

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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	OCT 1 2015 MULTIPLE CONSTRUCTION A. BUILDING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41622
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F 000 F 253 SS=D	<p>INITIAL COMMENTS</p> <p>A standard survey was conducted on 08/25-27/15. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and facility policy review, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior for two (2) of eighteen (18) sampled residents (Resident #4 and Resident #11) and one (1) unsampled resident (Resident A). Observations during the environmental tour on 08/27/15 revealed a "Care Foam Chair" (a one-piece chair utilized to reduce falls) for Resident A that was ripped in several of the seams, and fall mats in the rooms of Residents #4 and #11 that were torn and ragged around the edges.</p> <p>The findings include: A review of the facility's policy titled "Servicing Medical Equipment," date 03/13/04, revealed Maintenance should be contacted for issues concerning resident-related medical devices. The Maintenance Department, in conjunction with Clinical Services, would contact the equipment vendor to effect repairs or obtain replacement</p>	F 000 F 253	<p>Tag # F 253</p> <ol style="list-style-type: none"> Residents # 4 and # 11 fall mats that were ragged around the edges and torn were replaced. For Resident A, CareFoam replacement cover was ordered from CareFoam on 9/16/15 and received and installed on chair on 9/20/15. All residents have the potential to be affected by this practice. A 100% audit of resident rooms was completed on 9/17/15 by the Executive Director, Maintenance Director, and Director of Nursing to ensure that any resident chairs or fall mats with tears and/or ragged edges have been identified and a plan put into place to correct issues. The Maintenance Director in conjunction with the Director of Nursing replaced any fall mat or resident chair with visible tears and/or ragged edges. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *James V. Snyder* TITLE: EXECUTIVE DIRECTOR (X6) DATE: 10/1/15

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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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41622		
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F 253	<p>Continued From page 1</p> <p>equipment. The procedure was as follows: remove the device from the resident care area so it will not be inadvertently used on a resident, and affix a sign to the device identifying the medical equipment "Out of Service" and place in the soiled utility room.</p> <p>1. Observations made during the environmental tour on 08/27/15 at 4:23 PM revealed Resident A had a "Care Foam Chair" in his/her room that had a tear on the arm in the seam approximately four inches long, and two tears on the front of the chair approximately four inches long each.</p> <p>2. Observations made during the environmental tour on 08/27/15 at 4:31 PM revealed two fall mats, one for Resident #4 and one for Resident #11, were torn in several places and ragged around the edges.</p> <p>Interview with the Maintenance Supervisor on 08/27/15 at 5:20 PM revealed that Nursing Staff was responsible for notifying the company that provided the "Care Foam Chair" to get a replacement. The Maintenance Supervisor further stated he could remove the fall mats from the rooms and discard them, but it was the responsibility of the nursing staff to order new mats when they were needed.</p> <p>Interview with the Director of Nursing (DON) on 08/27/15 at 5:10 PM revealed nursing staff was required to monitor the fall mats and the "Care Foam Chair" for concerns with tears or maintenance. The DON stated that the fall mats should have been replaced, but staff had not identified the mats needed to be replaced. The DON stated she ordered a new cover, but could not produce evidence that the cover was ordered.</p>	F 253	<p>3. The Staff Development Coordinator will in-service all staff on or before September 18, 2015 regarding how to complete a work order and to who to turn it in related to torn or defective equipment. A maintenance log will maintained by the Executive Director/Maintenance Director for all maintenance requests. The Executive Director/ Maintenance Director will conduct random audits of 5 resident rooms Monday through Friday daily x 4 weeks, weekly x 4 weeks, then monthly x 4 months then randomly.</p> <p>4. The ED/Maintenance Director will present the finding of the audit in the monthly Performance Improvement Meeting. Revisions will be made to the system as appropriate. Audits will continue until the Performance Improvement Committee determines compliance. The PI Committee consists of at least the Executive Director, Director of Nursing, Assistant Director of Nursing, Activity Director, Social Services</p>		

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F 253	Continued From page 2	F 253	Director, Dietary Director, Maintenance Director, Housekeeping/Laundry Director and the Medical Director.	
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of eighteen (18) sampled residents (Resident #1). Resident #1's Comprehensive Care Plan contained interventions that included oxygen at two (2) liters per minute (LPM). However, observations on 08/25/15 and 08/26/15 revealed Resident #1's oxygen to be at three (3) LPM.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Resident Care Plan," dated December 2008, revealed the care plan will be reviewed at least quarterly and as needed to reflect the resident's current needs, problems, care, treatment, and services. Further review of the policy revealed no guidance to staff in following the plan of care.</p> <p>Review of Resident #1's medical record revealed</p>	F 282	<p>5. Date of Compliance - 9/30/15.</p> <p>Tag # F 282</p> <ol style="list-style-type: none"> Resident # 1 was not found to have been adversely affected by this practice. Upon notification of resident receiving the wrong liter of oxygen, the physician was notified and oxygen was placed on correct setting. Resident had no adverse reactions related to receiving the wrong dose. A 100% audit was completed by the Director of Nursing or designee on 8/27/15 of residents requiring oxygen administration to ensure that correct dosage was being administered and care plans and care directives reflect dosage to be administered. The Staff Development Coordinator will inservice all licensed staff on or before September 18, 2015 regarding the correct settings of administered oxygen matches 	

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
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F 282	<p>Continued From page 3</p> <p>the facility admitted Resident #1 on 06/19/14 with diagnoses that included Muscle Weakness, Acute Kidney Failure, Acute Respiratory Failure, Neoplasm of the Bladder, and Diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 05/20/15 revealed the facility assessed Resident #1 to require the use of oxygen. Review of the physician's order dated 06/19/14 revealed Resident #1 had an order to use oxygen at 2 LPM via nasal cannula. Review of the Comprehensive Care Plan dated 05/30/15 revealed Resident #1 to have care plan interventions for oxygen at 2 LPM per nasal cannula. Review of the Treatment Administration Record (TAR) revealed staff was to check the rate of Resident #1's oxygen and it was to be at 2 LPM.</p> <p>Observations on 08/25/15 at 4:00 PM, 5:00 PM, and 8:10 PM, and on 08/26/15 at 10:50 AM, 11:40 PM, and 12:20 PM revealed Resident #1 to be using oxygen per nasal cannula at 3 LPM.</p> <p>Interview with the Unit Manager on 08/27/15 at 8:30 PM revealed rounds were made every two hours to ensure residents were receiving what the physician ordered and receiving the interventions on the care plan. She further revealed she was responsible for Resident #1's oxygen and did not know exactly how the oxygen was increased to 3 LPM. She further stated Certified Nurse Assistants (CNAs) were not allowed to touch the dial that controls the amount of oxygen being administered on the concentrators.</p> <p>Interview with the Director of Nursing on 08/27/15 at 6:45 PM revealed audits were done often to ensure that staff was following the care plans. She further stated she does rounds daily to</p>	F 282	<p>the physician orders and care guides. Audits will be completed by the Director of Nursing or designee daily (Monday-Friday) x 1 week, weekly x 2 weeks, than monthly x 1 months to observe compliance with oxygen administration and following of resident care plans for every resident receiving oxygen.</p> <p>4. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. The PI Committee consists of at least the Executive Director, Director of Nursing, Assistant Director of Nursing, Activity Director, Social Services Director, Dietary Director, Maintenance Director, Housekeeping/Laundry Director and the Medical Director.</p> <p>5. Date of Compliance – September 30, 2105.</p>		

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F 282	Continued From page 4 ensure residents were receiving the care that was on the care plans, and no concerns had been identified with staff not following the care plans.	F 282		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to provide proper treatment and care related to oxygen therapy for Resident #1. Resident #1's physician orders included oxygen therapy at two (2) liters per minute (LPM). However, observations on 08/25/15 and 08/26/15 revealed Resident #1's oxygen was administered at three (3) LPM. The findings include: Review of the facility policy entitled "Oxygen Use, General," dated February 2011, revealed general information concerning oxygen safety and precautions during oxygen administration. Further review of the policy revealed no	F 328	Tag # F 328 1. Resident # 1 was not found to have been adversely affected by this practice. Upon notification of resident receiving the wrong liter of oxygen, the physician was notified and oxygen was placed on correct setting. Resident had no adverse reactions related to receiving the wrong dose. 2. A 100% audit was completed by the Director of Nursing or designee on 8/27/15 of residents requiring oxygen administration to ensure that correct dosage was being administered and care plans and care directives reflect dosage to be administered. 3. The Staff Development Coordinator will in-service all licensed staff on or before September 18, 2015 regarding the correct settings of administered oxygen matches the physician orders and care guides. Audits will be completed by the Director of Nursing or designee daily (Monday-Friday)	

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F 328	<p>Continued From page 5</p> <p>information regarding staff providing the oxygen rate as ordered.</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #1 on 06/19/14 with diagnoses that included Muscle Weakness, Acute Kidney Failure, Acute Respiratory Failure, Neoplasm of the Bladder, and Diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 05/20/15 revealed the facility assessed Resident #1 to require the use of oxygen. Review of the physician's order dated 06/19/14 revealed Resident #1 had an order for oxygen at 2 LPM via nasal cannula. Review of the Comprehensive Care Plan dated 05/30/15 revealed Resident #1 to have interventions for oxygen at 2 LPM per nasal cannula. Review of the Treatment Administration Record (TAR) revealed staff was to check Resident #1's rate of oxygen every shift to assure it was at 2 LPM.</p> <p>Observations on 08/25/15 at 4:00 PM, 5:00 PM, and 6:10 PM, and 08/26/15 at 10:50 AM, 11:40 PM, and 12:20 PM revealed Resident #1 to be using oxygen per nasal cannula at 3 LPM.</p> <p>Interview with the Unit Manager on 08/27/15 at 6:30 PM revealed staff made rounds every two hours to ensure the residents were receiving services according to the physician's orders. She further revealed she was responsible for Resident #1's oxygen and did not know exactly how the oxygen was increased to 3 LPM. Continued interview with the Unit Manager revealed Certified Nurse Assistants (CNAs) were not allowed to touch the dial that controls the amount of oxygen being administered on the concentrators and Resident #1 was not physically able to increase the oxygen concentrator.</p>	F 328	<p>x 1 week, weekly x 2 weeks, than monthly x 1 months to observe compliance with oxygen administration and following of resident care plans for every resident receiving oxygen.</p> <p>4. The results of these audits will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. The PI Committee consists of at least the Executive Director, Director of Nursing, Assistant Director of Nursing, Activity Director, Social Services Director, Dietary Director, Maintenance Director, Housekeeping/Laundry Director and the Medical Director.</p> <p>5. Date of Compliance – September 30, 2105.</p>		

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F 328	Continued From page 6	F 328		
F 371 SS=E	<p>Interview with the Director of Nursing (DON) on 08/27/15 at 6:45 PM revealed the nurses sign off on the TAR every shift to prove the oxygen rate was correct during their shift. She further revealed the Medication Administration Record (MAR) and the (TAR) were reviewed monthly to ensure that residents were receiving medications as ordered and treatments, including oxygen, as ordered by the physician. The DON stated she had not identified any concerns with residents not receiving the correct rate of oxygen.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, review of facility policies, and review of the 2009 United States FDA (Food and Drug Administration) Food Code it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for fifteen (15) of seventy-nine (79) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 08/26/15 revealed staff were touching cups and</p>	F 371	<p>Tag # F 371</p> <ol style="list-style-type: none"> 1. CNA #3, CNA #4, and LPN # 2 were given an in-service (8/27/15) on infection control involving food delivery to residents and bare skin contact on food-contact and lip-contact surfaces. All fifteen residents identified had no apparent adverse reactions related to food delivery. 2. All residents in the facility who are served food from the dietary department have the potential to be affected. 3. Staff involved with dining service were in-serviced by 9/17/15 by 	

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F 371	<p>Continued From page 7</p> <p>glasses on the food contact areas with their bare skin while serving food, and were transporting drinks to residents uncovered in the hallway.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Safe Food Handling," dated 01/01/07, revealed the policy stated "all food purchased, stored and distributed is handled with accepted food-handling practices." Further review of the policy revealed it did not address the handling of clean cups and glasses, or transporting food and drinks that were uncovered.</p> <p>Review of the 2009 FDA Food Code revealed Chapter 4-904.11 stated, "cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food- and lip-contact surfaces is prevented."</p> <p>1. Observations on 08/26/15 at 12:52 PM during the noon meal service revealed Certified Nursing Assistant (CNA) #3, CNA #4, and Licensed Practical Nurse (LPN) #2 were taking food trays off of the food cart and pouring drinks, and then transporting trays with drinks uncovered down the hall, up to 60 feet from the food cart to resident rooms, passing other staff and visitors in the hall.</p> <p>Interview with CNA #3 on 08/26/15 at 1:38 PM revealed she thought it was acceptable to transport uncovered drinks in the hallway.</p> <p>Interview with CNA #4 on 08/27/15 at 6:25 PM revealed that she should not have transported the drinks down the hall uncovered; she stated that was what she normally did.</p>	F 371	<p>the Staff Services Coordinator regarding Infection Control, specifically Safe Food Handling. This emphasized proper transporting of food down hallways and not touching food-contact and lip-contact surfaces of cups and glasses with bare skin (fingers) while serving drinks to residents.</p> <p>Staff will be observed at each meal service by Executive Director, DON, ADON, SDC, Dietary Manager, Activity Director or their designee for 2 weeks, then at random meal services daily for 2 weeks.</p> <p>4. Audits will be completed by the Executive Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Staff Development Coordinator, Director of Activities, or Social Services Director or their designee daily X 2 weeks, then weekly X 1 month to identify infection control issues with transporting food in hallways and any potential</p>		

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F 371	<p>Continued From page 8</p> <p>Interview with LPN #2 on 08/26/15 revealed that food was supposed to be covered when transported in the hallway; LPN #2 stated she had not thought about covering the drinks.</p> <p>2. Observation on 08/26/15 at 12:52 PM revealed CNA #3, CNA #4, and LPN #2 were touching the food-contact and lip-contact portion of cups and glasses, with their bare skin while serving drinks to residents at least 15 times during the lunch meal service.</p> <p>Interview with CNA #3 on 08/26/15 at 1:38 PM revealed that she should not have been touching the rim portion of the cups and had "never really thought about it."</p> <p>Interview with CNA #4 on 08/27/15 at 6:25 PM revealed she was nervous during the meal service and should not have touched the cups and glasses at the top with her bare hand.</p> <p>Interview with LPN #2 on 08/26/15 at 1:40 PM revealed she stated she was "not paying attention" and should not have been picking up the cups and glasses from the top portion.</p> <p>Interview with the Dietary Manager on 08/27/15 at 6:18 PM revealed that all food items must be covered when they are being transported in the hallways. The Dietary Manager further stated staff was not supposed to touch a food contact area with their bare skin. She stated the kitchen staff sends the cups and glasses to the floor upside down so there will not be contact with the food-contact or lip-contact surface.</p> <p>Interview with the Administrator on 08/27/15 at 7:56 PM revealed staff should have made sure all</p>	F 371	<p>or actual contamination of food-contact and lip-contact surfaces. The results of these audits will be reviewed in the monthly Performance Improvement Committee Meeting and revisions will be made to the system as appropriate. Audits will continue until the Performance Improvement Committee determines compliance. The PI Committee consist of at least the Executive Director, Director of Nursing, Assistant Director of Nursing, Activity Director, Social Services Director, Dietary Director, Maintenance Director, Housekeeping/Laundry Director and the Medical Director.</p> <p>5. Date of Compliance – September 30, 2015.</p>	

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F 371	Continued From page 9 food items were covered before transporting them any distance, and staff should not be touching the top portion of the cups and glasses.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	<u>Tag # F 441</u> 1. CNA feeding Resident #4 and Resident A and CNA in Hope Hall setting up and passing meal trays for Resident B and Resident C were retrained by the Executive Director on 8/27/15 on infection control involving food delivery to residents. These residents were observed for signs and symptoms of infection for three days with no signs or symptoms of infection noted. Laundry staff member delivering clean laundry for Resident #4 and Resident #11 was retrained on 8/27/15 by Laundry Supervisor on infection control, specifically covering laundry when transporting in hallways. These residents were observed for signs and symptoms of infection for three days with no signs or symptoms of infection noted.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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 PRINTED: 09/11/2015
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
(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	
F 441	<p>Continued From page 10</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for two (2) of eighteen (18) sampled residents (Resident #4 and Resident #11) and three (3) unsampled residents (Resident A, Resident B, and Resident C). Observation of the dinner meal service on 08/25/15 in the dining room revealed facility staff was feeding Resident #4 and Resident A after touching their clothing and skin without washing/sanitizing their hands. Observation of the lunch meal service on 08/28/15 in the Hope Hall revealed facility staff touched their clothing while setting up and passing meal trays for Resident B and Resident C without washing/sanitizing their hands. Observation on Hope Hall on 08/26/15 revealed clean laundry for Resident #4 and Resident #11 was uncovered, and laundry staff walked the uncovered laundry down the hall to deliver residents' clothing. Observation of the environmental tour in the laundry room on 08/28/15 revealed laundry staff was observed transferring soiled linen into the washer without wearing personal protective equipment to protect facility staff clothing while making contact with the soiled linen.</p>	F 441	<p>Laundry staff member transferring soiled linen into washer without wearing personal protective equipment was retrained on 8/27/15 by Laundry Supervisor on infection control, specifically wearing personal protective equipment while making contact with soiled linen. This employee was observed for signs and symptoms of infection for three days with no signs or symptoms of infection noted.</p> <p>2. All residents in the facility who are served food from the dietary department have the potential to be affected.</p> <p>All residents who have laundry washed buy the facility have the potential to be affected.</p> <p>3. Staff involved with dining service were retrained and in-serviced by 9/17/15 by the Staff Development Coordinator and Executive Director regarding Infection Control, specifically "Hand Hygiene" and "Handwashing".</p>		

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F 441	<p>Continued From page 11</p> <p>The findings include:</p> <p>Review of the facility's "Hand Hygiene" policy and procedure, last revised 05/01/12, revealed its purpose was to decrease the risk of transmission of infection by appropriate hand hygiene. Further review revealed it was the process of the facility to use soap and water in the following situations: When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids. The policy directed staff to wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. In addition, if hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than those listed under "Handwashing" above.</p> <p>A review of the facility's feeding policy did not address the use of hand hygiene during meal times.</p> <p>Review of the facility's "Infection Control" policy, undated, revealed the facility would provide an active and comprehensive Infection Control Program through surveillance, prevention, and control of infections acquired or brought into the facility between residents, visitors, associates, and/or from the community or other health care facilities.</p> <p>Review of the facility's "Laundry Department" policy, dated August 2011, revealed all clean linens should be stored and transported in covered carts used exclusively for this purpose.</p> <p>Review of the facility's "Infection Control policy Protecting Staff Who Sort Laundry," dated August</p>	F 441	<p>This will emphasize touching of body and clothing during the feeding process, and touching food service items, including drinking straws and utensils, after touching anything unsanitary, as well as touching clothing while setting up and passing meal trays to resident rooms.</p> <p>Staff will be observed at each meal service by Executive Director, DON, ADON, SDC, Dietary Manager, Activity Director or a designee for 2 weeks, then at random meal services daily for 2 weeks.</p> <p>Staff involved with laundry service were retrained and given an in-service on infection control involving transport of clean laundry and handling of soiled laundry by the Staff Development Coordinator by 9/17/15. Laundry staff are provided protective clothing to wear while handling soiled laundry and laundry is being covered when being transported. Two new covered</p>		

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F 441	<p>Continued From page 12</p> <p>2011, revealed, in the laundry department, hand washing facilities and protective barriers (e.g., gowns, gloves, mask) will be made available to staff who sort laundry. The policy stated gloves and gowns must be used while sorting soiled linen.</p> <p>1. Observations during the dinner meal service on 08/25/15 from 5:51 PM to 6:09 PM in the dining room located next to the kitchen revealed State Registered Nurse Aide (SRNA) #1 fed Resident #4 and Resident A. During the meal service, SRNA #1 touched her left ear, left eyebrow, adjusted her gait belt twice, opened Resident #4's straw, touched the straw to place it in the resident's drink, touched Resident #4's fork and cup of milk, cut the hamburger, coughed in her left hand, then placed her left hand on the left side of her face without washing or sanitizing her hands. SRNA #1 then assisted Resident A with his/her meal by touching the resident's spoon and then cut his/her hamburger without washing/sanitizing her hands.</p> <p>Interview with SRNA #1 on 08/25/15 at 6:36 PM revealed she should have washed/sanitized her hands after each contact she had with touching her skin, clothing, or coughing into her hand. SRNA #1 further stated the facility provides infection control in-services at least once a month.</p> <p>2. Observation of SRNA #2 on 08/26/15 during the lunch meal service at 12:19 PM revealed SRNA #2 adjusted his pants, and then set up a meal tray for Resident B without sanitizing/washing his hands. Additional observation at 12:23 PM revealed SRNA #2 adjusted his pants and then set up and delivered</p>	F 441	<p>laundry transport carts were ordered and received on 9/24/15 to transport clean laundry down the hall to deliver residents' clothing.</p> <p>4. Audits will be completed by the Executive Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Staff Development Coordinator, Director of Activities, or Social Services Director or their designee daily X 2 weeks, then weekly x 1 month to identify any potential or actual contamination of food contact and lip contact surfaces.</p> <p>This audit will also include proper handling of soiled laundry, wearing of protective clothing when handling soiled laundry and transporting covered laundry in hallways.</p> <p>The results of these audits will be reviewed in the monthly Performance Improvement Committee Meeting and revisions will be made to the system as</p>		

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F 441	<p>Continued From page 13 a meal tray to Resident C without washing/sanitizing his hands.</p> <p>Interview with SRNA #2 on 08/26/15 at 12:45 PM revealed he should have washed/sanitized his hands after adjusting his pants and before setting up and delivering residents' meal trays. Further interview with SRNA #2 revealed the facility trains on infection control monthly.</p> <p>Interview with the Dietary Manager on 08/26/15 at 9:19 AM revealed staff should be sanitizing/washing their hands after touching their skin/clothing while feeding the residents, setting up, and delivering meal trays.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 08/26/15 at 12:41 PM, revealed staff was supposed to wash/sanitize hands after touching their clothing, skin, and/or adjusting their belt/pants. Further interview with LPN #1 revealed she had not identified any problems with hand washing; however, the facility had monthly in-services on infection control.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 08/27/15 at 5:15 PM revealed staff should sanitize/wash hands before setting up meal trays, passing meal trays, and feeding the residents.</p> <p>3. Observation on 08/26/15 at 11:55 AM revealed Housekeeper #1 was on the Hope Hall delivering residents' clean clothing. The clothing cart was observed to be uncovered and Housekeeper #1 walked approximately 35 feet down the hall from the clothing cart to deliver Resident #4's and Resident #11's clean clothing.</p>	F 441	<p>appropriate. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – September 30, 2015.</p>		

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F 441	<p>Continued From page 14</p> <p>Interview with Housekeeper #1 on 08/26/15 at 11:56 AM, revealed she normally does not cover the linen/clothing cart when distributing clean clothing to resident rooms and she normally walks the clothing up and down the halls with no cover. Further interview with Housekeeper #1 revealed the housekeeper stated, "Maybe I should cover it up." Further interview with Housekeeper #1 revealed that she "should have not loaded the dirty laundry up in the washer without a protective gown on."</p> <p>4. Observation on 08/26/15 at 3:42 PM revealed Housekeeper #1 was loading soiled laundry into a washer without wearing a gown. Observations revealed the soiled linen was touching Housekeeper #1's exposed arms and scrub top as she was loading it into the washer. Housekeeper #1 was also observed to get soiled laundry out of the laundry cart, which made contact with the contaminated areas of the cart with her clothing. Observations further revealed Housekeeper #1 had to search several minutes to find a disposable gown when asked about wearing a gown.</p> <p>Interview with Housekeeper #1 on 08/26/15 at 3:53 PM, revealed that she should not have loaded the dirty laundry in the washer without a protective gown on, but that she usually does not wear a protective gown because "nobody told me I had to wear a gown."</p> <p>Interview with the Housekeeping/Laundry Supervisor on 08/27/15 at 6:08 PM revealed that Housekeeper #1 should have worn an apron when loading soiled laundry into the washer to prevent the soiled laundry from touching her clothing.</p>	F 441			

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F 441	Continued From page 15 Interview with the Infection Control Nurse on 08/27/15 at 7:05 PM, revealed staff should have washed/sanitized their hands after touching anything while feeding the resident, setting up, and delivering meal trays. Further interview with the Infection Control Nurse revealed she had not identified any problems with hand washing/infection control through her rounds that she performed hourly each day. Further interview revealed the clean laundry should have been covered while delivering residents' clothing. Further interview with the Infection Control Nurse revealed staff was required to wear proper Personal Protective Equipment when loading soiled laundry into the washer. Interview conducted with the Director of Nursing (DON) on 08/27/15 at 7:31 PM, revealed the facility conducted in-services monthly on infection control, and facility staff was observed during rounds of the building and meal services on a daily basis to ensure staff followed proper infection control measures. Further interview with the DON revealed staff should have washed/sanitized their hands after contact with their clothing or skin while feeding the residents, setting up, and passing meal trays. Further interview with the DON revealed clean laundry should be covered. According to the DON, the facility had not identified any problems related to infection control during meal service, or the delivery of residents' clean laundry. Interview with the Executive Director/Administrator (ED) on 08/27/15 at 6:50 PM and 7:39 PM, revealed staff should wash/sanitize their hands while feeding residents after touching their skin/clothing, before setting up	F 441			

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
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F 441	Continued From page 16 meal trays, and before delivering meal trays. Further interview with the ED revealed, "According to our policy clean linen/laundry shouldn't be uncovered while distributing to the residents." The ED further stated staff working in the laundry should follow facility policy when loading soiled laundry into the washing machine. The ED stated he performs rounds two or more times a day and had not identified any infection control problems.	F 441			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview, facility in-service training, and facility policy review it was determined the facility failed to ensure all staff was trained in emergency preparedness related to tomados. Interviews with staff revealed two (2) staff members, Certified Nursing Assistant (CNA) #6 and Licensed Practical Nurse (LPN) #2, were unable to explain appropriate precautions to enact during a tornado warning. The findings include: Review of the facility's policy titled "Tornado, Hurricane or High Wind Policy," dated 11/01/04, revealed the policy did not instruct staff on actions	F 518	Tag # F 518 1. Staff Development Coordinator completed in-service training on 9/17/15 regarding emergency preparedness related to tornadoes with facility associates. Associates in-serviced include the following departments: Nursing, Therapy, Dietary, Housekeeping, Laundry, Maintenance, Office, Administration and Activities. 2. All Residents have the potential to be affected. 3. To ensure that this training will not be missed during the year, the "Tornado, Hurricane or High Wind" policy will be placed on the yearly in-service schedule to be a mandatory in-service for all staff.		

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F 518	<p>Continued From page 17</p> <p>to take during a tornado warning, but stated if a Tornado Watch was received, this indicated that there was a possibility that a tornado may strike, and the facility may have several hours to prepare. Staff was directed to close all cubicle curtains, windows, window curtains, and blinds to provide a barrier between windows and the residents and remove items from window ledges and pictures from walls. The policy further directed staff to bring residents and staff in from the outside and to prepare emergency supplies (linens, food, emergency water and food supplies, medical and first aid supplies, flashlights, etc.) for possible use. The policy stated to identify safe areas (inside hallways and windowless rooms) within the building where residents should be brought if time allows.</p> <p>Interviews on 08/26/15 from 9:24 AM to 9:45 AM revealed two staff members, CNA #6 and LPN #2, stated the residents were to remain in their rooms and to cover them with a mattress during a tornado warning. CNA #6 and LPN #2 both stated they could not remember being trained on tornados.</p> <p>Interview with the Maintenance Supervisor on 08/27/15 at 5:09 PM revealed staff was trained on tornados in March 2012 with the National Weather Service. The Maintenance Supervisor stated this was the last training regarding tornados that the facility had conducted.</p> <p>Interview with the Administrator on 08/27/15, at 7:56 PM, revealed that the facility should have been training the staff on what to do during a tornado warning.</p>	F 518	<p>This emergency preparedness training will also be provided to new associates during orientation. This will be completed by the Maintenance Director, SDC or designee.</p> <p>4. The Director of Maintenance will maintain a log of required yearly in-services and indicate when the in-service will be conducted as well as maintain a log of those who attended the in-service. The Director of Maintenance or designee will conduct a tornado drill yearly and confirm associate understanding of this policy. The results of this in-service and drill will be shared by the Director of Maintenance or designee with the Performance Improvement Committee, consisting of at least the Executive Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Staff Development Coordinator, Director of Activities, Social Services Director and Medical Director.</p> <p>5. Date of Compliance – 9/30/2015</p>	

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185230	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/1/2015
Name of Facility MOUNTAIN VIEW HEALTH CARE CENTER	Street Address, City, State, Zip Code 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0328</u> Reg. # <u>483.25(k)</u> LSC _____	Correction Completed <u>09/30/2015</u>
ID Prefix <u>F0371</u> Reg. # <u>483.35(i)</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>09/30/2015</u>	ID Prefix <u>F0518</u> Reg. # <u>483.75(m)(2)</u> LSC _____	Correction Completed <u>09/30/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>AO</u>	Reviewed By <u>AO</u>	Date: <u>10/28/15</u>	Signature of Surveyor: <u>Alicia Dunn</u>	Date: <u>10/28/15</u>
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>8/27/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 100521	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/1/2015
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Name of Facility MOUNTAIN VIEW HEALTH CARE CENTER	Street Address, City, State, Zip Code 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>N0134</u> Reg. # <u>902 KAR 20:300-6(7)(a)2.</u> LSC _____	Correction Completed 09/30/2015	ID Prefix <u>N0144</u> Reg. # <u>902 KAR 20:300-6(7)(b)2.a.</u> LSC _____	Correction Completed 09/30/2015	ID Prefix <u>N0194</u> Reg. # <u>902 KAR 20:300-7(4)(c)2.</u> LSC _____	Correction Completed 09/30/2015
ID Prefix <u>N0228</u> Reg. # <u>902 KAR 20:300-8(9)(f)</u> LSC _____	Correction Completed 09/30/2015	ID Prefix <u>N0283</u> Reg. # <u>902 KAR 20:300-10(8)(b)</u> LSC _____	Correction Completed 09/30/2015	ID Prefix <u>N0371</u> Reg. # <u>902 KAR 20:300-15(11)(b)</u> LSC _____	Correction Completed 09/30/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>ad</u>	Reviewed By <u>ad</u>	Date: <u>10/28/15</u>	Signature of Surveyor: <u>Ashia Dunn</u>	Date: <u>10/28/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/27/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185130	(X2) MULTIPLE CONSTRUCTION A. BUILDING # 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2015
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Division of Health Services Southern Enforcement Branch TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1980 Facility type: SNF/NF Type of structure: One story, Type III (unprotected) Smoke Compartments: 6 Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectors in laundry and kitchen area. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by diesel. A life safety code survey was initiated and concluded on 08/25/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147		

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

TITLE

(X6) DATE

James V. Snyder

EXECUTIVE DIRECTOR

9/19/15

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: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2015
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522	
(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
K 147	<p>Continued From page 1 with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected one (1) of six (6) smoke compartments, staff, and approximately eighteen (18) residents. The facility has the capacity for 106 beds with a census of 87 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 08/25/15, at 2:10 PM with the Director of Maintenance (DOM), power strips with long cords were observed to be attached to the walls in resident rooms 408 and 409. Power strips cannot substitute for a power source in areas that need a permanent receptacle.</p> <p>An interview on 08/25/15 at 2:10 PM with the DOM revealed he was aware power strips could not be used for permanent wiring. The DOM stated he did not notice the power strips were in use.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p>	K 147	<p>Tag # K 147</p> <ol style="list-style-type: none"> The power strips in room 408 and 409 use to power TV's have been removed on 9/17/15 by maintenance. All residents have the potential to be affected. On 9/17/15, the Director of Maintenance reviewed all 6 smoke compartments for use of power strips with no other power strips found to be in use. The Director of Maintenance will educate maintenance staff of the prohibited use of power strips by 9/17/15 and will monitor monthly all resident rooms to ensure no power strips are in use. Resident rooms will be checked monthly by the maintenance department to ensure no power strips have been installed. The director of Maintenance will present findings of the monthly smoke compartment check for power strip usage to the PI 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2015
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522	
(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
K 147	Continued From page 2 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	committee. The PI committee will consist of at least the Executive Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Staff Development Coordinator, Director of Activities, Social Services Director and Medical Director. 5. Date of Compliance – September 30, 2015	