DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020 FORM APPROVED 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	
-		185151	B. WNG			05/19/2020	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, Z 79 SPARROW LANE PRESTONSBURG, KY 41653			E F
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	A COVID-19 focused initiated on 05/18/2020 The fact compliance with 42 Cand has implemented Medicaid Services (C Disease Control and recommended practices)	d infection control survey was 20 and concluded on ility was found to be in CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for ient practice was identified.	FO	DEFICI			
LABORATORY	DIRECTOR'S OR BROVIDER	/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.

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WNG_ 100504 05/19/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **79 SPARROW LANE RIVERVIEW HEALTH CARE CENTER** PRESTONSBURG, KY 41653 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 N 000 **Initial Comments** A COVID-19 focused infection control survey was initiated on 05/18/2020 and concluded on 05/19/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTH CARE CENTER 185151 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW LANE PRESTONSBURG, KY 41653	/19/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW LANE 79 SPARROW LANE	(X5)
	(X5) COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
E 000 Initial Comments E 000	-
A COVID-19 focused Emergency Preparedness survey was initiated on 05/18/2020 and concluded on 05/19/2020. The facility was found	- , [
to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	
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The state of the s	14
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE	

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