| DEPARTMENT OF HEALTH AND HUMAN SERVICES             |   |  |  |  |          | FORM APPROVED              |  |
|---|---|--|--|--|----------|----------------------------|--|
| CENTER  | S FOR MEDICARE &  | MEDICAID SERVICES  |  |  |          | NO. 0938-0391              |  |
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | PLE CONSTRUCTION<br>G  |          | TE SURVEY<br>MPLETED       |  |
|   |   | 185089   | B. WING  |  | 0        | 8/07/2020                  |  |
| NAME OF PF  | ROVIDER OR SUPPLIER   | -  |  | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                            |  |
| SIGNATUR  | RE HEALTHCARE OF BO   |  |  | 550 HIGH ST.   |          |                            |  |
| CICILATO  |   |  |  | BOWLING GREEN, KY 42101  |          |                            |  |
| (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                                      | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 000   | INITIAL COMMENTS  |  | F 00   | 00   |          |                            |  |
|   | #KY32123 and a CO <sup>V</sup><br>Control Survey was in<br>concluded on 08/07/2<br>unsubstantiated with<br>and severity of a "D". | a deficiency cited at a scope<br>There was no deficient<br>42 CFR 483.80 infection<br>d the facility has<br>ters for Medicare &<br>MS) and Centers for<br>Prevention (CDC)<br>ces to prepare for |  |  |          |                            |  |
|   |   |  |  |  |          |                            |  |
| LABORATORY  | DIRECTOR'S OR PROVIDER/S  | SUPPLIER REPRESENTATIVE'S SIGNATUR   | <e< td=""><td>TITLE</td><td></td><td>(X6) DATE</td></e<> | 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: 08/14/2020

| DEPARTI   | MENT OF HEALTH AN                            | D HUMAN SERVICES   |  |   |   | FORM APPROVED                 |  |  |
|---|--|--|--|---|---|-------------------------------|--|--|
| CENTER  | S FOR MEDICARE & I                           | MEDICAID SERVICES  |  |   | (   | OMB NO. 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 |  |  |
|   |  | 185089   | B. WING _                              |   |   | 08/07/2020                    |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER                          |  |  | STREET ADDRESS, CITY, STATE             | E, ZIP CODE   |                               |  |  |
| SIGNATURE HEALTHCARE OF BOWLING GREEN               |  |  |  | 550 HIGH ST.<br>BOWLING GREEN, KY 42101 |   |                               |  |  |
|   | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES    |  |  | -                                       | AN OF CORRECTION  | ECTION (X5)                   |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)                             | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | (EACH CORRECTI)<br>CROSS-REFERENCE      | VE ACTION SHOULD BE<br>ED TO THE APPROPRIA<br>FICIENCY) | COMPLETION                    |  |  |
| E 000   | Initial Comments                             |  | E 0                                    | 00                                      |   |                               |  |  |
|   | Survey was initiated of concluded on 08/07/2 | d Emergency Preparedness<br>on 08/05/2020 and<br>020. There was no deficient<br>n 42 CFR 483.73 related to |  |   |   |                               |  |  |
|   |  | SUPPLIER REPRESENTATIVE'S SIGNATUR   |  | 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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|   | Inspector General  |   |  |          | (¥2) DATE                     |                         |
|---|--|---|--|----------|-------------------------------|-------------------------|
| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         100410       100410 |  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING  |          | (X3) DATE SURVEY<br>COMPLETED |                         |
|   |  |   |  |          |                               |                         |
|   |  | I   |  | 08       | 08/07/2020                    |                         |
| AME OF PI   | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE,   | ZIP CODE |                               |                         |
| IGNATU  | RE HEALTHCARE OF B   | OWLING GREEN  | IG GREEN, KY 4210  | 01       |                               |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID PROVIDER'S PLAN OF CORRECTION<br>PREFIX (EACH CORRECTIVE ACTION SHOULD BE<br>TAG CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |          |                               | (X5)<br>COMPLET<br>DATE |
| N 000   | Initial Comments   |   | N 000  |          |                               |                         |
|   | Focused Infection Co<br>08/05/2020 and cond<br>#KY32123 was unsu<br>cited. There was no<br>at 42 CFR 483.80 inf<br>and the facility has in<br>Medicare & Medicaid<br>Centers for Disease | (#KY32123) and a COVID-19<br>ontrol Survey was initiated on<br>cluded on 08/07/2020.<br>Ibstantiated with a deficiency<br>deficient practice identified<br>fection control regulations<br>mplemented the Centers for<br>d Services (CMS) and<br>Control and Prevention<br>d practices to prepare for<br>isus 140. |  |          |                               |                         |

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

TITLE

(X6) DATE