

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

PRINTED: 07/24/2015
FORM APPROVED
OMB NO. 0938-0391

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| 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 06/10/2015 |
| 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 | F 000 | | |
| F 282 SS=D | <p>**Amended</p> <p>A standard health survey was conducted on 06/08-10/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <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 facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for three (3) of twenty-one (21) sampled residents (Residents #3, #16, and #17). The facility developed a care plan with interventions for Residents #3, #16, and #17's nails to be trimmed. Observations on 06/09/15 during a skin assessment for Resident #3, and observation on 06/10/15 of Resident #16 and Resident #17's nails, revealed the residents' toenails were long and in need of trimming.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Using The Care Plan," revised August 2006, revealed a care plan would be used in developing the resident's daily care routines and would be available to staff personnel who had the responsibility for providing</p> | F 282 | <p>Riverview Healthcare Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right 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. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> | |

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

Melissa J. Allen

TITLE

Administrator

(X6) DATE

7/29/15

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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| F 282 | <p>Continued From page 1 care or services to the resident.</p> <p>1. Review of the medical record for Resident #17 revealed the resident had been admitted by the facility on 02/23/07, with diagnoses which included Head Trauma and COPD.</p> <p>Review of a quarterly MDS assessment for Resident #17 dated 03/23/15, revealed the resident was assessed to require extensive assistance of one staff person to provide personal hygiene needs and total assistance of two for bathing. Further review of the MDS assessment revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had been assessed to have severe cognitive impairment. Review of a plan of care for Resident #3 dated 03/23/15, revealed staff would provide nail care. However, the care plan did not specify which staff would provide nail care.</p> <p>Resident #17 was observed on 06/10/15, at 1:46 PM, to be lying in bed. Observation of the resident's left foot revealed the toenails were observed to be long and curved over the resident's fourth and fifth toes.</p> <p>Interview conducted with State Registered Nursing Assistant (SRNA) #8 on 06/10/15, at 1:46 PM, revealed she had been assigned to Resident #17, and the nurse was responsible for the resident's nail care. The SRNA stated she was required to review the care plan daily for any changes. The SRNA stated she was required to provide nail care when bathing Resident #17.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 06/10/15, at 2:00 PM, revealed that the</p> | F 282 | F 282 | | |
| | | | <ol style="list-style-type: none"> 1. A Licensed Nurse trimmed resident #3, #16 and #17 toenails that could be trimmed by a nurse and confirmed podiatrist scheduled visit for 7/1/15. Podiatrist trimmed "thick toenails of Resident #16, and #17 on 7/2/15. Resident #3 was out of the facility during the podiatrist's visit. 2. All residents have the potential to have long untrimmed toenails. A 100% observation was completed by 7/3/15 by the DON, ADON, and Unit Managers to ensure all resident's toenails were trimmed. No other issues were identified. 3. Education will be provided by the SDC, DON or ADON for nursing staff by 7/3/15 regarding following a nursing care plan and a nursing assistant care plan to meet professional | | |

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| F 282 | <p>Continued From page 2</p> <p>SRNAs were supposed to provide nail care for Resident #17. The LPN stated staff was required to check the care plan daily for any changes.</p> <p>2. Review of the medical record for Resident #3 revealed the facility admitted the resident on 09/21/10, with diagnoses that included Diabetes Mellitus, Hypertension, and Cerebral Vascular Accident. Review of a quarterly Minimum Data Set (MDS) assessment for Resident #3 dated 05/13/15, revealed the resident required extensive assistance of two persons for personal hygiene. The MDS also revealed the resident was moderately cognitively impaired. Review of a plan of care for Resident #3 dated 01/02/15, revealed staff would provide nail care. However, the care plan did not specify which staff would provide nail care.</p> <p>Observation of a skin assessment for Resident #3 on 06/09/15, at 9:15 AM completed by Licensed practical Nurse (LPN) #2, revealed the resident was observed to have long toenails that were in need of trimming. However, LPN #2 was not observed to trim the resident's nails.</p> <p>Interview conducted with LPN #2 on 06/09/15, at 3:00 PM, revealed Resident #3 was seen by the podiatrist every six months. The LPN stated she was required to check each resident's care plans daily for any changes. The LPN stated she normally trimmed Resident #3's toenails once a month. The LPN stated she should have trimmed the resident's toenails because they were long.</p> <p>3. Review of the medical record for Resident #16 revealed the facility admitted the resident on 09/29/14, with diagnoses that included Diabetes Mellitus, End Stage Renal Disease, and</p> | F 282 | <p>standards and ensure resident basic ADL care needs, to include nail care, are met.</p> <p>4. The DON, Unit Managers or SDC will complete an audit of resident's toenails daily M-F x4 weeks, weekly x4 weeks and then monthly for two months to ensure toenail care has been provided to meet professional standards and care plan followed. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated.</p> | 7-5-15 |

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| F 282 | <p>Continued From page 3</p> <p>Cardiovascular Disease. Review of a quarterly MDS dated 03/15/15, revealed the resident required the extensive assistance of two persons for personal hygiene. Review of the plan of care for Resident #16 dated 11/12/14, revealed nail care would be provided for Resident #16 by staff. However, the care plan did not specify which staff was responsible for trimming Resident #16's nails.</p> <p>Observation of Resident #16's nails on 06/10/15, at 2:15 PM, with LPN #2 revealed Resident #16's toenails were observed to be long and in need of trimming.</p> <p>Interview conducted with LPN #2 on 06/10/15, at 2:30 PM, revealed she was responsible to ensure Resident #16's nails were trimmed because the resident was diabetic. The LPN stated she was required to check the residents' care plans every shift to identify any changes. LPN #2 stated she had not been aware Resident #16's toenails were in need of trimming and should have been.</p> <p>Interview with the Director of Nurses (DON) on 06/10/15 at 4:55 PM, revealed she also conducted resident rounds two to three times daily to monitor staff to ensure resident care needs were being provided. The DON stated LPN #2 should have trimmed Resident #3, Resident #16, and Resident #17's nails when completing his/her skin assessment. The DON stated nurses were required to assess a resident's nails when conducting a weekly skin assessment. The DON stated both nurses and SRNAs were required to check the care plans daily for any changes. The DON further stated she had not identified any concerns with staff not following the residents' care plans.</p> | F 282 | | |

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| F 312 SS=D | <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure three (3) of twenty-one (21) sampled residents (Residents #3, #16, and #17) who were unable to carry out activities of daily living received the necessary services to maintain personal hygiene. Resident #3, Resident #16, and Resident #17 were assessed by the facility to require extensive assistance of staff to perform personal hygiene/grooming needs. However, the residents were observed to have long toenails that were in need of trimming.</p> <p>The findings include:</p> <p>Review of the Nails-Cleaning and Trimming policy (dated December 2010) revealed the nursing staff was responsible to provide observation and care of nails for all residents daily and as necessary.</p> <p>1. Resident #17 was observed on 06/10/15, at 1:48 PM, to be lying in bed. Observation of the resident's left foot revealed the resident's toenails were long and curved over the fourth and fifth toes.</p> | F 312 | <p>F 312</p> <ol style="list-style-type: none"> 1. A Licensed Nurse trimmed resident #3, #16 and #17 toenails that could be trimmed by a nurse and confirmed podiatrist scheduled visit for 7/1/15. Podiatrist trimmed "thick toenails of Resident #16, and #17 on 7/2/15. Resident #3 was out of the facility at the time of the podiatrist's visit. 2. All residents have the potential to have long untrimmed toenails. A 100% observation was completed by 7/3/15 by the DON, ADON, and Unit Managers to ensure all resident's toenails were trimmed. No other issues were identified. 3. Education will be provided by the SDC, DON or ADON for nursing staff by 7/3/15 regarding following a nursing care plan and a nursing assistant care plan to meet professional | | |
| | Review of the quarterly MDS assessment dated | | | | |

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| F 312 | <p>Continued From page 5</p> <p>03/23/15, revealed the resident was assessed to require extensive assistance of one staff person to provide personal hygiene needs and total assistance of two for bathing. Further review of the MDS assessment revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had been assessed to have severe cognitive impairment.</p> <p>Interview conducted with State Registered Nursing Assistant (SRNA) #6 on 06/10/15, at 1:46 PM, revealed she had been assigned to Resident #17 and the nurse was responsible for the resident's nail care.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 06/10/15, at 2:00 PM, revealed that the SRNAs are supposed to provide nail care for Resident #17. The LPN stated she had not identified that the resident's nails were long and in need of trimming.</p> <p>2. Review of Resident #3's medical record revealed the facility admitted the resident on 09/21/10, with diagnoses that included Hypertension, Diabetes Mellitus, and Cerebral Vascular Accident. Review of a quarterly MDS assessment for Resident #3 dated 05/13/15, revealed Resident #3 required extensive assistance of two persons for personal hygiene. A review of Resident #3's plan of care dated 01/02/15, revealed staff would provide nail care.</p> <p>Observation of Resident #3's skin assessment by LPN #2 on 06/09/15, at 9:15 AM, revealed the resident was observed to have long toenails that were in need of trimming. However, LPN #2 was not observed to trim the resident's nails.</p> | F 312 | <p>standards and ensure resident basic ADL care needs, to include nail care, are met.</p> <p>4. The DON, Unit Managers or SDC will complete an audit of resident's toenails daily M-F x4 weeks, weekly x4 weeks and then monthly for two months to ensure toenail care has been provided to meet professional standards and care plan followed. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated.</p> | 7-5-15 |

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| F 312 | <p>Continued From page 6</p> <p>An interview conducted with LPN #2 on 06/09/15, at 3:00 PM, revealed Resident #3 required staff to trim his/her toenails and she had been responsible for trimming the resident's nails. The LPN stated she normally trimmed Resident #3's toenails once a month. The LPN stated she should have trimmed the resident's toenails.</p> <p>3. Review of Resident #16's medical record revealed the facility admitted the resident on 09/29/14, with diagnoses that included Diabetes Mellitus, Hypertension, End Stage Renal Disease, and Cardiovascular Disease. Review of a quarterly MDS dated 03/15/15, revealed Resident #16 required the extensive assistance of two persons for personal hygiene. A review of Resident #16's plan of care dated 11/12/14, revealed nail care would be provided for Resident #16 by staff.</p> <p>Observation of Resident #16's nails on 06/10/15, at 2:15 PM, with LPN #2 revealed Resident #16's toenails were observed to be long and in need of trimming.</p> <p>An interview conducted with LPN #2 on 06/10/15, at 2:30 PM, revealed she had been responsible to ensure Resident #16's nails were trimmed. LPN #2 stated she had not been aware Resident #16's toenails were in need of trimming and should have been.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/10/15, at 4:55 PM, revealed LPN #2 should have trimmed Resident #3, Resident #16, and Resident #17's nails when completing his/her skin assessment. The DON revealed nurses were required to assess a</p> | F 312 | | | |

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| F 312 | Continued From page 7 resident's nails when conducting a weekly skin assessment. The DON stated she had not identified any concerns with nail care not being provided previously. | F 312 | | | |
| 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 manufacturer's specifications, it was determined the facility failed to ensure two (2) of twenty-one (21) sampled residents (Residents #17 and #16) received proper treatment and care regarding enteral feedings. Observations on 06/08/15, 06/09/15, and on 06/10/15 of Resident #17's and Resident #16's room revealed enteral tube feeding sitting on the windowsill in direct sunlight. The findings include: Interview with the Facility Administrator on 06/11/15 at 1:35 PM revealed there was not a policy for storage of tube feeding products. | F 328 | F 328 1. Resident #16 and #17 were assessed by a nurse with no concerns noted. Tube feeding container, noted in window seal, was thrown in trash. New Tube Feeding bottle was hung to ensure resident received new bottle of tube feeding. 2. All residents have the potential to be affected. All residents' medications and tube feedings were audited by 7/3/15 by DON, ADONs, Unit Managers to ensure all medications and tube feedings were stored appropriately. No other concerns were noted. All residents that receive Tube feeding were audited by 7/3/15 by DON, ADONs, and/or Unit managers to ensure Tube feeding container was stored | | |

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| F 328 | Continued From page 8 1. Observation of Resident #17's room on 06/10/15 at 11:25 AM, revealed a bottle of Two-Cal HN (nutritional supplement) sitting on a windowsill in direct sunlight. The bottle was warm to the touch. The tube feeding liquid was beige in color and there were beads of clear liquid (condensation) noted on the inside top of the bottle. The affixed manufacturer's label read "Contains light sensitive nutrients." Review of the medical record for Resident #17 revealed the facility admitted the resident on 02/23/07 with diagnoses which included Head Trauma and Chronic Obstructive Pulmonary Disease (COPD). Review of a quarterly Minimum Data Set (MDS) assessment for Resident #17 dated 03/23/15, revealed the resident was assessed to require the total assistance of one (1) staff person for feeding and had a gastrostomy tube. Further review of the MDS assessment revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of one (1), which indicated the resident had been assessed to have severe cognitive impairment. The MDS revealed the resident had not had a weight loss. 2. Review of the medical record for Resident #16 revealed the facility admitted the resident on 09/29/14, with diagnoses that included Diabetes Mellitus, End Stage Renal Disease, and Cardiovascular Disease. Review of a quarterly MDS dated 03/15/15, revealed the resident had been assessed to have severely impaired cognition and to require the total assistance of one (1) person for eating. The MDS also revealed the resident required a gastrostomy tube | F 328 | properly. No other concerns noted. 3. Nursing staff were educated by 7/4/15 by DON, ADONs, Unit managers on medication and tube feedings, to include tube feeding container storage. 4. The DON, Unit Managers or SDC will complete an audit of resident's medication and tube feedings, to include tube feeding containers, daily M-F x4 weeks, weekly x4 weeks and then monthly for two months to ensure residents medication and tube feedings, to include tube feeding containers have been stored appropriately. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. | 7-5-15 | |

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| F 328 | <p>Continued From page 9 feeding.</p> <p>Observation of Resident #16 during Initial tour of the facility on 06/08/15 at 2:00 PM, revealed two (2) full bottles of Vital 1.5 Cal Therapeutic Nutrition (nutritional supplement) sitting on the windowsill of the resident's room.</p> <p>Observation of Resident #16 on 06/09/15, at 10:30 AM, revealed one (1) full bottle of Vital 1.5 Cal Therapeutic Nutrition (nutritional supplement) was observed to be sitting on the windowsill.</p> <p>Review of the manufacturer's label on the bottle of Vital 1.5 Cal Therapeutic Nutrition (nutritional supplement) revealed the nutritional supplement contained nutrients which were light sensitive, had the potential for microbial contamination, and should be stored at room temperature.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 06/10/15 at 2:23 PM, revealed that tube feeding products were usually not stored on the windowsill. The LPN stated they were usually sitting on the resident's sink and should not have been stored in the window.</p> <p>Interview with the Director of Nursing (DON) on 06/10/15 at 2:27 PM revealed that the Two-Cal HN should not have been stored on the resident's windowsill; it was usually stored on the resident's sink.</p> <p>Interview with the Registered Dietitian (RD) on 06/10/15, at 4:30 PM revealed that she does not generally monitor the storage of tube feeding products but she thought it should be stored at around 75 degrees, and it should not have been stored on the windowsill in direct sunlight.</p> | F 328 | | | |

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

PRINTED: 07/24/2015
FORM APPROVED
OMB NO. 0938-0391

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|--|--|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186161 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/10/2015 |
| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW LANE PRESTONSBURG, KY 41663 | | |
| (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 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> | F 441 | <p>F441</p> <ol style="list-style-type: none"> Resident # 2 had an order to discontinue contact precautions on 6-9-15 due to no longer having signs and symptoms of Clostridium Difficile toxin. All residents have the potential to be affected All residents have been audited and those with orders for contact precautions have all policy and procedure interventions in place. Education will be provided by 7-4-15 to nursing staff by the DON, ADON, and Unit Managers to ensure all residents with isolation orders have appropriate interventions in place per policy and procedures. The DON, ADON, or Unit Managers will audit all residents with isolation | | |

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|--|--|--|---|----------------------|--|
| 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 06/10/2015 |
| 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) | (X6) COMPLETION DATE | |
| F 441 | Continued From page 11 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 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 one (1) of twenty-one (21) sampled residents (Resident #2). Resident #2 had a physician's order for contact precautions due to the resident having stool cultures which were positive for Clostridium Difficile toxin (contagious bacterial infection). Observation of Resident #2 and the resident's room on 06/08/15, at 2:00 PM, during initial tour revealed no signage was observed on Resident #2's door or outside the room to indicate the resident was on contact precautions. The findings include: Review of the facility policy titled "Clostridium Difficile," with a revision date of August 2013, revealed preventive measures would be taken to prevent the occurrence of Clostridium Difficile (contagious bacterial infection) among residents and precautions would be taken while caring for residents with Clostridium Difficile (contagious bacterial infection) to prevent transmission to others. The policy revealed residents who tested positive for Clostridium Difficile toxin (contagious bacterial infection) would be placed on Contact Precautions which included that both staff and visitors would be required to wear gloves and gowns when entering the resident's room. | F 441 | orders in place weekly to ensure all policy and procedure interventions are followed. Findings of the audits will be discussed monthly for three months in the Quality Assurance meeting for further follow up as indicated. | 7-5-15 | |
| | Review of Resident #2's medical record revealed | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186151 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/10/2015 |
|--|---|--|---|----------------------|--|
| 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 12</p> <p>the resident was admitted by the facility on 12/02/14, with diagnoses which included Bacterial Enteritis, Cardiovascular Accident, and Hypertension. Review of a significant change Minimum Data Set (MDS) assessment dated 04/24/15, revealed Resident #2 had been assessed to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 11. The MDS also revealed the resident had been assessed to be incontinent of both bladder and bowel and to require the extensive assistance of two persons for incontinence care. Review of Resident #2's physician's order dated 05/22/15 revealed the resident was to have contact precautions because the resident's stool was positive for Clostridium Difficile toxin (contagious bacterial infection). Review of a care plan intervention dated 05/22/15, revealed Resident #2 was required to be on Contact Precautions.</p> <p>Observation of Resident #2 on 06/08/15 at 2:00 PM, and 06/08/15 at 3:30 PM, revealed no signage was observed on Resident #2's door or outside the room to indicate the resident was on contact precautions.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 06/08/15, at 3:50 PM, revealed Resident #2 was on Contact Precautions for Clostridium Difficile (contagious bacterial infection) and staff and visitors were required to wear gowns and gloves prior to entering the room.</p> <p>Interview conducted with State Registered Nursing Assistant (SRNA) #8 on 06/08/15, at 3:55 PM, revealed there was supposed to be a sign on Resident #2's door to indicate anyone entering should check at the nurses' station prior to entering the room because the resident was on</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: 185151 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/10/2015 |
|--|--|--|---|----------------------|--|
| 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 | Continued From page 13 Contact Precautions. The SRNA stated she was unaware of what happened to the sign. Interview conducted with the Director of Nursing on 06/10/15, at 4:55 PM, revealed Resident #2's Contact Precautions had been discontinued on 06/09/15. The DON stated she had personally placed the sign on Resident #2's door and was unsure of what had happened to the sign. The DON stated she had not identified that Resident #2's Contact Precaution sign had been removed prior to a physician's order discontinuing Contact Precautions for Resident #2. | F 441 | | | |

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

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OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185151 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/10/2015 |
|---|---|---|---|----------------------|---|
| 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 | |
| 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 (Short Form)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 2-story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: 5</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 06/10/15, 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 |

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.