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

PRINTED: 03/10/2021 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		
185195			B. WING			03/05/2021	
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER				10456 US HIG	ESS, CITY, STATE, ZIP CODE GHWAY 62 ITY, KY 42029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EAC	ROVIDER'S PLAN OF CORRECTION SHOULD SHOULD SHOULD TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 03/02/2021 and concluded on 03/05/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention		FO	00			
	(CDC) recommend COVID-19. Total ce	ed practices to prepare for ensus: 66.					
ADOBATODY	/ DIRECTORIS OR PROVID	ER/SLIPPI IFR REPRESENTATIVE'S SIG	NATURE		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	
185195			B. WING			03/05/2021		
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER					10	TREET ADDRESS, CITY, STATE, ZIP CODE 0456 US HIGHWAY 62 CALVERT CITY, KY 42029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments			ΕŒ	000			
	Survey was initiated concluded on 03/05	sed Emergency Prep d on 03/02/2021 and s/2021. The facility w with 42 CFR 483.73	as found					
	V DIPECTADIO AD DECIVIE	DER/SUPPLIER REPRESEN	TATINE'S SIGN	NATURE		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.

PRINTED: 03/10/2021 **FORM APPROVED** Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ **B. WING** 100330 03/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **10456 US HIGHWAY 62 OAKVIEW NURSING & REHABILITATION CENT CALVERT CITY, KY 42029** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 03/02/2021 and concluded on 03/05/2021. 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