DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185187	B. WING			07/	01/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENWO	OOD NURSING & REHAE	BILITATION CENTER			079 SCOTTSVILLE RD.		
011221111				E	BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Survey was initiated of concluded on 07/01/2	d Emergency Preparedness on 06/23/2020 and 020. The facility was found rith 42 CFR 483.73 related					
ABORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR	35		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: 07/02/2020

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		185187	B. WING			07/01/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
GREENWO	OOD NURSING & REHAE			5079 SCOTTSVILLE RD.		
				BOWLING GREEN, KY 42	104	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
F 000	INITIAL COMMENTS		F 0	F 000		
	and a COVID-19 Foc Survey was initiated of concluded on 07/01/2 to be in compliance w control regulations an Centers for Medicare and Centers for Disea (CDC) recommended COVID-19. Total cens	2020. The facility was found with 42 CFR 483.80 infection d has implemented the & Medicaid Services (CMS) ase Control and Prevention practices to prepare for				
LABORATORY	DIRECTOR'S OR PROVIDER/S	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.

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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100498			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING		07/01/2020			
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	1 0.			
REENW	OOD NURSING & REHA	BILITATION CENTER	OTTSVILLE RD. IG GREEN, KY 4210	04			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	ON SHOULD BE COMPLE IE APPROPRIATE DATE	
N 000	Initial Comments		N 000				
	Focused Infection Co 06/23/2020 and con Complaint KY#3188	(KY#31882) and COVID-19 ontrol Survey was initiated cluded on 07/01/2020. 2 was unsubstantiated with a facility was found to be in t to 42 CFR 483.80.					

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

TITLE

(X6) DATE

L4KV11