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

PRINTED: 12/22/2020 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	
		185317	B. WING	B. WING		12/22/2020	
NAME OF PROVIDER OR SUPPLIER  GREENVILLE NURSING AND REHABILITATION			•	STREET ADDRESS, CITY, STATE, ZIF 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	X (EACH CORRECTIVE A) CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 12/2 <sup>1</sup> 12/22/2020. The facil compliance with 42 C regulations and has i Medicare & Medicaid Centers for Disease C	d Infection Control Survey 1/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention If practices to prepare for	F	000			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	=	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.

Facility ID: 100342

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185317	B. WING	B. WING		12/22/2020	
NAME OF PROVIDER OR SUPPLIER  GREENVILLE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZI 521 GREENE DRIVE GREENVILLE, KY 42345	IP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD			
E 000	Survey was initiated of concluded on 12/22/2	d Emergency Preparedness on 12/21/2020 and 2020. The facility was found with 42 CFR 483.73 related	E				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	IRF	TITLE	<del></del>	(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

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  521 GREENE DRIVE  GREENVILLE, KY 42345   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
GREENVILLE NURSING AND REHABILITATION  521 GREENE DRIVE GREENVILLE, KY 42345  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XX1) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPONENT TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROPRIATE COMPONENT TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROPRIATE DAT	100342			B. WING	12/22/2020	12/22/2020		
GREENVILLE, KY 42345  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER			TE, ZIP CODE			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DAT	GREENVI	LLE NURSING AND REH	ABILITATION					
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPL	.ETE	
N 000 Initial Comments N 000	N 000	Initial Comments		N 000				
A COVID-19 Focused Infection Control Survey was initiated 12/21/2020 and concluded on 12/22/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	N 0000	A COVID-19 Focused was initiated 12/21/20 12/22/2020. The faci	020 and concluded on lity was found to be in	N 000				

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

TITLE (X6) DATE