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

PRINTED: 05/21/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CO A, BUILDING	(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED C		
185042			B. WING		2/2020		
	ROVIDER OR SUPPLIER	ND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719				
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	TS	F 000				
	a COVID-19 focus initiated on 05/11/2 05/12/2020. The cand no deficient pur facility was found to CFR 483.80 Infect implemented the CM Medicaid Services Disease Control at recommended pra	andard survey (KY31666) and ed infection control survey was 2020 and concluded on complaint was unsubstantiated ractice was identified. The to be in compliance with 42 ion Control and has Centers for Medicare & (CMS) and Centers for nd Prevention (CDC) ctices to prepare for that census was 65.					
=					T)		
	DIRECTORIS OF PROVIDE	EB/SI IPPI IED DEPRESENTATIVE'S SIGNATI I	<u> </u>	TITLE		YEL 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: 05/21/2020 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: _ C B. WING_ 100393 05/12/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **640 WATER TOWER BYPASS** THE GRANDVIEW NURSING AND REHABILITATION FA CAMPBELLSVILLE, KY 42719 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 Initial Comments N 000 A complaint investigation (KY31666) and a COVID-19 focused infection control survey was initiated on 05/11/2020 and concluded on 05/12/2020. The complaint was unsubstantiated and no deficient practice was identified. 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

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: 185042			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING				C _05/12/2020	
	ROVIDER OR SUPPLIER	D REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
- H	survey was initiated on 05/12/2020. The compliance with 42	ed Emergency Preparedness I on 05/11/2020 and concluded e facility was found to be in CFR 483.73 Emergency ed to E0024. No deficient ied.					ř.
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	No.						
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	DISEATONIC OR COOL IN	DISTIDUTED DEDDESENTATIVES SIGNATUD		TITLE			(YA) DATE

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