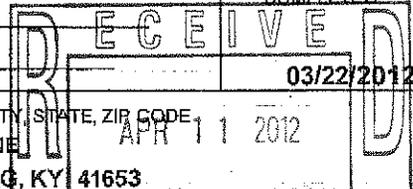


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2012
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	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 000	INITIAL COMMENTS  A standard survey was conducted on 03/20-22/12. Deficient practice was identified at "D" level.	F 000	<b>Riverview Health Care Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding.</b>	
F 441 SS=D	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	F 441		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Melissa J. Allen* TITLE: *Administrator* (X8) DATE: *4/10/12*

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  <b>RIVERVIEW HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>79 SPARROW LANE PRESTONSBURG, KY 41653</b>		
(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 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to establish and maintain an effective infection control program to prevent the development and transmission of disease and infection for one of twenty-six sampled residents (Resident #23). Observation of a procedure to monitor the resident's blood glucose level on 03/20/12 revealed Registered Nurse (RN) #1 failed to wash/sanitize her hands and apply gloves prior to performing the procedure for Resident #23.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Handwashing" (dated December 2010) revealed staff was required to wash/sanitize their hands before and after caring for each resident.</p> <p>An interview with the Director of Nursing (DON) on 03/22/12, at 9:45 AM, revealed the facility did not have a policy related to the step-by-step procedure for blood glucose monitoring.</p> <p>Observation of a blood glucose test performed by RN #1 on 03/20/12, at 4:30 PM, for Resident #23 revealed the nurse cleansed the third finger of Resident #23's right hand, used a disposable</p>	F.441	<p><b>The Facility offers its response, credible allegations of compliance and plan of correction as part of its on-going efforts to provide quality of care to residents.</b></p> <p><b>F441</b></p> <p><b>Resident #23 was assessed for signs and Symptoms of infection and there were none noted.</b></p> <p><b>All other residents having the potential for infection have been assessed, with no signs or symptoms of infection identified.</b></p> <p><b>Inservicing of all licensed personnel began on March 20, 2012 on proper hand washing by the Staff Development Coordinator and the Director of Nursing. Inservicing will be completed by April 16, 2012 by the Director of Nursing and Staff Development Coordinator.</b></p> <p><b>Random checks of licensed personnel will be conducted three (3) times per week to ensure proper protocol is being followed regarding proper hand washing and gloves use with blood glucose checks.</b></p>	

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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	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 2</p> <p>lancet to pierce the resident's skin to obtain a specimen of blood, and applied the blood specimen to a test strip. However, RN #1 failed to wash/sanitize her hands prior to performing the procedure and failed to wear gloves during the procedure.</p> <p>An interview conducted with RN #1 on 03/20/12, at 5:05 PM, revealed the RN was aware she should have washed/sanitized her hands prior to performing the procedure and also stated she was aware she should have worn gloves.</p> <p>An interview conducted with the DON on 03/22/12, at 9:45 AM, revealed nurses were expected to wear gloves when obtaining a blood specimen to monitor a resident's blood glucose level and were also expected to wash/sanitize their hands before and after performing the procedure. The DON stated the facility conducted skills assessments of all nurses at the time of their employment and on an annual basis. The DON stated RN #1 had been assessed to be proficient in the performance of skills, including obtaining specimens of blood for blood glucose procedures.</p>	F 441	<p><b>All results of these audits will be brought to the monthly QA meeting to ensure continued compliance. Any concerns identified will be addressed and the plan revised as necessary.</b></p>	4/16/12	

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NAME OF PROVIDER OR SUPPLIER  <b>RIVERVIEW HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>79 SPARROW LANE PRESTONSBURG, KY 41653</b>	
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1976</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 2-story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: 2</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 03/22/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a), and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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