DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR		(>	(3) DATE SURVEY COMPLETED
		185089	B. WING				11/25/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET AD	DDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF BC	WLING GREEN		550 HIGH	ST. G GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
	was initiated on 11/24 11/25/2020. The facili 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					
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: 11/25/2020

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		185089	B. WING _			11/	25/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
SIGNATURE HEALTHCARE OF BOWLING GREEN				550 HIGH ST. BOWLING GREEN, KY 42101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000				
	Survey was initiated of concluded on 11/25/2	d Emergency Preparedness on 11/24/2020 and 02. The facility was found to 42 CFR 483.73 related to						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	F		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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COM A. BUILDING:		(X3) DATE SURVEY COMPLETED 11/25/2020	
		100410	B. WING			
	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, Z H ST. IG GREEN, KY 4210			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
N 000	was initiated 04/01/2 04/02/2020. The fa	ed Infection Control Survey 2020 and concluded on cility was found to be in at to 42 CFR 483.80.	N 000			