE, KY 40219 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 01/25/2021. 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