		ID HUMAN SERVICES				FO	RM APPROVED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185317	B. WING	B. WING			12/02/2020	
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	·		
GREENVIL	LE NURSING AND REH	ABILITATION			NE DRIVE /ILLE, KY 42345			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000				
	was initiated on 12/01 12/02/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for						
LABORATORY	DIRECTOR'S OR PROVIDER/S	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.

PRINTED: 12/02/2020

		ID HUMAN SERVICES			FORM APPRO	VED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	1391	
		185317	B. WING _		12/02/2020	12/02/2020	
NAME OF PROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENVII	LE NURSING AND REH	ΔΒΙΙ ΙΤΔΤΙΟΝ		521 GREENE DRIVE			
ORELITY				GREENVILLE, KY 42345			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLET		
E 000	Initial Comments		E 0	00			
	Survey was initiated of concluded on 12/02/2	d Emergency Preparedness on 12/01/2020 and 2020. The facility was found with 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE	(X6) DATE		

PRINTED: 12/02/2020

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.

PRINTED: 12/02/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 12/02/2020	
		100342	B. WING			
		STREET	ADDRESS, CITY, STATE,		· · ·	
REENVIL	LE NURSING AND REI	GREEN	VILLE, KY 42345			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLE D THE APPROPRIATE DATE	
N 000	Initial Comments		N 000			
	was initiated 12/01/2	ed Infection Control Survey 2020 and concluded on cility was found to be in t to 42 CFR 483.80.				

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

TITLE

(X6) DATE