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

PRINTED: 01/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
185042		B. WING _	75	12	12/22/2020		
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)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	(X5) COMPLETION DATE		
F 000	conducted on 12/2 to be in compliance Control and has in Medicare & Medic Centers for Disease (CDC) recommen	sed infection control survey was 22/2020. The facility was found to with 42 CFR 483.80 Infection inplemented the Centers for aid Services (CMS) and see Control and Prevention ded practices to prepare for efficient practice was identified.	F 00				
LABORATOR	! RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	I GNATURE	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 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	185042		B. WING				12/22/2020	
NAME OF PROVIDER OR SUPPLIER THE GRANDVIEW NURSING AND REHABILITATION FACILITY				640	REET ADDRESS, CITY, STATE, ZIP CODE WATER TOWER BYPASS MPBELLSVILLE, KY 42719	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR THE APP DEFICIENCY)			(X5) COMPLETION DATE	
E 000	A COVID-19 focus survey was conduct facility was found to CFR 483.73 Emerg	ted Emergency Preparedness sted on 12/22/2020. The obe in compliance with 42 gency Preparedness related to not practice was identified.	E	000	DEFICIENCY)			
		DER/SUPPLIER REPRESENTATIVE'S SIG			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.

Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: __ B. WING 12/22/2020 100393 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **640 WATER TOWER BYPASS** THE GRANDVIEW NURSING AND REHABILITA **CAMPBELLSVILLE, KY 42719** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 12/22/2020. 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