

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

PRINTED: 07/01/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2020
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NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating Complaint KY#00031848 and a COVID-19 Focused Infection Control Survey was initiated on 06/16/2020 and completed on 06/18/2020. Complaint KY#00031848 was substantiated with related deficiencies cited at a Scope and Severity of a "C". It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 52.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/16/2020 and concluded on 06/18/2020. It was determined there were no concerns with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/18/2020
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NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006
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N 000	<p>Initial Comments</p> <p>A Complaint Survey investigating Complaint KY#00031848 and a COVID-19 Focused Infection Control Survey was initiated on 06/16/2020 and completed on 06/18/2020. Complaint KY#00031848 was substantiated with related deficiencies. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p>	N 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____