DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185361	B. WING _			05/19/2020		
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
KINDRED HOSPITAL - LOUISVILLE				1313 ST. ANTHONY PLACE				
				LC				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SHOULD BE COMPLETION			
F 000	INITIAL COMMENTS		F	000				
	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 05/18/2020 and concluded on 05/19/2020. 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 (CDC) recommended practices to prepare for COVID-19. Total census 38.			F 000				
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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: 05/22/2020

							APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
185361		B. WING			05/19/2020			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
KINDRED	KINDRED HOSPITAL - LOUISVILLE			1313 ST. ANTHONY PLACE				
				LOUISVILLE, KY 40205				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DRRECTIVE ACTION SHOULD BE COMPLETIC FERENCED TO THE APPROPRIATE DATE		
E 000	Initial Comments		E 00		D			
	Survey was initiated of concluded on 05/19/2	d Emergency Preparedness on 05/18/2020 and 2020. The facility was found <i>i</i> th 42 CFR 483.73 related						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	F		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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 100765			(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		B. WING		05/19/2020			
AME OF PF	OVIDER OR SUPPLIER	1	DDRESS, CITY, STATE		03/13/2020		
	HOSPITAL - LOUISVILL	E 1313 ST	. ANTHONY PLACE	i			
		LOUISV	ILLE, KY 40205				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ACTION SHOULD BE COMPL TO THE APPROPRIATE DATI		
N 000	Initial Comments		N 000				
	was initiated 05/18/2	d Infection Control Survey 020 and concluded on cility was found to be in t to 42 CFR 483.80.					