CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185435	B. WING			05/	/07/2020
NAME OF PROVIDER OR SUPPLIER					1		
MAGNOLIA VILLAGE					1381 CAMPBELL LANE BOWLING GREEN, KY 42104		
(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 SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		BE	(X5) COMPLETION DATE
F 000	was initiated on 05/06 05/07/2020. The facili compliance with 42 C regulations and has ir Medicare & Medicaid Centers for Disease C	d Infection Control Survey 5/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for	F	000			
		SUPPLIER REPRESENTATIVE'S SIGNATUR			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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CENTERS FOR MEDICARE & MEDICAID SERVICES				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			
		185435	B. WING			05/	/07/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
MAGNOLI	MAGNOLIA VILLAGE			1381 CAMPBELL LANE BOWLING GREEN, KY 42104				
(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 SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		BE	(X5) COMPLETION DATE	
E 000	Initial Comments A COVID-19 Focused Survey was initiated o concluded on 05/07/2	d Emergency Preparedness		000	DEFICIENCY)			
	DIRECTORS OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		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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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100647			(X2) MULTIPLE CO A. BUILDING:	NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		05	05/07/2020		
ame of Pf	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE			
IAGNOLI	A VILLAGE		MPBELL LANE	94			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ACTION SHOULD BE COMP TO THE APPROPRIATE DAT		
N 000	Initial Comments		N 000				
	was initiated 05/06/20	d Infection Control Survey 020 and concluded on ility was found to be in to 42 CFR 483.80.					

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

TITLE

(X6) DATE