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

PRINTED: 12/17/2020 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	
		185410	B. WING _	B. WING		12/17/2020	
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE  300 BEECH STREET  KUTTAWA, KY 42055			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 12/16 12/17/2020. The facil compliance with 42 C regulations and has i Medicare & Medicaid Centers for Disease 6	d Infection Control Survey 6/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention	F	DEFICIE 0000	INCY)		
LABORATORY	 DIRECTOR'S OR PROVIDER/:	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	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: 100686

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185410	B. WING _	B. WING		12/17/2020	
NAME OF PROVIDER OR SUPPLIER  RIVER'S BEND RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE  300 BEECH STREET  KUTTAWA, KY 42055			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 Focuse Survey was initiated of concluded on 12/17/2	d Emergency Preparedness					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RF	TITLE			(X6) DATE

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Office of Inspector General

MANIE OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   300 BEECH STREET XUTURAN, KY 42055	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
RIVER'S BEND RETIREMENT COMMUNITY    X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)   REGULATORY OR LSC IDENTIFYING INFORMATION)   N 000      N 000   Initial Comments   N 000   A COVID-19 Focused Infection Control Survey was initiated 12/16/2020 and concluded on 12/17/2020. The facility was found to be in   N 000   N 0	100686			B. WING 12			2/17/2020	
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/16/2020 and concluded on 12/17/2020. The facility was found to be in			MMUNITY 300 BEEC	H STREET				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 12/16/2020 and concluded on 12/17/2020. The facility was found to be in			KUTTAW		DDOWDEDIO DI AN OF CODDECT	FION		
A COVID-19 Focused Infection Control Survey was initiated 12/16/2020 and concluded on 12/17/2020. The facility was found to be in	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETE	
was initiated 12/16/2020 and concluded on 12/17/2020. The facility was found to be in	N 000	Initial Comments		N 000				
		A COVID-19 Focused was initiated 12/16/20 12/17/2020. The faci	020 and concluded on lity was found to be in					

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

TITLE (X6) DATE