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

PRINTED: 05/22/2020 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	
		185341	B. WING _	B. WING		05/07/2020	
NAME OF PROVIDER OR SUPPLIER  GREEN ACRES HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 05/06 05/07/2020. The facil compliance with 42 Cregulations and has in Medicare & Medicaid Centers for Disease Cregory (CDC) recommended COVID-19. Total cens	d Infection Control Survey 6/2020 and concluded on ity was found to be in EFR 483.80 infection control implemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for sus 58.		000			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185341	B. WING			05/07/2020	
NAME OF PROVIDER OR SUPPLIER  GREEN ACRES HEALTHCARE				4	STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 Focused Survey was initiated to concluded on 05/07/2	d Emergency Preparedness		0000	DEFICIENCY)	ME.	

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.

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Office of Inspector General

AND PLAN OF CORRECTION IDENTIFICATION	JPPLIER/CLIA ON NUMBER:			COMPLETED	DATE SURVEY COMPLETED		
100144		B. WING	05/07/20	05/07/2020			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  402 W. FARTHING STREET  MAYFIELD, KY 42066							
(X4) ID SUMMARY STATEMENT OF DEFICI PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING INI	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) DMPLETE DATE		
N 000 Initial Comments  A COVID-19 Focused Infection Contr was initiated 05/06/2020 and conclud 05/07/2020. The facility was found to compliance pursuant to 42 CFR 483.4	ed on be in	N 000					

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

TITLE (X6) DATE