STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185187	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Nursing and Rehabilitation Center	5079 Scottsville Road Bowling Green, KY 42104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1, the facility failed to ensure its Minimum Sata Set (MDS) Assessments accurately reflected the status of 1 of 1 sampled residents, (Resident [R] 8).The findings include: Review of a statement provided by the facility, dated 08/01/2025 and signed by the Director of Nursing (DON), Minimum Data Set Nurse (MDS) 1, and the Administrator, revealed the facility does not have a specific policy on MDS, we follow state/federal guidelines and the RAI. Review of the CMS RAI 3.0 User's Manual Version 1.19.1, Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0, revealed the definition of a fall was the unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g. onto a bed, chair, or bedside mat). Per review, the rationale of assessing falls, as related to health-related quality of life was: falls were a leading cause of morbidity and mortality among nursing home residents; falls resulted in serious injury, especially hip fractures; and previous falls, especially recurrent falls and falls with injury, were the most important predictor of future falls and injurious falls. Additional review revealed identification of residents who were at high risk of falling was a top priority for care planning. Review of R8's electronic medical record (EMR) revealed the facility admitted the resident on 02/19/2025, with diagnoses to include: unspecified fracture of left femur, adult failure to thrive, and chronic atrial fibrillation. Review of the Prospective Payment System (PPS) Part A Discharge MDS Assessment, with an ARD of 07/08/2025, revealed the facility assessed R8 to have a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating the resident had severe cognitive impairment. Review of the facility report titled, Incidents by Incident Type (Fall Incidents), revealed R8 sustained a fall on 03/13/2025 at 12:00 AM. However, review of the Quarterly MDS Assessment, with an ARD of 04/11/2025, revealed the question J1800 stating, Has the resident had any falls since admission/entry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent, had been answered as 0 (which indicated No) even though R8 sustained the fall on 03/13/2025. Continued MDS review revealed J1800 being answered 0, inactivated question J1900 which addressed extent of injury resulting from a fall. Review of the facility report titled, Incidents by Incident Type (Fall Incidents), revealed R8 sustained a fall on 04/17/2025 at 6:08 AM. However, review of the Discharge Return Anticipated MDS Assessment, with an ARD of 05/05/2025, revealed for question J1800, Has the resident had any falls since admission/entry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent, was answered as 0 (which indicated No) even though R8 sustained the fall on 04/17/2025. The 0 for J1800 inactivated question J1900 which addressed extent of injury resulting from a fall. Review of the facility report titled, Incidents by Incident Type (Fall Incidents), revealed R8 sustained a fall on 06/13/2025 at 5:00 PM and on 06/17/2025 at 12:46 AM. However, review of the End of PPS Part A Stay MDS Assessment, with an ARD of 07/08/2025, revealed the question J1800, Has the resident had any falls since admission/entry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent, was answered as 0 (No) even though R8 sustained falls on 06/13/2025 and 06/17/2025. The 0 for J1800 inactivated the question J1900 which addressed extent of injury resulting from a fall.In interview on 08/01/2025 at 6:30 PM, MDS Nurse 2 stated she had been in her position for three years, and said she interviewed the residents and reviewed the nurse's notes when completing a MDS Assessment. She reported after the State Survey Agency (SSA) Surveyors asked for copies of R8's MDS Assessment, she reviewed them. MDS Nurse 2 said when reviewing the MDS Assessment she saw the inaccuracies related to R8's falls in section J of the MDS Assessments with ARD's of 04/11/2025, 05/05/2025, and 07/08/2025, and made corrections. When the SSA Surveyor asked the MDS Nurse what had happened when the MDS Assessments were originally completed, she stated they probably just fell through the cracks. In interview on 08/01/2025 at 8:02 PM, the Administrator stated communication with the staff and the staff following the facility's policies was how residents were kept safe.

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	185187	A. Building B. Wing	08/01/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident for 1 of 3 residents sampled for accidents/falls, (Resident (R)8). The findings include: Review of R8's electronic medical record (EMR) revealed the facility admitted the resident on 02/19/2025, with diagnoses that included: chronic atrial fibrillation, unspecified fracture of left femur, and adult failure to thrive. Review of the Prospective Payment System (PPS) Part A Discharge MDS Assessment, with an ARD of 07/08/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. Review of the facility's Incidents by Incident Type, Fall Incidents, with a date range of 01/01/2025 through 07/31/2025, revealed R8 experienced falls on the following dates: 03/13/2025 at 12:00 AM; 04/17/2025 at 6:08 AM; 06/12/2025 at 5:00 PM; 06/17/2025 at 12:46 AM; 07/18/2025 at 9:30 AM; and 07/22/2025 at 11:58 PM. Review of R8's Comprehensive Care Plan (CCP), last revised on 07/18/2025, revealed a focus statement for Risk for falls related to the resident's history of falls, injury, and multiple risk factors of: functional capabilities, Impaired mobility, bowel incontinence. Per review, R8 also had a decline in functional status from: a recent hospitalization due to a right femur neck fracture; osteoporosis; dementia; left hip fracture, thoracic compression fracture; falls; and the resident's preference to be in floor. Continued review revealed the Interventions included: keeping the resident in high traffic areas when up in the wheelchair for higher visibility from staff to ensure safety, initiated 04/17/2025; resident to be up in wheelchair during daytime hours to prevent injury from resident climbing out of bed; initiated 06/13/2025; and Non-skid strips to bedside; initiated 06/17/2025. Observation on 07/29/2025 at 10:45 AM, revealed R8 sitting in a wheelchair in his room with a staff member speaking to him. Per observation, the staff member exited the room leaving R8 unsupervised. Further observation revealed there were no non-skid strips on the floor to R8's bedside. Observation on 07/29/2025 at 4:30 PM, revealed R8 was not in his room and there were no non-skid strips on the floor to his bedside. Observation on 07/30/2025 at 8:20 AM, revealed R8 lying on his bed resting, with no non-skid strips on floor to the bedside. Observation on 08/01/2025 at 9:48 AM, revealed R8 lying on the bed with bolsters in place in his room (room [ROOM NUMBER]); however, there were no non-skid strips on floor to the resident's bedside. Observation on 08/01/2025 at 2:05 PM, revealed R8 up in the wheelchair facing towards the end of the hallway, between rooms [ROOM NUMBERS] with no staff member present. The State Survey Agency (SSA) Surveyor observed R8 for three minutes without seeing a staff member with him or near him. Observation on 08/01/2025 at 5:15 PM, revealed R8 lying on the bed with bolsters in place; however, with no non-skid strips on floor at bedside. Observation on 08/01/2025 at 6:45 PM, revealed R8 lying on the bed with bolsters in place; In interview on 07/30/2025 at 1:35 PM with Family Member (FM) 5, son of R8, he stated his only concern with his father's care was, it seems he has had a lot of falls recently. FM 5 stated he wonders what is going on with that (the falls). In interview on 08/01/2025 at 5:15 PM, Certified Nurse Aide (CNA) 11 stated the aides had a care guide sheet they referred to for caring for the residents. She reported R8 was supposed to be located at the nurse's desk when up in his wheelchair and not in his room. CNA 11 said R8 needed to have his bed in the lowest position; his call light within reach; and needed to have on non-skid socks. She further stated she was not aware R8 needed to have non-skid strips on the floor by his bed. In interview on 08/01/2025 at 5:20 PM, Registered Nurse (RN) 7 stated if a resident was to have non-skid strips on the floor by their bed, that would be listed on the resident's care guide and care plan. She reported she did not have it in R8's care guide that he was supposed to have non-skid strips on the floor by his bed. RN 7 further stated non-skid strips usually were for when people have falls as one of their interventions. She additionally stated a negative outcome of not following (implementing) a resident's care plan could be for an injury from a fall. In interview on 08/01/2025 at 7:30 PM, the Director of Nursing (DON) confirmed there were no non-skid strips beside R8's bedside until earlier today when the SSA Surveyor started asking questions. She said daytime was defined as day shift, or the 7:00 AM - 7:00 PM shift, as allowed by the resident (in reference to R8's care plan interventions to be up in the wheelchair during daytime hours.) The DON further stated the care plan for R8 meant he was, to be in a highly visible area when he is in his wheelchair instead of in his room. She clarified the nurses' desk was an example of a highly visible area and not meant to be the only place he could be located. In interview on 08/01/2025 at 8:02 PM, the, Administrator stated the residents were kept safe through communication with staff; staff following the facility's policies; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185187	A. Building B. Wing	08/01/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, record review and review of facility policy, the facility failed to ensure that 2 of 2 residents reviewed for care plan participation were afforded the opportunity to participate in the development of their care plan (Resident (R)1 and R6). The findings include: Review of the facility's Care Plan Invitation and Documentation Guidelines policy, dated 08/2019, revealed that, To comply with regulatory requirements, invitations are extended to attend the care plan meetings to the resident, resident's representative, or other family members as/if when applicable. Per policy review, documentation of a resident, resident's representatives' or family member's attendance or nonattendance at the care plan meeting was to be placed in the Care Plan General Progress Notes. Continued review revealed Frequently, the facility sends out invitations that are in the form of cards or letters to enhance the participation of the residents and their representatives in the care planning process. Review revealed the following guidelines should be followed as necessary . These steps included a follow up call to the resident resident's representative, offering alternate dates/time if either the resident and/or their representative could not attend at the time the facility initially scheduled the meeting, and documenting names, times, and dates of those contacts. Further policy review revealed, If the [care plan] review occurs in person, the resident, the resident's representative as applicable, and the team members should sign the Signature page of the care plan to denote their attendance and review of the care plan. 1) Review of R1's admission Record revealed the facility initially admitted the resident in 2016. Review of R1's Minimum Data Set (MDS) Assessments, revealed an Annual MDS, with an Assessment Reference Date (ARD) of 03/28/2025, and a Quarterly MDS with an ARD of 06/20/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. Review of R1's care plan generated after the Annual MDS Assessment revealed a start date of 04/04/2025, and a care plan with a start date of 07/07/2025, after the 06/20/2025 MDS Assessment. Review of R1's clinical record, including, but not limited to, the Progress Notes section, revealed no documented evidence the resident attended care plans meetings for neither of the two care plans reviews completed in 2025. Review of the Social Service (SS) Progress Notes dated 02/24/2025, revealed a note that stated, SS met with resident and/or RR [resident representative] on file in person or via phone and letter mail [sic] to provide information for resident care plan meeting for March. Per review, SS also offered resident and/or RR a copy of resident care plan at this time as well. Care plan was offered to be held in person, via phone conference, or via telehealth. No concerns voiced at this time. SS to f/u [follow up] as needed. Continued review revealed however, the Note did not detail whether it was actually the resident, a representative, or both, who was contacted regarding the care plan, nor did it specify which of the three ways listed (in person, via phone, or by mail) the facility actually provided the information. Review revealed although it noted there was to be a care plan meeting in 03/2025, no specific date, time, or location for the meeting was documented. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Social Services Progress Note dated 05/20/25, revealed the same, non-specific information was documented as in the previous Note, with the only change being it referenced a June care plan meeting (instead of March). Review of the care plan signature pages and Progress Notes, including the Care Plan General Progress Notes, revealed no documented evidence the resident, a representative, and/or a family member had been present for either care plan review (in March or June), and there was no documentation indicating why their participation would not have been practicable. In interview on 07/30/2025 at 8:37 AM, R1 stated she was able to speak, and both her short and long-term memory were intact. R1 reported she had not regularly been invited to the scheduled care plan meetings where she was able to discuss and provide input on the services she was receiving. R1 said she was a nurse and was her own guardian. The resident further stated she felt she had lost her autonomy, and said she, would like to go to at least one [care plan meeting] to see how it goes. In interview on 07/31/2025 at 9:58 AM, the SSD reviewed R1's records and stated he could not find evidence of the resident being informed of the specific date and time of her care plan meetings. The SSD stated he could not find where a signature sheet for R1 resident was recorded, and he did not recall attending care plan meetings with R1 since he began his position (in March, 2025). He further stated he could find no documentation in R1's chart to explain why the resident and and/or representative had not attended the care plan meetings. 2) Review of R6's clinical record, including, but not limited to, the Progress Notes section, revealed no documented evidence the resident attended care plans meetings for either of the two care plans reviews completed for him in 2025. in interview on 07/31/2025 at 9:57 AM, MDS 1 stated at one time, their department was responsible for running the care plan meetings and issuing invitations. MDS 1 further stated however, currently, SS staff was responsible for scheduling the residents' care plan meetings. In interview on 07/31/2025 at 11:09 AM, R6 stated he had not been invited to any care planning meetings and did not know anything about them. In continued interview on 07/31/2025 at 9:58 AM, the Social Services Director (SSD) stated he just started his position in 03/2025. He said care plan meetings were to be documented in the facility's EMR system for residents. He stated his assistant was supposed to go and talk with the residents about attending their care plan meetings, and if the resident was alert and oriented, a letter was given to the resident. The SSD provided the State Survey Agency (SSA) Surveyor a copy of the letter referenced for review. Review of the letter revealed, During and after admission, you or a loved one may have been evaluated, and care plan was developed to meet required needs. If you are ever interested in reviewing this care plan, please reach out to our facility to schedule a care plan meeting with our team. If you plan to attend, please let us know in advance by calling. Continued review of the letter revealed it did not provide a specific date, time, or location for the care plan meeting, and indicated the care plan had already been developed, and the meeting was to review the care plan (rather than for the resident to participate in its development.) (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In further interview on 07/31/2025 at 9:58 AM, the SSD reported he could provide no evidence of the residents having been informed of the logistics (time and location) of their care plan meetings however. He stated SS staff scheduled the care plan meetings based on a calendar of scheduled assessments and placed a check on the calendar after they had talked to the resident. The SSD reported however, he could provide no evidence of such a system having been completed, as they discarded the calendars at the end of the month. He explained he could provide no evidence the resident, their representative, and/or family had, in fact, attended the care plan meeting and participated in the development of the care plan. In an additional interview on 07/31/2025 at 11:28 AM, the SSD stated R6 had just been invited to his care planning meeting within the hour that morning, and had not had a care plan meeting prior to that. The SSD reported there was a sign in page signed by all present when they completed a resident's care planning; however, there was no evidence of a sign in sheet for R1 and R6. In interview on 08/01/2025 at 7:48 PM, the Director of Nursing (DON) confirmed SS staff ran the resident care plan meeting process. She stated residents and family members were supposed to be asked to those meetings. The DON reported her expectation was for the SS staff to follow the facility's policy, including keeping a record of who attended the care plan meetings, obtaining signatures, and recording the date of the meeting. She further stated she was aware there needed to be documentation in the residents' medical records if the resident and/or their RP's participation was not practicable for some reason.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185187	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 483.25 Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistive devices to ensure the safety of its residents for 1 of 5 residents, (Resident (R)8). The findings include: Review of the facility's electronic medical record (EMR) for R8 revealed the facility admitted him on 02/19/2025, with diagnoses including: adult failure to thrive; unspecified fracture of left femur; and chronic atrial fibrillation. Review of the Discharge Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/08/2025, revealed the facility assessed R8 to have a Brief Interview for Mental Status (BIMS) of 7 out of 15, indicating he was severely cognitively impaired. 1. Review of the facility document titled, Incidents by Incident Type, Fall Incidents, with a date range of 01/01/2025 through 07/31/2025, revealed R8 sustained a fall on 03/13/2025 at 12:00 AM. Review of the facility's document, Incident Report dated 03/13/2025, revealed a the Interdisciplinary Team (IDT) performed a Root Cause Analysis (RCA) and determined R8 got up unassisted without turning on his call light, attempted to ambulate with the walker to the recliner and lost his balance and fell. Per review, R8 was not able to ambulate without assistance. Further review revealed the immediate intervention was for red tape to be placed to his call light to serve as a visual reminder to R8 to call for assistance before attempting to transfer or ambulate on own. Review of the facility's document titled, Fall Risk Evaluation (FRE), signed 03/14/2025, revealed R8 had a history of falls in the past 31-180 days instead of the past 30 days. Additional review revealed a total score of 10 or higher indicated R8 was at risk for falls and follow-up was required. Further review revealed a score of 14 for R8; however the question for follow-up required, had been answered no, therefore, no follow-up comments or actions taken were documented in the space provided. 2. Review of the facility's FRE document, signed 04/15/2025, revealed no falls in the past 30 days was documented. 3. Review of the facility's document titled, Incidents by Incident Type, Fall Incidents, with a date range of 01/01/2025 through 07/31/2025, revealed R8 experienced a fall on 04/17/2025 at 6:08 AM. Review of the facility's document, Incident Report, dated 04/17/2025, revealed a RCA had been performed by IDT that determined R8 got up from his wheelchair in the hallway and attempted to ambulate without staff assist and fell backwards. Per review, the immediate intervention was noted for when R8 was up in a wheelchair, to keep him in high traffic areas such as by the nurses' station for higher visibility from staff to ensure his safety. Further review revealed the IDT agreed that intervention would work best for R8 as he was not safe to ambulate on his own. In addition, review revealed that intervention would also be best for R8 because if he was in a higher traffic area when he was in the wheelchair and attempted to get up on his own, staff would have a higher chance to see him and assist him to ensure no major injury occurred with a fall. Review of the facility's care plan for R8 revealed a focus for risk for falls characterized by history of falls/actual falls, injury, multiple risk factors . Continued review of the risk for falls focus, revealed an intervention for when resident is up in wheelchair, keep in high traffic areas such as nurses station for higher visibility from staff to ensure safety that had been initiated on 04/17/2025. Review of the facility's FRE document for R8, signed 04/17/2025, revealed falls in the past 31-180 days, instead of fall in past 30 days being noted. 4. Review of the facility's FRE document for R8, signed 05/15/2025, revealed, no falls in the past 30 days was documented instead of fall in past 30 days. 5. Review of the facility's FRE document for R8, FRE, signed 06/04/2025, revealed, no falls in the past 30 days was documented instead of fall in past 31-180 days. 6. Review of the facility's FRE document for R8, signed 06/05/2025, revealed the resident's gait was noted as chairfast - total assist with transport instead of as, ambulates with gait problem and device. Additional review revealed a total score of 10 or higher indicated R8 was at risk for falls and follow-up was required. Review further revealed R8's score was 13 indicating the resident was at risk for falls. In addition, review revealed the question for, follow-up required, was answered yes; however, no there was no documented evidence of follow-up comments or actions taken noted in the space provided. 7. Review of the facility's document titled, Incidents by Incident Type, Fall Incidents, with a date range of 01/01/2025 through 07/31/2025, revealed R8 sustained a fall on 06/12/2025 at 5:00 PM. Review of the facility's document, Incident Report, dated 06/13/2025, revealed the IDT performed RCA and determined R8 rolled out of his bed. Per review, the IDT noted R8's bed had been in the lowest position at the time of the fall and bolsters had been in place which the resident rolled right over. Continued review revealed R8 had not had his call light at time of rolling out of his bed, the lighting had been good in his room, and he had just been toileted and assisted to lie down. Further review revealed the IDT's immediate

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	185187	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 483.45Based on observation, interview, record review, and facility policy review the facility failed to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Observation of 300 hall medication refrigerator revealed expired medications for 2 residents (Resident (R)19, R115).The findings include: Review of the facility's policy titled, Medication Storage, dated 09/2020, revealed no information pertaining to expiration dates or discarding expired medications. 1. Review of R19's facesheet revealed the facility admitted the resident on 09/20/2024, with diagnoses that included: second degree burn of lower back, chronic pain, and autistic disorder. 2. Review of R115's facesheet revealed the facility admitted the resident on 09/03/2020, with diagnoses that included: type 2 diabetes mellitus, allergy status to other antibiotic agents, muscle weakness, and chronic kidney disease. Observation of 300-hall medication room refrigerator on 08/01/2025 at 8:55 AM, revealed four elastomeric ball pumps (medical device used for administering medications), containing 3.375 grams of the antibiotic piperacillin/tazobactam that expired on 07/27/2025, and were labeled for R19. Further observation of the medication room refrigerator revealed six additional elastomeric ball pumps containing 100 milligrams of gentamicin that were expired (one expired on 07/24/2025 and five expired on 07/27/2025) labeled for R115. During interview with Certified Medication Technician (CMT) 8 on 08/01/2025 at 9:00 AM, she stated the nurses were responsible for removing expired medications from the refrigerator and medication rooms. She stated a negative outcome of giving expired medications could be the resident experiencing an allergic reaction. In interview on 08/01/2025 9:03 AM, the Assistant Director of Nursing (ADON) stated the expired antibiotic medications in the refrigerator might have been discontinued. The ADON said or the antibiotic medications might have been a medication requiring peak and trough levels (laboratory level indicating high and low levels of a medication) and might not have been infused due to the resident having a high trough level. She explained the nurses and pharmacy technician were responsible for removing and discarding any expired medications. The ADON stated the pharmacy technician came once a month and typically discarded expired medications. She further stated negative outcomes of giving expired medications, especially intravenous (IV) antibiotics could be the resident having an adverse reaction to the medication and/or the medication might not be as effective. During interview with the Director of Nursing (DON) on 08/01/2025 at 7:21 PM, she stated if medications were expired, she expected her staff to return them or destroy them if applicable. She stated she also expected the unit managers to do checks and audits of the medication rooms and refrigerators. The DON said pharmacy also did weekly checks for expired medications in medication rooms. She further stated negative outcomes of giving residents expired medications were them experiencing adverse effects and decreased effects of the medications. During interview with the facility's Administrator on 08/01/2025 at 8:06 PM, he stated the DON took care of expired medications as well as the pharmacy. He reported he expected his staff to monitor the medication rooms for expired medications and discard or return the medications to the pharmacy that were beyond their expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185187	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 483.60Based on observation, interview, record review, and review of facility documents and policy, the facility failed to ensure each resident received food that accommodated the resident's allergies, intolerances, and preferences for 4 of 4 residents reviewed for accommodation of preferences (Resident (R)1, R38, R68, R5). [NAME], [NAME] (1) [NAME], [NAME] (27868) - Food No Notes [NAME], [NAME] (1) [NAME], [NAME] (27868) - RESIDENT NOTE No Notes The findings include: Review of the facility's policy titled, Initial Comprehensive assessment dated 08/2013, revealed residents were to be assessed for nutritional status, their likes and dislikes and was to include clinical considerations. 1) Review of R1's comprehensive care plan dated 07/07/2025, revealed the resident was to be assessed for and provided had food preferences and those preferences updated as indicated. Review of the Nutritional Screen assessment for R1 dated 06/19/2025, revealed no listed preferences. Per review, in area titled, Food Preferences/ Allergies/ Religious or Cultural Considerations revealed resident's meal preferences reviewed and updated per resident request and will follow up PRN (as necessary) with no further specific instructions. Observation during the hall lunch tray pass on 07/30/2025 at 11:57 AM, revealed Certified Nurse Aide (CNA) 13 delivering R1's meal tray. Per observation, R1 only had one (1) single serving of vegetables; however, her meal card noted she was always to receive a first and second choice vegetable. In interview, at the time of observation, R1 stated she had requested extra vegetables and although she received dialysis, she often had potatoes on her tray with an occasional banana, which the resident said was contraindicated for her dialysis. Additionally, in interview on 07/30/2025 on 11:57 AM , CNA 13, was asked by the State Survey Agency (SSA) Surveyor what R1's second vegetable was as indicated on the meal card. CNA 13 reported she could not identify a second vegetable on R1's meal tray, and could not explain why there was no second-choice vegetable present. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Observation on 07/29/2025 at 11:53 AM, of the lunch tray pass and review of the meal cards, revealed R5 was missing the resident's preferred almond milk. Continued observation revealed R38 was missing a can of lemon lime soda, and chocolate milk. Further observation revealed although R38's meal card stated, “No Straws” the resident had a straw in his coke. In addition, observation further revealed R68 was ordered a ground diet; however, received a dessert that was not ground. In interview on 08/01/2025 at 8:06 PM, the Administrator stated physician diet orders were to be followed as written. He further stated they tried to get what a resident preferred, and he expected the residents' preferences to be accommodated within their ordered diet.

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	185187	A. Building B. Wing	08/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of facility policy, the facility failed to maintain an effective infection prevent program to help prevent the development and transmission of communicable infections for 2 of 7 residents reviewed for infection control (Resident (R)106 and R6). Staff failed to implement Enhanced Barrier Precautions (EBP) by wearing gowns during high contact resident care activities for the two residents, who had clinical indications which required EBP. The findings include: Review of the facility's Enhanced Barrier Precautions policy, revised 04/01/2024, revealed EBP are used in conjunction with Standard Precautions to reduce the risk of MDRO [Multidrug Resistant Organisms] transmission during high-contact resident care activities. Per review, EBP included the use of both gown and gloves, and was meant to be in place for the duration of the resident's stay or until resolutions of a wound or discontinuation of an indwelling medical device occurred. Continued review revealed EBP applied to residents with any of the following…Wounds with or without the presence of an MDRO infection…Presence of indwelling medical devices with or without the presence of an MDRO infection or colonization. 1. Review of R106's admission Record revealed the facility admitted the resident in 2017, with diagnoses that included gastrostomy tube (g-tube or feeding tube) and dementia. Review of R106's current physician orders, as well as the facility's, Care Plan Report, initiated 11/24/2017 for the resident, revealed she had orders for a g-tube and to be on EBP. Observation during the initial tour of the facility, on 07/29/2025 at 10:30 AM, revealed a container of personal protective equipment (PPE), including gloves and gowns, hanging from the door to R106's room. Continued observation revealed however, no sign on R106's door indicating what type of precautions were to be used or which of the two residents residing in the room (R106 in Bed A, or R99 in Bed B) was to be on precautions. Further observation revealed R106 was lying on her bed with eyes closed, and did not respond to the State Survey Agency (SSA) Surveyor's knocking on her door. In interview on 07/30/2025 at 10:20 AM, Registered Nurse (RN) 2 confirmed R106, the resident in Bed A, was on the EBP. Observation on 07/30/2025 at 1:38 PM, revealed a sign on the door indicating the resident in Bed A (R106) was on EBP. Observation of the sign which stated, Stop – Enhanced Barrier Precautions, revealed, All Healthcare Personnel must wear gloves and gown for the following high contact resident care activities . Providing hygiene. Observation on 07/30/2025 at 1:38 PM, revealed R106's door was closed, and no response received when the SSA Surveyors knocked. Observation revealed upon entering the room Certified Nurse Aide (CNA) 2 was observed in R106's room providing personal care and stated to the SSA Surveyors, Patient Care and the Surveyors then exited the room. During the observation of CNA 2 providing personal care for R106 revealed the CNA had not been wearing a gown. Further observation at 1:39 PM, revealed while the SSA Surveyors were standing outside R106's door, the resident's door opened a small amount, and a hand came out and pulled a gown from the PPE holder on the resident's door into the room, and then closed the door. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/30/2025 at 1:48 PM, revealed CNA 2 exited the room. In interview, at the time of observation, CNA 2 stated when the SSA Surveyors observed her providing R106's care, she had been cleaning under the resident's breasts because the resident got sweaty there. The CNA said she then put on powder the area to keep it dry. She reported she had not been wearing a gown while providing personal care/hygiene to F106, because the other resident in the room (R99), was who was on the EBP. When the SSA Surveyor asked how she knew which resident was on EBP, CNA 2 stated it was on the care guide used by direct care staff to know how to care for the residents. Per observation, CNA 2 went to the nurse's station and obtained a copy of the care guide document. In review of the facility's, Resident Care Guide with CNA 2, confirmed R106 (not R99) was on the EBP. In continued interview, CNA 2 stated, Well, it used to be on the door. Further observation revealed CNA 2 went with the SSA Surveyors and observed the door showed Bed A (R106) was the resident on the EPB. In further interview, CNA said she should have donned a gown when providing personal care/hygiene to R106. In interview on 08/01/25 at 10:20 AM, Assistant Director of Nursing (ADON) 1, who also served as the facility's Infection Preventionist (IP), stated she was aware of the incident with R106, explaining that CNA 2 had told her that she had not donned a gown prior to providing the resident's care, but should have. ADON 1 confirmed in the interview that a gown should have been worn during R106's care since the resident had orders for EBP related to her indwelling feeding tube placement. 2. Review of the current physician orders for R6 revealed orders to treat R6's sacral pressure wound. Review of the facility's Care Plan Report, for R6 revealed a care plan with the orders for the wound care treatment and for the resident to be on EBP. During observation of a wound dressing change for R6 on 08/01/2025 at 9:39AM, revealed no signage observed designating EBP was required, and the room did not have PPE available for use hanging on the door. Per observation, the treatment nurse did not don a gown, and initiated wound care for R6. Continued observation revealed after removing the soiled dressing, fecal material was observed under the dressing nearest to the resident's anus. Observation revealed the treatment nurse positioned the clean dressing on the sacral area of the buttock; however, did not place the dressing in a way to seal fecal material from getting under the dressing. In interview at the time of observation, the Treatment nurse stated EBP was not needed due to the wound having been cultured and found not to be colonized with infectious organisms. In interview by telephone on 08/01/2025 at 10:49 AM, the Medical Director stated any resident with a feeding tube, as well as other care issues such as wounds, were to be on EBP. In interview on 08/01/2025 at 7:16 PM, the Director of Nursing (DON) stated the potential consequences related to failure to use EBP as required included transmission of different disease and infections to residents as well as staff. In interview on 08/01/2025 at 8:10 PM, the Administrator stated his expectation was for staff to use EPB as indicated and/or ordered and follow the facility's policies.

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	185187	A. Building B. Wing	08/01/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 483.90Based on observation, interview, record review, and facility policy review, the facility failed to ensure it was adequately equipped to allow residents to call for staff assistance through a communication system (call light system) for 2 residents (Resident (R)98, and R117). The findings include: When asked to provide a policy pertaining to residents' call lights, the Director of Nursing (DON) provided a signed statement dated 07/30/2025, stating the facility did not have a specific call light policy. 1. Review of R98's facesheet revealed the facility admitted the resident on 01/28/2025, with diagnoses that included: occlusion and stenosis of left carotid artery, morbid obesity, chronic diastolic heart failure, and chronic obstructive pulmonary disease. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R98 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Observation on the 300-hall of room [ROOM NUMBER] on 07/29/2025 at 11:00 AM, revealed the call light malfunctioning. Further observation revealed R98 had a cow bell sitting on her bedside table and her roommate (R117) had no type of an alternative device to call for assistance. Observation on the 300-hall on 07/29/2025 at 11:20 AM, revealed the door to room [ROOM NUMBER] was closed and R98 was ringing her cow bell. Further observation revealed the cow bell could not be heard unless one was within approximately 15 feet of room and it was unclear which room the cow bell sound was coming from. During interview on 07/29/2025 at 11:07 AM, R98 stated her call light had been out since Friday afternoon. She stated that no one came to check on her and her roommate. R98 said staff had been running around labeling stuff since state had been there at the facility. She reported she did not have a way to get a hold of anybody, and one day no one even entered their room to check on them for over four hours. R98 explained on Sunday, the Registered Nurse (RN) on duty called the Director of Maintenance and told him about the malfunctioning call light. She stated the RN and Maintenance Director also told the Administrator on Sunday as well; however, the part needed still had not been ordered. R98 said she and her roommate had no way of communicating their needs to staff. She reported the face plate on the call light panel had just been replaced that morning and had been replaced at least twice in a matter of two weeks. RN 98 further stated it (call light panel) had been leaking water and she got squirted with water when she pressed the call light button. 2. Review of R117's facesheet revealed the facility admitted the resident on 12/04/2023, with diagnoses that included: type 2 diabetes mellitus, muscle weakness, bipolar disorder, and chronic obstructive pulmonary disease. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed R117 to have a BIMS score of 15 out of 15, indicating intact cognition. Observation on 07/29/2025 at 11:00 AM of room [ROOM NUMBER], revealed the residents' call light was malfunctioning, and R117 had no alternative device for requesting assistance from staff. During interview with R117 on 07/29/2025 at 11:08 AM, she stated her call light had not been working since last Friday. She stated she had been living here (facility) for two years, and it was hard to get anyone to help them (her and her roommate). R117 reported she had a hard time getting ice water and it took staff two to three hours to bring them something that they asked for. She further stated she did not like this place. During interview with the Maintenance Assistant (MA) on 07/29/2025 at 11:30 AM, he stated he had worked here for about 10 months now. He stated the reason R98's and R117's call light kept malfunctioning was because of the condensation leaking into the call light box and that had been an issue. The MA reported they were trying to get the facility's air conditioning system replaced, and they had put dehumidifiers in the attic. He explained they usually tried to dry the call light box out first and if that did not work then they would replace the call light board. The MA said when the resident (R98) pressed the call light it sprayed her with water. He further stated when a resident's call light system was not working, they had cow bells they gave the residents to use. During interview with the Director of Maintenance on 07/29/2025 at 2:15 PM, he stated a new call light board had just been put in R98's and R117's room. He said the residents kept it so cold in that room, that condensation formed causing the problem. The Director of Maintenance further stated he replaced the board on Friday and then again today. During interview with Certified Medication Technician (CMT) 8 on 08/01/2025 at 8:55 AM, she stated if a resident's call light malfunctioned staff were supposed to call maintenance to fix it. She said in the meantime (while waiting for it to be fixed), if there were extra call lights they gave the resident(s) another call light to use or gave them a cow bell. CMT 8 further stated both roommates in room [ROOM NUMBER] should have been given a cow bell so they could call for help. She also said staff were supposed to check on the residents with

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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	185187	A. Building B. Wing	08/01/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation and interview, the facility failed to ensure a functional, sanitary, environment for residents, staff and the public. Observation of the facility's back 300 Hall revealed water damage to the ceilings, which affected two residents (Resident (R)99 and R106) and had the potential to affect any of the 28 residents residing on the hall.The findings include: 1. Observation on 07/29/2025 at 3:06 PM, revealed Licensed Practical Nurse (LPN) 1 was in the 300 Back Hall, which housed 28 residents. Per observation, a large wet spot was noted on the carpet, and a bucket filled with water and a soiled glove were on the floor, directly under an approximately 2-inch-long hole in the hallway's ceiling. Continued observation revealed the ceiling surface was broken with white bits of ceiling debris littering the floor. In interview, at the time of observation, LPN 1 stated there had been condensation in the ceiling, and it cracked. In addition to the 2-inch-long hole in the ceiling, observation revealed a water stain approximately 10-inches, which ended at an overhead light fixture. Observation on 07/29/2025 at 3:40 PM, revealed staff had removed the overhead light fixture. In interview with the Maintenance Director on 07/29/2025 at 4:21 PM, he stated he had to remove the light fixture due to water in the ceiling and was screwing a metal plate over where the missing fixture had been. He said his belief was the water issues were coming from condensation problems in the attic. Observation on 08/01/2025 at 3:52 PM revealed that the light was still missing from the ceiling and water stains were still present on the ceiling. Interview with the Maintenance Director, who was present during this observation, revealed that the water problems had been caused because the condensation drain to the pan that goes outside had build-up in it. Further interview with the Maintenance Director revealed he believed the issue was taken care of, as the drain had been cleaned and ceiling repairs were scheduled for the next week. 2. Observation during initial tour on 07/29/2025 at 10:30, revealed R99 and R106 shared a room. Per observation, the ceiling in each resident's portion of the room had water damage. Observation on 07/29/2025 at 4:35 PM, revealed R99 had large water stains on the ceiling, which were dotted with a dark grey/green moldy looking substance on the ceiling above the resident's bed in two areas, approximately 6-inches across. Observation on 07/30/2025 at 8:22 AM, revealed R99's ceiling continued to have evidence of water damage. Per observation, R106 also had an approximate 9 x8 inch water stain on the ceiling, and a 4-inch hole in the middle of the stain was cut out of the ceiling. Continued observation revealed a fuzzy, dark grey/green substance indicative of mold was visible where the textured ceiling spackling was missing. Additional observation on: 07/30/2025 at 8:26 AM, 10:20 AM and 2:00 PM; 07/31/2025 at 8:42 AM; and 08/01/2025 at 3:52 PM, revealed the water damage and mold-appearing substance remained on the ceiling in R99's and R106's room. During the observation on 08/01/2025 at 3:52 PM, the Maintenance Director had been present, he confirmed the size and appearance of each of the areas, and stated the ceiling area appears wet. Per observation, the Maintenance Director, using a flashlight, he shone his light on the ceiling areas, which appeared to glisten as if wet. He inspected the areas with the fuzzy, greenish/grey substance and stated the areas could be mold. In continued interview the Maintenance Director stated he was unaware of the issues in that room prior to the State Survey Agency (SSA) Surveyor's notification and said no work order had been initiated. He reported, in addition to the issues identified in Example 1, the facility needed to determine the cause of the problems in that room so that it could also be corrected. The Maintenance Director said the water stains on the ceiling, the missing portions of ceiling, and the mold-like substance on the ceiling all appeared to be located on the same water line and they would need to figure out what the problem was. He further stated, Condensation has been my enemy this year, adding that, This appears to be a water issue in the ceiling which has no place to go. In interview with the Administrator on 08/01/2025 at 8:10 AM, he stated the issue with the water damage on the 300 Hall was from condensation and he thought they were on the way to fixing the problem.