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

PRINTED: 10/26/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--------------------|--|--------|-------------------------------|--|
| | | 185195 | B. WING _ | | | 10/21/2021 | |
| NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZI 10456 US HIGHWAY 62 CALVERT CITY, KY 42029 | P CODE | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | | | |
| F 000 | was conducted 10/19 There was no deficie CFR 483.80 Infection facility has implemen & Medicaid Services Disease Control and recommended practic COVID-19. Census 6 | d Infection Control Survey 0/2021 through 10/21/2021. Int practice identified at 42 In Control regulations and the ted the Centers for Medicare (CMS) and Centers for Prevention (CDC) Inception Control Survey | | 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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| | | 185195 | B. WING _ | | | 10/ | 21/2021 |
| NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP 10456 US HIGHWAY 62 CALVERT CITY, KY 42029 | CODE | | - |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIA | | (X5) COMPLETION DATE |
| E 000 | Initial Comments A COVID-19 Focuse Survey was conducte 10/21/2021. There was | d Emergency Preparedness ed 10/19/2021 through as no deficient practice 483.73 related to E-0024 (b) | | | | NE. | |
| ARORATORY | DIRECTOR'S OP DROVINCED! | SUPPLIER REPRESENTATIVE'S SIGNATUR | F | 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: 100330

PRINTED: 10/26/2021 FORM APPROVED

Office of Inspector General

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | |
|--|---|---------------|
| | 100330 B. WING | 10/21/2021 |
| OAKVIEW NURSING & REHABILITATION CENTER 10456 US HIGHWAY 62 CALVERT CITY, KY 42029 | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO | ' MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL SC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRO | D BE COMPLÉTE |
| N 000 Initial Comments A COVID-19 Focused Infection Control Survey was conducted 10/19/2021 through 10/21/2021. There was no deficient practice identified pursuant to 42 CFR 483.80. | Infection Control Survey 2021 through 10/21/2021. It practice identified | |

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

TITLE (X6) DATE