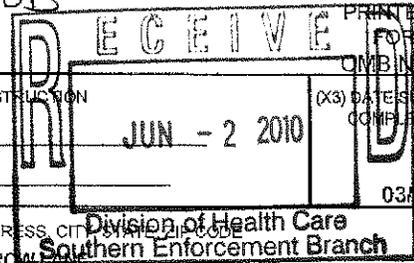


Amended SOD

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

PRINTED: 05/26/2010
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 03/25/2010
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW... PRESTONSBURG, KY 41653
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(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 F 281 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on March 23-25, 2010. Deficiencies were cited with the highest scope and severity at an "E" level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services to meet professional standards of quality related to administration of enteral feedings for one (1) of twenty-three (23) sampled residents. Resident #9 was not administered enteral feeding in accordance with physician's orders.</p> <p>The findings include:</p> <p>Observations conducted on March 23, 2010, from 9:55 a.m. to 3:15 p.m., and on March 24, 2010, from 8:20 a.m. to 9:45 a.m., revealed that resident #9 was administered Two Cal HN enteral feeding at a rate of 44 cubic centimeters (cc) per hour.</p> <p>A review of the medical record for resident #9 revealed a physician's order dated February 18, 2010, for Two Cal HN enteral feeding to be administered at a rate of 40 cc per hour.</p> <p>An interview conducted on March 24, 2010, at 11:40 a.m., with the Licensed Practical Nurse (LPN) responsible for administering the enteral</p>	F 000 F 281	<p>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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Melissa J. Allen* TITLE: *Administrator* (X6) DATE: *6/1/10*

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 RIVERVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 79 SPARROW LANE PRESTONSBURG, KY 41653	
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F 281	Continued From page 1 feeding to resident #9 on March 23 and 24, 2010, revealed that the LPN had not checked the physician's order for the enteral feeding and had documented an incorrect rate on the bottle and set the feeding pump at the incorrect rate. An interview conducted with the Director of Nursing (DON) on March 25, 2010, at 9:55 a.m., revealed the Unit Manager was responsible to review each resident's physician's orders and compare the types of enteral feedings and the rates ordered for each resident. According to the DON, the Unit Manager had not identified any concerns regarding enteral feeding being administered at an incorrect rate.	F 281	proceeding. 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.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve food at a palatable temperature for the breakfast meal on March 24, 2010, to residents on the South hall. The breakfast food cart was observed to have already arrived at the 100 South unit at 8:15 a.m. on March 24, 2010. The last breakfast tray was removed from the cart at 8:46 a.m. on March 24, 2010, when the tray was intercepted by the surveyor in order to obtain food temperatures and conduct a palatability test of the food on the breakfast tray. The foods on the test	F 364	F281 Resident #9 was assessed by nursing staff and MD was notified of the incorrect rate of tube feeding. No new orders were received. This was done on 3/24/10. All residents with tube feeding were assessed to ensure proper feeding rate. No other residents were identified. All licensed staff will be inserviced on F-281 and its intent. Licensed staff will be inserviced on maintaining correct rates for all tube feedings. The QA Nurse/designee will monitor 3 residents with tube feedings per week, to ensure feedings at correct rate. All findings will be reported	

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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		
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F 364	<p>Continued From page 2</p> <p>tray were not at the appropriate temperatures for resident consumption.</p> <p>The findings include:</p> <p>A group interview was conducted with seven residents at 3:45 p.m. on March 23, 2010. The facility residents complained that the food was cold by the time it was served to the individual residents. The residents further stated that breakfast was usually the meal that was never hot.</p> <p>Observation at 8:15 a.m. on March 24, 2010, of the breakfast food cart revealed the cart had already arrived at the 100 South hall, and the food cart contained 16 resident breakfast trays. Staff was observed to already be in the process of passing the food trays. The last breakfast tray was ready to be removed from the food cart at 8:46 a.m., when the surveyor requested staff to obtain another tray for that resident in order for the surveyor to obtain temperatures of the food. The temperatures were as follows: cornflakes with milk - 63.1 degrees Fahrenheit, sausage and gravy -104.5 degrees Fahrenheit, French toast - 96.1 degrees Fahrenheit, milk - 54.1 degrees Fahrenheit, and orange juice - 57 degrees Fahrenheit. A palatability test was conducted with two surveyors accompanied by the Director of Nursing. The palatability test revealed the sausage and gravy and the French toast were cold and not palatable.</p> <p>A review of the feeder list for the 100 South hall revealed that ten residents on the 100 South hall were totally fed by staff.</p> <p>An interview was conducted at 9:00 a.m. on</p>	F 364	<p>to the QA Committee monthly and any concerns will be addressed and changes made as necessary.</p> <p>F364 No specific residents were identified in this deficiency. All applicable residents will be interviewed regarding the food to ensure it is palatable and at the proper temperature. Food distribution changes will be made to ensure all residents receive his/her food at the proper temperature. The Dietary Manager/designee will check 3 trays per week to ensure proper temperatures. All results will be brought to the monthly QA committee meeting for review. Any concerns will be addressed and changes made as necessary.</p>	4/30/10	4/30/10

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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		
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F 364	Continued From page 3 March 24, 2010, with two certified nursing assistants (CNAs) on the 100 South hall. The CNAs stated that all of the trays came to the unit on the same cart. Staff further stated that the trays were passed by room numbers, and when a staff member obtained a tray from the cart for a resident that had to be fed, staff had to stop passing trays in order to feed that resident. Therefore, it took longer to pass the other residents' meal trays. According to the CNAs, there were six staff members available to pass the breakfast trays for 28 residents on the South hall.	F 364			
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	F 441	F441 Resident #23 has been assessed and no concerns were identified. No other residents were identified. Licensed staff were inserviced on the intent on F441 and the hand washing policy as it relates to medication administration. The unit managers/designee will monitor 2 licensed staff weekly during medication administration to ensure compliance with proper hand washing. All findings will be brought to the monthly QA		

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F 441	<p>Continued From page 4</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an Infection Control Program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Facility staff failed to wash/sanitize hands during medication administration on March 23, 2010, for one (1) of twenty-three (23) sampled residents.</p> <p>The findings include:</p> <p>Observation of medication administration conducted on March 23, 2010, at 4:35 p.m., revealed a Licensed Practical Nurse (LPN) retrieved a cup from the floor, and did not wash/sanitize hands prior to administering medications to resident #23.</p> <p>An interview conducted with the LPN revealed the LPN was aware of the need to wash/sanitize hands, however, was nervous, and forgot to wash/sanitize hands prior to administering</p>	F 441	<p>committee for review. Any concerns will be addressed and changes made as necessary.</p>	4/30/10

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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		
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F 441	Continued From page 5 medications to resident #23. A review of the facility handwashing policy dated July 2002 revealed that facility staff was required to wash/sanitize hands as necessary to prevent the spread of infection or germs.	F 441			

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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 03/23/2010
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>A life safety code survey was initiated and concluded on March 23, 2010, for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility 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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