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

PRINTED: 07/30/2020 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	
		185243	B. WING		07/27/2020	
	N VIEW NURSING AND I	REHABILITATION CENTER	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 9 FERNDALE APARTMENTS ROAD INEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	conducted on 07/27/2 to be in compliance of Control and has impl Medicare & Medicaid Centers for Disease (CDC) recommended	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection remented the Centers for d Services (CMS) and Control and Prevention d practices to prepare for ient practice was identified. s 45.				
LABORATORY	DIDECTOR'S OR BROWNE	RISLIPPLIER REPRESENTATIVE'S SIGNATUL	DE .	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.

Facility ID: 100496

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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			07/27/2020	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING AND REHABILITATION CENTER				39	REET ADDRESS, CITY, STATE, ZIP CODE FERNDALE APARTMENTS ROAD NEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
E 000	survey was conducte facility was found to t CFR 483.73 Emerger	t Emergency Preparedness d on 07/27/2020. The se in compliance with 42 ncy Preparedness related to practice was identified.	E	000	DEFICIENCY)		
		SUPPLIER REPRESENTATIVE'S SIGNATUR	27		TITL €		(XS) 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 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 100496 07/27/2020 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 (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 **Initial Comments** N 000 A COVID-19 focused infection control survey was conducted on 07/27/2020. 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