DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED		
CENTER	S 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		
		185008	B. WING			05/05/2020		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	)E			
		BERG COMMUNITY HOSPITAL LTC		440 HOPKINSVILLE STREET				
OWENSBO				GREENVILLE, KY 42345				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	LD BE COMPLETION		
F 000	INITIAL COMMENTS		F 0	00				
	was initiated on 05/04 05/05/2020. The facil 42 CFR 483.80 infect	Prevention (CDC) ces to prepare for						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE		(X6) DATE		
	JINEOTONO OR FROMDER/G	JOH I LIEN NEI NEUENIAHVEU UIGNATUR	· <b>-</b>					

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: 05/22/2020 

DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-0391	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185008	B. WING			05/	05/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
OWENSB	ORO HEALTH MUHLENE	BERG COMMUNITY HOSPITAL LTC			10 HOPKINSVILLE STREET			
				G	REENVILLE, KY 42345			
(X4) ID	(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	_	(X5) COMPLETION	
			PREFIX TAG	G CROSS-REFERENCED TO THE AF				
					DEFICIENCY)			
E 000	Initial Comments		E	000				
	A COVID-19 Focuse	d Emergency Preparedness						
	Survey was initiated of							
	concluded on 05/05/2 compliance with 42 C	2020. The facility was in						
	E-0024 (b)(6).							
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			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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nspector General OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 05/05/2020		
100734		B. WING				
ROVIDER OR SUPPLIER	STREET A 440 HOF	KINSVILLE STREE				
(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
was conducted on 05/05/2020. The fac	5/04/2020 through illity was in compliance	N 000				
	F CORRECTION OVIDER OR SUPPLIER ORO HEALTH MUHLEN SUMMARY S (EACH DEFICIENC REGULATORY OR Initial Comments A COVID-19 Focuse was conducted on 03 05/05/2020. The fac	F CORRECTION       IDENTIFICATION NUMBER:         100734       100734         OVIDER OR SUPPLIER       STREET A         PRO HEALTH MUHLENBERG COMMUNITY I       440 HOF         GREENV       SUMMARY STATEMENT OF DEFICIENCIES         SUMMARY STATEMENT OF DEFICIENCIES       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)       Hereit A	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         100734       B. WING         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE         PRO HEALTH MUHLENBERG COMMUNITY I       440 HOPKINSVILLE STREE         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Initial Comments       N 000         A COVID-19 Focused Infection Control Survey       N 000         A COVID-19 Focused Infection Control Survey       N 000         OS/05/2020. The facility was in compliance       Integration	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:       COMING         100734       B. WING       05         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         PRO HEALTH MUHLENBERG COMMUNITY I       440 HOPKINSVILLE STREET GREENVILLE, KY 42345       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Initial Comments       N 000       <	

TITLE

(X6) DATE

VG6X11