DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		185224	B. WING		o	1/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		1561 NEWTON AVE.		
BOWLING	GREEN NORSING AND	REHABIENATION CENTER		BOWLING GREEN, KY 42104		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0(00		
	was initiated on 01/1 ² 01/12/2021. The facil compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	KE	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.

PRINTED: 01/14/2021

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		185224	B. WING		0	1/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	GREEN NURSING AND	REHABILITATION CENTER		1561 NEWTON AVE.		
Boweinte		REHADIENTATION GENTER		BOWLING GREEN, KY 42104		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX		HOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)		5/112
E 000	Initial Comments		EC	000		
	Survey was initiated of concluded on 01/12/2 be in compliance with	d Emergency Preparedness on 01/11/2020 and 202. The facility was found to 42 CFR 483.73 related to				
	E-0024 (b)(6).					
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	9E	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.

PRINTED: 01/14/2021

PRINTED: 01/14/2021 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE COMF	SURVEY PLETED	
		100409			01/12/2021		
	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,		01	01/12/2021	
	GREEN NURSING AND	1561 NF	WTON AVE.				
		BOWLIN	G GREEN, KY 4210				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ED TO THE APPROPRIATE DATE		
N 000	Initial Comments		N 000				
	was initiated 01/11/2	d Infection Control Survey 021 and 01/12/2021. The be in compliance pursuant to					

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

TITLE

(X6) DATE