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

PRINTED: 06/12/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185271	B. WING _	B. WING		05/19/2020	
NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP C 1002 GLENVIEW DRIVE GLASGOW, KY 42141	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 05/19/05/19/2020. There waidentified at 42 CFR 4 regulations and the fa Centers for Medicare (CMS) and Centers for Prevention (CDC) recorded prepare for COVID-19	d Infection Control Survey 9/2020 and concluded on as no deficient practice 483.80 infection control acility has implemented the and Medicaid Services or Disease Control and commended practices to 9. Total census 50.		000			
LABORATORY	I DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	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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E 000	Initial Comments A COVID-19 Focuse Survey was initiated of concluded on 05/19/2	d Emergency Preparedness				AI E	
ADODATODY		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE			(X6) DATE

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Facility ID: 100012

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
100012		B. WING	05/19/2020				
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE			
GLENVIE\	W HEALTH CARE FACILI	TY	NVIEW DRIVE N, KY 42141				
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETI	E	
N 000	A COVID-19 Focused was initiated 05/19/2020. There w	as no deficient practice	N 000				
	identified pursuant to						

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

TITLE (X6) DATE