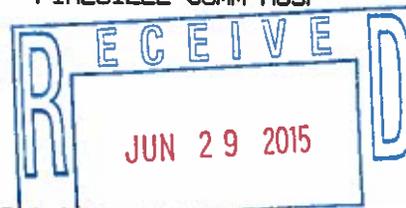


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PINEVILLE COMM HOSP

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

 PRINTED: 06/05/2015
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: Health Care Southern Enforcement Branch B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 868 RIVERVIEW AVENUE PINEVILLE, KY 40377	
(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 health survey was conducted on 06/19-21/15. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	F 323 The Daily Engineering Log was revised to ensure monitoring of water temperatures daily on morning rounds and increasing the number of areas where water temperatures are checked. See attached examples of Daily Engineering Log for 6/5/15-6/10/15 indicating water temperature checks for resident rooms, men's and women's bathrooms, lounge area, etc.	6/12/15
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility water temperature policy, it was determined the facility failed to assure the resident environment was free of accident hazards. The hot water temperature was observed to be 130 degrees Fahrenheit (F) at the bathtub faucet in the men's shower room on 05/21/15. The findings include: Review of the facility policy titled "Maintaining Temperature of Water," with a revision date of June 2012, revealed water temperatures were to be maintained at 110 degrees Fahrenheit or less in patient areas. Further review of the policy revealed the Maintenance Department was responsible for daily checking of water temperatures. According to the policy if the water temperature exceeds 110 degrees F the area was	F 323	During construction on geriatric psychiatric unit, there was interference with maintaining correct water temperatures due to a mixing valve and circulation pump having to be shut off. This resulted in frequent adjustments to water temperatures. As of 6/3/15, this construction project has been completed. A new circulation pump has been installed and water temperature issues have been resolved. See attached Work Order # 136769. Any abnormal temps result in a work order being generated, appropriate staff notified and water supply shut down until corrected. Results of findings will be tallied weekly and report bimonthly to the Safety Committee and quarterly to the hospital wide QI Committee.	

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

TITLE

(X5) DATE

CAO

6/29/15

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: 186182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 580 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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 323	<p>Continued From page 1</p> <p>to be "flagged" out of order, and a work order completed. Necessary actions were to be taken to bring the water temperature within required limits.</p> <p>Observation of hot water temperatures was conducted with facility maintenance staff on 05/21/15 at 10:50 AM. The hot water was observed to be 130 degrees F at the bathtub faucet in the men's shower room. The facility thermometer was utilized for the measurements and accuracy was verified by maintenance staff with ice water prior to the measurements.</p> <p>Interview conducted with State Registered Nursing Assistant (SRNA) #2 on 05/21/15 at 12:55 PM revealed the staff did not utilize the tub for bathing residents and could not recall the last time the tub was utilized, but if a resident requested a bath then the tub would be used.</p> <p>Interview conducted with SRNA #1 on 05/21/15 at 1:36 PM revealed he did not utilize the tub for bathing residents and was not aware of the tub ever being utilized, but if a resident requested a tub bath, the tub would be utilized for bathing.</p> <p>An interview conducted with the Maintenance Director on 05/21/15 at 1:05 PM, revealed he checked the hot water temperatures daily in the men's shower, but had not checked the temperature of the hot water in the tub because staff did not utilize the tub.</p> <p>A review of daily engineering logs from 05/01-21/15, revealed water temperatures were checked daily in resident areas; however, there was no evidence documented on the logs that the water temperature had been checked at the tub in</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 830 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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 323	Continued From page 2 the men's shower room.	F 323			
F 363 SS=0	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, interview, and record review, it was determined the facility failed to follow the planned menu at the evening meal on 05/19/15. Harvard beets were on the planned menu for the evening meal on 05/19/15. A palatability test tray revealed the beets were served plain. The findings include: A review of the facility's policy for menu development (dated 01/17/15) revealed the facility did not have a policy related to following the planned menu. Observation of the evening meal on 05/19/15 revealed the residents were served pork chops, scalloped potatoes, beets, and fruit. The beets appeared to be plain beets. Two surveyors and the unit manager conducted a palatability test tray at 4:45 PM on 05/19/15. The beets did not taste as though any seasoning/ingredients had been added to the beets.	F 363	F 363 The General Manager updated the recipe for Harvard Beets and the recipe was reviewed with the vegetable cook at time of Survey. The General Manager updated departmental policy on staff-tasting of food. The General Manager of Food Services updated policies/procedures to reflect the need to ensure that planned menu items are delivered to residents accordingly. See attached policies/procedures titled "Purpose of Food Service Department Performance Improvement, and Tray Service Quality Control". Policy/Procedure review occurred on 6/11/2015 resulting in revisions to "Tray Service Quality Control" policy to require tasting of food at each meal period. The results of findings of taste testing (# of instances of tasting versus number not following planned menu) will be compiled by the General Manager for quarterly reporting to the F&T/Dietary Committee and Nursing Facility Committee.	6/12/15	

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NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 860 RIVERVIEW AVENUE PINEVILLE, KY 40377		
(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 363	Continued From page 3 The group interview was conducted with three alert and oriented residents on 05/20/15 at 10:00 AM. The residents stated the beets for the evening meal on 05/19/15 were plain, without any seasoning. The residents further stated, "The beets tasted as though they came from a can and heated." Review of the recipe for Harvard beets revealed the following ingredients were to be added to the beets: granulated sugar, cornstarch, distilled vinegar, water, margarine, salt, and pepper. Interview with the cook at 9:05 AM on 05/21/15 revealed she forgot to add any margarine, salt, and pepper to the beets. The cook stated she did not know the ingredients for Harvard beets. Interview with the Dietary Manager (DM) at 2:30 PM on 05/21/15 revealed he was responsible to ensure staff followed the recipes. The DM stated he monitored the food by tasting the food. However, the DM stated he did not taste the beets on Tuesday, 05/19/15.	F 363			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 On the AM 5/22/15, the DON discussed 1:1 with the physician of Resident #6 the absence of diagnosis to support the use of Remeron. The physician provided an indication for use for Remeron. The Policy and Procedure has been revised to outline a step by step approach for the communication of the consultant pharmacist recommendations to the physician and the follow-up steps for when the physician does not respond within an appropriate amount of time to ensure the safety of the patient.	6/12/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 860 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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 428	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure pharmacy recommendations were reviewed and acted upon by the attending physician for one (1) of ten (10) sampled residents (Resident #6). Resident #6 had physician's orders to receive Remeron (antidepressant medication) routinely at bedtime. According to the pharmacy reviews dated January, February, and April 2015, the consultant pharmacist recommended the physician review the diagnoses for an indication for the use of the medication for Resident #6; however, there was no evidence the physician had responded to the recommendations made by the pharmacist.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Monitoring" policy (dated March 2009) revealed the resident's medication regimen would be evaluated when an irregularity was identified in the pharmacist's monthly medication regimen review. The policy further included a medication order would be evaluated for a written diagnosis, an indication, and/or documented objective findings to support each medication.</p> <p>Review of the medical record revealed Resident #6 was readmitted from the hospital on 01/27/15 with diagnoses of Hypertension, Diabetes Mellitus, Peripheral Neuropathy, Dementia, Hypothyroidism, Chronic Kidney Disease, Congestive Heart Failure, and Osteoarthritis. According to the physician's orders dated 01/27/15, Remeron 7.5 mg (milligrams) was to be</p>	F 428	<p>(F 428 Continued)</p> <p>B. The consultant pharmacist will send the recommendation to the physician by facsimile with the request that the recommendation be signed and returned by facsimile. The original will be filed on the Skilled Nursing Facility, a copy will be given to the Chief Nursing Officer and a copy will be kept by the consultant pharmacist.</p> <p>C. If the physician does not respond within one month then the Unit Supervisor will re fax the recommendation to the physician office. If the physician still does not respond then the physician will be contacted in person upon return to the facility. Each time the physician refuses to address the recommendation his or her refusal will be documented on the recommendation document.</p> <p>D. After the physician is contacted in person and still refuses to address the recommendation the refusal will be communicated to the Nursing Facility Medical Director. If the physician still refuses to address the recommendation then the Medical Director will communicate the refusal to the Hospital Chief Executive Officer."</p> <p>The hospital Medication Reconciliation process will be adjusted to encourage the physicians to enter an indication for each medication when the medication list is being reviewed. This will aid in the gathering of the diagnosis. A Performance Improvement Study was already in place. (See attached Medication Use data collection tool.)</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40377		
(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 428	<p>Continued From page 5</p> <p>administered routinely at bedtime to Resident #6. Review of the Medication Regimen Review conducted by the Consultant Pharmacist on 01/29/15 revealed the pharmacist made recommendations for the physician to provide an indication for the use of Remeron. However, there was no evidence the physician responded to the recommendation. Further review of the Medication Regimen Reviews conducted on 02/25/15 and on 04/24/15 by the Consultant Pharmacist revealed the recommendation was made again for the physician to provide an indication for the use of Remeron for Resident #6. As of 05/21/15, there was no evidence the physician had responded to the request by the pharmacist.</p> <p>Interview conducted with Unit Manager (UM) #1 on 05/21/15 at 2:30 PM revealed she reviewed the pharmacy recommendations weekly to see if the physician had responded. The UM stated if the physician had not responded she would re fax the recommendation to the physician's office and call the physician to remind him about the recommendation. UM #1 stated she had re faxed each of the recommendations for Resident #6 to the attending physician for review and signature; however, the physician had not responded. In addition, the UM stated she had verbally asked the physician to review the recommendation and the physician had responded by pointing at the clock on the wall.</p> <p>Interview with the Consultant Pharmacist on 05/21/15 at 2:40 PM revealed she had made the recommendations regarding no indication for Remeron for Resident #6; however, she had not been able to get the physician to respond.</p>	F 428	(F 428 Continued) The Unit Manager and Chief Pharmacist will continue to monitor the Medication Regimen Review process as part of Nursing and Pharmacy Performance Improvement. Findings will be reported quarterly to the P & T and Nursing Facility Committees by the Chief Pharmacist. The CNO will continue to receive monthly Medication Regimen Reviews.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40377	
(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 428	Continued From page 6 Interview with the Director of Nurses (DON) on 05/21/15 at 3:15 PM revealed the pharmacist sent her and the physician a copy of the pharmacy recommendations. The DON stated she had talked to the physician about the pharmacy recommendation and was aware the physician had not been acting on the recommendation.	F 428		
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	F 441	F 441 On 5/20/15, the Laboratory Manager and Infection Control Preventionist reviewed the Policy/Procedure for bedside glucose testing. A decision was made to place the PDI Sani-Cloth /Bleach Wipes on the procedure trays for the Laboratory techs to use to disinfect glucometers between each patient. The policy/procedure titled "Glucose Testing Using Accu-Chek Inform II Monitor was revised on 6/3/15 to reflect the manufacturers recommendations. (See attached revised policy/procedure). Laboratory Staff were trained 6/9 -6/19/15 on the process. (See attached competency tools for staff performing glucose checks.) Compliance of staff will be monitored by the Laboratory Manager Conducting weekly spot checks of staff utilizing the "Glucose Bedside Testing Using Accu-Chek Inform II Competency Tool". Results of findings will be reported quarterly to the Infection Control Committee and the Nursing Facility QI Committee by the Laboratory Manager.	6/20/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 880 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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)	(X6) COMPLETION DATE	
F 441	<p>Continued From page 7</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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, and facility policy review, the facility failed to have an effective infection control program to prevent the spread of infectious disease for two (2) unsampled residents (Residents A and B). Observation on 05/20/15 revealed facility staff failed to disinfect/sanitize the glucometer between resident use when conducting blood glucose monitoring checks for Residents A and B.</p> <p>The findings include:</p> <p>Review of the facility policy for maintenance and care of the glucometer machine (no date) revealed facility staff should disinfect the glucometer according to the manufacturer's recommendations.</p> <p>Review of the Operator's Manual for the "Accu Check Inform II" revealed the manufacturer's recommendations were as follows: glucometer should be disinfected before each use by using a product containing 0.625% sodium hypochlorite (bleach), ammonium chloride with isopropyl alcohol, or 0.05% solution of a phenol compound</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 880 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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 8</p> <p>in water.</p> <p>On 05/20/15 at 3:50 PM, facility staff (Laboratory Technician #1) was observed to obtain a blood sugar level for Resident A. The laboratory technician was observed to put on gloves and obtain the specimen with a glucometer machine and to dispose of the lancet in the sharps container. Laboratory Technician #1 then removed the soiled gloves and washed her hands at the sink. The laboratory technician then proceeded to obtain a sample of blood from Resident B at 4:15 PM using the same glucometer machine used on Resident A without cleaning or disinfecting the glucometer machine between residents.</p> <p>Interview with Laboratory Technician #1 on 05/20/15, at 4:30 PM revealed she had disinfected the glucometer machine in the lab with a Sani-wipe, which contained bleach, prior to obtaining the blood glucose level on Resident A. The laboratory technician stated she had been trained to clean the glucometer with an alcohol wipe between each resident, but "forgot" to clean it between Resident A and Resident B.</p> <p>Interview with the Laboratory Manager on 05/21/15 at 9:40 AM, revealed staff had been trained to clean/disinfect the glucometer between each resident with either a bleach wipe or an alcohol wipe. The Laboratory Manager stated she was not aware of the manufacturing guidelines for disinfecting the glucometer. The Laboratory Manager further stated spot checks and competency evaluations were conducted to monitor staff performance and no problems had been identified.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 860 RIVERVIEW AVENUE PINEVILLE, KY 40377		
(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	Continued From page 9 Interview with the Director of Nurses (DON) on 05/21/15 at 3:15 PM, revealed she also believed alcohol wipes could be used to disinfect the glucometer machine between each resident use when monitoring blood sugar levels. The DON stated laboratory staff performed all blood sugar level monitoring.	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2015
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 1 (322)</p> <p>SMOKE COMPARTMENTS: 3</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>PARTIALLY SPRINKLERED (WET SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 05/20/15, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found 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

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.