| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | RM APPROVED IO. 0938-0391 | |
|---|--|--|---------------------|---|-----------|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | (X3) DAT | (X3) DATE SURVEY COMPLETED | |
| | | 185341 | B. WING | | 0 | 8/27/2020 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| GREEN A | CRES HEALTHCARE | | | 402 W. FARTHING STREET MAYFIELD, KY 42066 | | | |
| (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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 000 | #KY31601 and #KY3 Focused Infection Co on 08/25/2020 and co #KY31601 and #KY3 with no deficiencies c to be in compliance w control regulations an Centers for Medicare (CMS) and Centers for | ey investigating Complaints 1996 and a COVID-19 ntrol Survey, was initiated oncluded on 08/27/2020. 1996 were unsubstantiated ited. The facility was found with 42 CFR 483.80 infection id has implemented the and Medicaid Services or Disease Control and commended practices to | F 00 | | | | |
| | | SUPPLIER REPRESENTATIVE'S SIGNATU | DE | TITLE | | (X6) DATE | |

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(X6)

PRINTED: 08/28/2020

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.

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | | 0. 0938-0391 |
|------------------------------|--|--|--|-----|---|-------------------------------|----------------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 185341 | B. WING | | | 08/ | 27/2020 |
| NAME OF PROVIDER OR SUPPLIER | | | • | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GREEN A | CRES HEALTHCARE | | | | 02 W. FARTHING STREET AYFIELD, KY 42066 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 000 | | ncy Preparedness Survey | E | 000 | | | |
| | 08/27/2020. The facili compliance with 42 C E-0024 (b)(6). | ty was found to be in | | | | | |
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| | | 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 08/28/2020 FORM APPROVED OMB NO 0938-0391

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| Induction Induction Image: Construction Ima | (X3) DATE SURVEY COMPLETED 08/27/2020 | |
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| IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GREEN ACRES HEALTHCARE MAYFIELD, KY 42066 (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 CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments N 000 A Complaint Survey (#KY31601 and #KY31996) and a COVID-19 Focused Infection Control Survey, was initiated on 08/25/2020 and concluded on 08/27/2020. #KY31601 and #KY31996 were unsubstantiated with no deficiencies cited. The facility was found to be in N 000 | | |
| SPREEN ACRES HEALTHCARE MAYFIELD, KY 42066 (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey (#KY31601 and #KY31996) and a COVID-19 Focused Infection Control Survey, was initiated on 08/25/2020 and concluded on 08/27/2020. #KY31601 and #KY31996 were unsubstantiated with no deficiencies cited. The facility was found to be in N 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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