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

PRINTED: 05/15/2020 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	
		185294	B. WING			04/17/2020	
NAME OF PROVIDER OR SUPPLIER MAPLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 04/15 04/17/2020. The facil compliance with 42 Cregulations and has in Medicare and Medicar Centers for Disease Cregulation (CDC) recommended COVID-19. Total cens	d Infection Control Survey 5/2020 and concluded on ity was found to be in CFR 483.80 infection control implemented the Centers for aid Services (CMS) and Control and Prevention It practices to prepare for sus 91.					
LABORATORY	DIRECTOR'S OR PROVIDER/S	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.

Facility ID: 100343

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	18529		B. WING _	B. WING		04/17/2020	
NAME OF PROVIDER OR SUPPLIER MAPLE HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345			
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E 000	Survey was initiated concluded on 04/17/2	ed Emergency Preparedness on 04/15/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	000	DEFICIENCY)		
LABORATORY	DIRECTOR'S OR PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATUR	RF.		TITLE		(X6) DATE

(X6) DATE TITLE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
100343			B. WING 04/17/2020					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE								
MAPLE HI	MAPLE HEALTH AND REHABILITATION GREENVILLE, KY 42345							
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T	BE	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000					
N 000	A COVID-19 Focused		N 000					

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

TITLE (X6) DATE