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

PRINTED: 08/14/2020 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	
		185317	B. WING	B. WING		08/11/2020	
	ROVIDER OR SUPPLIER	ABILITATION	,	STREET ADDRESS, CITY, STATE, ZIP 521 GREENE DRIVE GREENVILLE, KY 42345	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN O  X (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	and a COVID-19 Foo Survey was initiated of concluded on 08/11/2 was unsubstantiated. The facility was found CFR 483.80 infection implemented the Cer Medicaid Services (C Disease Control and recommended practic COVID-19. Total cens	ey investigating #KY32168 used Infection Control on 08/10/2020 and 2020. Complaint #KY32168 with no deficiencies cited. If to be in compliance with 42 control regulations and has atters for Medicare & EMS) and Centers for Prevention (CDC) toes to prepare for		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 08/11/2	d Emergency Preparedness					
ADODATORY		SUPPLIER REPRESENTATIVE'S SIGNATUF		TITLE		(X6) DATE	

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Facility ID: 100342

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Office of Inspector General

		(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER					3) DATE SURVEY COMPLETED	
100342				B. WING			08/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
GREENVII	LLE NURSING AND REH	IABILITATION	521 GREEN GREENVILI	IE DRIVE LE, 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	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 000	Initial Comments  A Complaint Survey of Focused Infection Community (1987) 108/10/2020 and conditions facility was found to be	#KY32168) and COVID- ontrol Survey was initiated duded on 08/11/2020. The oe in compliance pursuar 32168 was unsubstantiat	19 d ne nt to	TAG N 000			DATE	

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

TITLE (X6) DATE