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

PRINTED: 05/20/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER (V4.) ID FOR INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 04/20/2020 and concluded on 04/21/2020. The facility was found to be in compiliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicare & Medicare Scottopian devices (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 113.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104 (X4) ID PREFIX TAG			185187	B. WING			04/	21/2020
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 04/20/2020 and concluded on 04/21/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for					5079 SCOTTSVILLE RD.	DE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focused was initiated on 04/20 04/21/2020. The facil compliance with 42 Coregulations and has in Medicare & Medicaid Centers for Disease (CDC) recommended COVID-19. Total cens	d Infection Control Survey 0/2020 and concluded on ity was found to be in EFR 483.80 infection control implemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for sus 113.					

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	185187		B. WING _	B. WING		04/21/2020	
NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER			•	STREET ADDRESS, CITY, STATE, ZIP 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000			
	Survey was initiated of concluded on 04/21/2	d Emergency Preparedness on 04/20/2020 and 2020. The facility was found with 42 CFR 483.73 related					

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

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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Office of Inspector General

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED		
100498			B. WING			04/21/2020		
NAME OF PROVIDER OR SUPPLIER STREET AD 5079 SCO				DDRESS, CITY, STATE, ZIP CODE DTTSVILLE RD. G GREEN, KY 42104				
(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 OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 000	A COVID-19 Focused was initiated 04/20/20	I Infection Control Surving and concluded on lity was found to be in to 42 CFR 483.80.	ey	N 000				

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

TITLE (X6) DATE