DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CON		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A. BUILDING			
	185151	B. WNG		11/17/2020		
NAME OF PROVIDER OR SUPPRIVERVIEW HEALTH CAP		STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW LANE PRESTONSBURG, KY 41653				
PREFIX (EACH D	IMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
conducted or to be in comp Control and I Medicare & M Centers for D (CDC) recom	focused infection control survey was a 11/17/2020. The facility was found bliance with 42 CFR 483.80 Infection has implemented the Centers for Medicaid Services (CMS) and Disease Control and Prevention has implemented practices to prepare for No deficient practice was identified.	F 000	X			
					N	

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.

Event ID: D1Y711

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

PRINTED: 11/20/2020 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	
		185151	B. WING			11/17/2020	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW LANE PRESTONSBURG, KY 41653				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	:-	E	000	= W		
	A COVID-19 focused Emergency Preparedness survey was conducted on 11/17/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.						
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ADODATOS	V DIRECTOR'S OR PROVIDE	R/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.

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 11/17/2020 100504 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **79 SPARROW LANE** RIVERVIEW HEALTH CARE CENTER PRESTONSBURG, KY 41653 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 11/17/2020. 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