DEPART IMENT OF HEALTH AND HUMAN SERVICES FORM APP   STATEMENT OF DEFICIENCIES OMB END. 903   STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV   AND PLAN OF CORRECTION (X1) PROVIDENSUPPLER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV   NAME OF PROVIDER OR SUPPLER 345380 B. WING R 07/27/20   VILLAGE GREEN HEALTH AND REHABILITATION FREETADDRESS, CITY, STATE, ZIP CODE 1601 PURDUE DRIVE PROVIDER'S PLAN OF CORRECTION NUMBER: 07/27/20   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM   (Y4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM   (Y4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM   (Y4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM   (Y4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM   (Y4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COM   (Y4) ID SUMMARY STATEMENT OF DEFICIENCIES ID ID PROVIDER'S PLAN OF CORRECTION SHOULD BE   (	STATEMENT ( AND PLAN OF			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D/	LABORATORY			

Electronically Signed

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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