## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/14/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		185042	B. WING	08	08/05/2020	
	OVIDER OR SUPPLIER	REHABILITATION FACILITY	640	REET ADDRESS, CITY, STATE, ZIP CODE WATER TOWER BYPASS MPBELLSVILLE, KY 42719	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL)	SHOULD BE	(X5) COMPLETION DATE
F 000	conducted on 08/05 to be in compliance Control and has imp Medicare & Medicai Centers for Disease (CDC) recommende	ed infection control survey was /2020. The facility was found with 42 CFR 483.80 Infection plemented the Centers for d Services (CMS) and control and Prevention ed practices to prepare for cient practice was identified.	F 000			
LABORATORY	DIRECTOR'S OR PROVIDE	R/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

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ONIE NO. 0936-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185042				08/05/2020	
NAME OF PROVIDER OR SUPPLIER  THE GRANDVIEW NURSING AND REHABILITATION FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 640 WATER TOWER BYPASS CAMPBELLSVILLE, KY 42719			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	A COVID-19 focused survey was conducted facility was found to CFR 483.73 Emerge	d Emergency Preparedness and on 08/05/2020. The period in compliance with 42 ancy Preparedness related to practice was identified.	E	000			
LABORATORY	PIRECTOR'S OR REQUIRE	OF THE PERSON ATTACKS SIGNATI	IDE		TITLE	2000	(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.

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ B. WING\_ 08/05/2020 100393 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **640 WATER TOWER BYPASS** THE GRANDVIEW NURSING AND REHABILITATION FA CAMPBELLSVILLE, KY 42719 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) N 000 N 000 **Initial Comments** A COVID-19 focused infection control survey was conducted on 08/05/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE