DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185187	B. WING _			07	/15/2020
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENWO	OOD NURSING & REHA			507	79 SCOTTSVILLE RD.		
ORELIW				вс	DWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was initiated on 07/14 07/15/2020. 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 practices to prepare for					
	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE		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: 07/15/2020

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185187	B. WING			07/	15/2020
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENWO	OOD NURSING & REHAE			50	79 SCOTTSVILLE RD.		
ORELIN				В	OWLING GREEN, KY 42104		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		
					DEFICIENCY)		
E 000	Initial Comments		E	000			
	Survey was initiated of concluded on 07/15/2 to be in compliance w	d Emergency Preparedness on 07/14/2020 and 020. The facility was found vith 42 CFR 483.73 related					
	to E-0024 (b)(6).						
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATU	RF		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 CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		07	07/15/2020		
	ROVIDER OR SUPPLIER OOD NURSING & REHA	BILITATION CENTER 5079 SC	DDRESS, CITY, STATE, OTTSVILLE RD.				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
N 000	was initiated 07/14/2	d Infection Control Survey 020 and concluded on illity was found to be in t to 42 CFR 483.80.	N 000				

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