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

PRINTED: 06/11/2020 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED						
		185243	B. WING		C 06/08/2020						
	PALIBER OF CURRENTS	1002.10		DEET ADDRESS CITY STATE 718 CODE	00/00/2020						
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  39 FERNDALE APARTMENTS ROAD											
MOUNTAIN	N VIEW NURSING AND F	REHABILITATION CENTER	I								
			1	PINEVILLE, KY 40977  D PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG								
F 000	KY31794) and a COV control survey was in concluded on 06/08/2 unsubstantiated and	dard survey (KY31792, VID-19 focused infection itiated on 06/03/2020 and 2020. The complaints were no deficient practice was	F 000								
	and has implemented	CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for									
277											
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185243	B. WING			C 06/08/2020	
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW NURSING AND REHABILITATION CENTER				39	TREET ADDRESS, CITY, STATE, ZIP CODE 9 FERNDALE APARTMENTS ROAD INEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	SHOULD BE COMPLET	
E 000	survey was initiated of concluded on 06/08/2 to be in compliance w	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	E	000			
LADODATORY	DIDECTORS OF SECUREES	SUPPLIED REPRESENTATIVE'S SIGNATURE			TITLE		(YE) 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 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WNG\_ 06/08/2020 100496 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **39 FERNDALE APARTMENTS ROAD** MOUNTAIN VIEW NURSING AND REHABILITATION CE PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 **Initial Comments** A complaint investigation (KY31792, KY31794) and a COVID-19 focused infection control survey was initiated on 06/03/2020 and concluded on 06/08/2020. The complaints were 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