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

PRINTED: 05/27/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |  | IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |         |
|---|--|---|--|-----|--|-------------------------------|---------|
|   |  | 185243  | B. WING                                |     |  |                               | 21/2020 |
| NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW NURSING AND REHABILITATION CENTER |  |   |  | 39  | REET ADDRESS, CITY, STATE, ZIP CODE<br>FERNDALE APARTMENTS ROAD<br>NEVILLE, KY 40977                                   |                               |         |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               |         |
| An a a CC initia 05/2 and facili CFR imple Med Dise reco                      | OVID-19 focused ated on 05/19/202 ated on 05/19/ | dard survey (KY31705) and infection control survey was 20 and concluded on inplaint was unsubstantiated tice was identified. The pe in compliance with 42 in Control and has inters for Medicare & EMS) and Centers for Prevention (CDC) ces to prepare for | F                                      | 000 |  |                               |         |
|   |  |   |  | ँ   | 25 25 25 25 25 25 25 25 25 25 25 25 25 2   |                               |         |

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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2020 **FORM APPROVED** OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |          |   | CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|----------|---|--------------|-------------------------------|----------------------------|
|   |  | 185243  | B. WING  |   |              |                               | C<br>05/21/2020            |
| NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW NURSING AND REHABILITATION CENTER |  |   |          | STREET ADDRESS, CITY, STATE, ZIP CODE  39 FERNDALE APARTMENTS ROAD  PINEVILLE, KY 40977                               |              |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |          | ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY) |              |                               | (X5)<br>COMPLETION<br>DATE |
| E 000   | Initial Comments  A COVID-19 focuses survey was initiated concluded on 05/21/2 to be in compliance with the compliance of the compliance o | d Emergency Preparedness<br>on 05/19/2020 and<br>2020. The facility was found<br>with 42 CFR 483.73<br>dness related to E0024. No |          | 000   |              |                               |                            |
| •   |  |   |          |   |              |                               |                            |
| ADODATORY   | DIRECTOR'S OR BROVIDER   | VICIADI IED DEDDESENTATIVE'S SIGNATI IDS  | <u> </u> |   | TITLE        |                               | (VE) 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: 05/27/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING 100496 05/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD **MOUNTAIN VIEW NURSING AND REHABILITATION CE** PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A complaint investigation (KY31705) and a COVID-19 focused infection control survey was initiated on 05/19/2020 and concluded on 05/21/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE