| DEPARTI   | MENT OF HEALTH AN   | D HUMAN SERVICES  |                     |                               |   | FORM APPROVED                 |
|---|---|---|---------------------|-------------------------------|---|-------------------------------|
| CENTER  | S FOR MEDICARE &  | MEDICAID SERVICES   |                     |                               |   | OMB NO. 0938-0391             |
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION              |   | (X3) DATE SURVEY<br>COMPLETED |
|   |   | 185187  | B. WING             |                               | -   | 08/06/2020                    |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STA     | ATE, ZIP CODE   |                               |
|   | OOD NURSING & REHA  |   |                     | 5079 SCOTTSVILLE RD.          |   |                               |
| GREENW  | JOD NORSING & REHAL   | SELITATION CENTER   |                     | BOWLING GREEN, KY 4           | 2104  |                               |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BE<br>CED TO THE APPROPRIA<br>EFICIENCY) |                               |
| F 000   | INITIAL COMMENTS<br>A COVID-19 Focused Infection Control Survey<br>was initiated on 08/05/2020 and concluded on |   | FO                  | 00                            |   |                               |
|   | regulations and has in<br>Medicare & Medicaid<br>Centers for Disease (  | FR 483.80 infection control<br>nplemented the Centers for<br>Services (CMS) and<br>Control and Prevention<br>practices to prepare for |                     |                               |   |                               |
|   |   |   |                     |                               |   |                               |
|   |   |   |                     |                               |   |                               |
|   |   |   |                     |                               |   |                               |
|   |   |   |                     |                               |   |                               |
| LABORATORY  | DIRECTOR'S OR PROVIDER/   | 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.

## PRINTED: 08/06/2020

| DEPARTI   | MENT OF HEALTH AN                            | D HUMAN SERVICES   |  |                         |  |                               | APPROVED                   |
|---|--|--|--|-------------------------|--|-------------------------------|----------------------------|
| CENTER  | S FOR MEDICARE &                             | MEDICAID SERVICES  |  |                         |  | OMB NC                        | 0. 0938-0391               |
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                         |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|   |  | 185187   | B. WING                                |                         |  | 08/                           | 06/2020                    |
| NAME OF P   | ROVIDER OR SUPPLIER                          |  |  | ST                      | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| GREENWO   |  | BILITATION CENTER  |  | 50                      | 079 SCOTTSVILLE RD.  |                               |                            |
| OREERIN   | GREENWOOD NURSING & REHABILITATION CENTER    |  |  | BOWLING GREEN, KY 42104 |  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)                             | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                       | ID<br>PREFIJ<br>TAG                    |                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| E 000   | Initial Comments                             |  | E                                      | 000                     |  |                               |                            |
|   | Survey was initiated of concluded on 08/06/2 | d Emergency Preparedness<br>on 08/05/2020 and<br>020. The facility was found<br>rith 42 CFR 483.73 related |  |                         |  |                               |                            |
|   |  | SUPPLIER REPRESENTATIVE'S SIGNATUR   | 25                                     |                         | 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: 08/06/2020

## PRINTED: 08/06/2020 FORM APPROVED

| Office of Inspector General           STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:           100498 |                        |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |   | (X3) DATE SURVEY<br>COMPLETED<br>08/06/2020 |  |
|--|------------------------|--|---|---|---|---|--|
|  |                        | B. WING  |   | 08  |   |   |  |
| AME OF PF  | ROVIDER OR SUPPLIER    | STREET A   | DDRESS, CITY, STATE,                    | ZIP CODE  |   |   |  |
| REENWO   | DOD NURSING & REHAI    | BILITATION CENTER  | OTTSVILLE RD.<br>IG GREEN, KY 4210      | )4  |   |   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC        | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)              | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN C<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TC<br>DEFICIE! | ACTION SHOULD BE COMPLET<br>TO THE APPROPRIATE DATE |   |  |
| N 000  | Initial Comments       |  | N 000                                   |   |   |   |  |
|  | was initiated 08/05/20 | d Infection Control Survey<br>D20 and concluded on<br>lity was found to be in<br>to 42 CFR 483.80. |   |   |   |   |  |
|  |                        |  |   |   |   |   |  |

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

TITLE

(X6) DATE