

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
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 02/20/2026
NAME OF PROVIDER OR SUPPLIER Riverview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 79 Sparrow Lane Prestonsburg, KY 41653	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to establish and maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 25 sampled residents (Residents (Rs)38, R57, R96, and R102). The findings include: Review of the facility policy titled, Infection Control, revised on 01/30/2026, revealed the facility must maintain infection control practices intended to provide a safe, sanitary, and comfortable environment and to prevent, detect, investigate, and control infections. Per policy review, infection control practices were to apply equally to all residents, personnel, visitors, and volunteers. Continued review revealed the facility was to establish and implement guidelines for Standard Precautions and Transmission-Based Precautions (TBP), including ensuring the availability and accessibility of supplies and equipment necessary to follow those precautions. Further review revealed staff were to be trained upon hire and periodically thereafter on infection control practices appropriate to their job duties. In addition, the facility was to ensure infection control policies and practices were implemented, monitored, and followed through the Quality Assurance and Performance Improvement (QAPI) and Infection Control Committees. Review of the facility policy titled, Enhanced Barrier Precautions, last reviewed on 01/31/2026, revealed the facility was to implement Enhanced Barrier Precautions (EBP) as additional infection control measures to reduce the transmission of multidrug-resistant organisms. Per review, the facility's infection control practices, including EBP, to apply equally to all residents, personnel, consultants, visitors, and volunteers. Continued review revealed when a resident was placed on EBP appropriate signage was to be posted at the resident's room entrance. Policy review revealed the signage was to be posted to inform staff and visitors of the need for and type of precautions, including instructions regarding the use of personal protective equipment (PPE) prior to entering the room. Further policy review revealed residents with chronic wounds and/or indwelling medical devices were required to have EBP regardless of multidrug-resistant organism (MDRO) status. Review of the facility policy titled, Hand Hygiene Policy, effective 06/27/2025, revealed the facility required hand hygiene to be performed by all stakeholders (staff) to reduce the transmission of infectious agents and healthcare-associated infections. Continued review revealed the policy defined hand hygiene as handwashing with soap and water or the use of alcohol-based hand rub. Further review revealed staff were to perform hand hygiene before and after resident contact, before performing aseptic tasks, after removing gloves, in accordance with resident-specific isolation guidelines when indicated, and when hands were visibly soiled. 1). Review of R38's Electronic Health Record (EHR) revealed active physician's orders for EBP, including orders dated 02/10/2026, noting EBP to be followed every shift, days and nights, with nursing staff instructed to provide education and maintain required isolation precautions for the duration ordered. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued record review revealed R38 was transferred to room [ROOM NUMBER] on 02/13/2026 at approximately 12:00 AM. However, observation on 02/15/2026 revealed despite the ongoing EBP orders, there was no EBP signage or required PPE present outside of room [ROOM NUMBER]. In interview, on 02/15/2026 at 1:15 PM, Unit Manager (UM) 1 stated R38 had been moved to room [ROOM NUMBER] on 02/13/2026 at 12:00 AM. The UM said however, staff failed to move the EBP signage and required PPE products to the resident's new room. The UM further stated staff had been providing care to R38 without following the necessary EBP and PPE requirements from 02/13/2026 through 02/15/2026 at approximately 1:15 PM. In interview, on 02/18/2026 at 10:38 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated EBP and PPE should have been transferred immediately when R38 was moved to the new room. The ADON/IP acknowledged uncertainty regarding how that oversight occurred. In interview, on 02/18/2026 at 11:27 AM, the Director of Nursing (DON) stated the EBP signage and required PPE for R38 should have been transferred immediately at the time of the resident's room change. She said she was unable to identify why the EBP signage and necessary PPE had not been moved as required upon the room change. 2). Review of R102's EHR revealed active physician's order for EBP, with an order start date of 03/29/2024, listed as open-ended. Continued review revealed the physician's order directed EBP be followed every shift, days and nights. Further record revealed the EBP order were related to wound care needs, requiring staff to follow infection control practices to reduce the risk of transmission of infectious organisms during resident care. Observation on 02/15/2026 at 12:45 PM, revealed State Registered Nurse Aide (SRNA) 3 entering resident room [ROOM NUMBER] (R102's room) and exiting the room without performing hand hygiene. Continued observation revealed the SRNA then proceeded to enter resident room [ROOM NUMBER] to open a soft drink for that resident. Further observation revealed SRNA 3 handed the soft drink to that resident, and exited room [ROOM NUMBER] without performing hand hygiene. In interview, on 02/15/2025 at 12:50 PM, SRNA 3 stated she had not performed the proper hand hygiene before entering and after exiting residents' rooms. The SRNA reported she should have washed her hands and proper hand hygiene was necessary to prevent the spread of germs from one resident to another. She further stated failure to perform hand hygiene could result in residents becoming sick. 3). Review of R57's EHR revealed an active physician's order for EBP with instructions for every shift, days and nights and the precaution order was active and open-ended. Observation on 02/17/2026 at 10:10 AM revealed however, the signage posted outside R57's room noted the resident was on Contact Precautions and not the ordered EBP. Continued observation revealed Environmental Services (EVS) staff 2 exiting resident room [ROOM NUMBER] (R57's room) and place the cleaning equipment used in that room onto the housekeeping cart without sanitizing or disinfecting the equipment prior to placement on the cart. In interview, on 02/17/2026 at 10:10 AM, EVS 2 stated she had forgotten to sanitize the mop handle after exiting the contact precaution room (room [ROOM NUMBER]). She reported sanitizing the cleaning equipment after use in a contact precaution room was important to ensure the equipment remained clean when used in other residents' rooms. EVS 2 further stated sanitizing the equipment was also important to prevent the spread of germs and potential illness to other residents. 4). Review of R 96's EHR revealed an active physician's order for EBP with instructions for every shift, days and nights. Continued review revealed the precaution order was active and open-ended. Observation on 02/17/2026 at 3:00 PM, revealed SRNA 8 entered resident room [ROOM NUMBER] (R96's room) which displayed an EBP sign. Continued observation revealed SRNA 8 entered and exited room [ROOM NUMBER] without performing hand hygiene. In interview, on 02/16/2026 at 9:04 AM, the Administrator stated failure to follow EBP and proper PPE use could result in the spread of infection to residents. In interview, on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/16/2026 at 10:45 AM, the DON stated failure to follow EBP and proper PPE use could place residents at risk for acquiring an infection. The DON further stated facility staff were expected to follow all infection prevention and control policies to prevent the spread of germs and potential infection to residents and staff. In continued interview, on 02/18/2026 at 10:38 AM, the ADON/IP stated staff were required to perform hand hygiene upon entering and exiting EBP rooms to prevent the spread of germs, particularly due to the unknown nature of infections that might be present in resident wounds. In additional interview, on 02/18/2026 at 11:46 AM, the Administrator stated when a resident was transferred to a different room, all EBP signage and required PPE were expected to be transferred with the resident. She reported facility staff were expected to know and comply with all applicable policies and regulatory requirements. The Administrator further stated it was the responsibility of facility administration to ensure staff were educated on and adhered to infection prevention and control policies.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review, the facility failed to provide housekeeping services to ensure a clean and sanitary environment for 5 of 25 sampled residents (Residents (R)40, R62, R64, R67, and R81). The findings include: Review of the facility's policy titled, Resident Rights, undated, revealed residents had a right to a safe, clean, comfortable and homelike environment. Review of the facility's policy for housekeeping titled, Housekeeping Daily Duties, dated 12/2001, revealed a schedule of what housekeeping staff were to do on each day of the week. Further review revealed the policy stated, All corners and along all baseboards must be dust mopped to prevent buildup. 1. Observation on 02/15/2026 at 11:42 AM, of R640's room, revealed a cracked ceiling tile in the bathroom, as well as holes in the corners of tiles due to the use of the incorrect size. Further observation revealed the flooring in the bathroom was sticking up approximately one inch off the floor, which created a fall hazard for residents. 2. Observation on 02/15/2026 at 11:51 AM, of R62's room, revealed a large brown stain on the ceiling tile in the bathroom. 3. Observation on 02/15/2026 at 11:58 AM, of R64's room, revealed broken ceiling tiles in the bathroom. Continued observation revealed a yellow stain around the caulking on the toilet. In interview with R64 at the time of observation, the resident stated, The stuff around the toilet is yellow and brown and it looks like someone has pissed all over it and it dried. Makes me feel dirty. 4. Observation on 02/15/2026 at 12:38PM, of R67's room, revealed chipped paint on the wall beside the resident's bed. 5. Observation on 02/15/2026 at 12:54PM, of R81's room, revealed wood chipped beside the resident's bed. Further observation revealed an approximate two inch hole in the bathroom ceiling due to the ceiling tiles being the incorrect size. 6. Observation on 02/15/2026 at 1:18 PM, of first floor door labeled, Hazardous Material revealed the door frame had multiple holes in it at the bottom. Further observation revealed a gold/yellow tape over the large holes in the doorframe. In interview on 02/16/2026 at 11:42 AM, the Maintenance Director stated staff used a book on both floors to write down any maintenance issues that needed to be addressed. He said the facility had a system called TELS (a building management and maintenance platform designed for senior living communities to streamline work orders, preventive maintenance, compliance tracking, and asset management). The Maintenance Director stated however, he just checked the books on the floors. He reported, We always check the books on both floors daily to see if there is anything that needs to be done. The State Survey Agency (SSA) Surveyor asked the Maintenance Director if he performed walk throughs of the facility checking for environmental issues, and he stated, Yes, once a month. The Maintenance Director further stated, Currently we are waiting for a part to fix the sink in the kitchen. But, that's the only thing that has been reported to me that needs to be fixed as of right now. During interview with the Housekeeping Manager on 02/16/2026 at 1:12 PM, she stated, Every resident room gets a deep clean once a week and on the days we don't deep clean, we spot clean. She said she instructed her staff to always notify maintenance of anything problems identified needing to be fixed. The Housekeeping Manager reported she went around and helped her housekeeping staff if needed. She further stated she also went around to check that certain rooms and areas got cleaned daily. In interview with the Administrator on 02/18/2026 at 9:32 AM, revealed she was new to her position and had only been in it since December 2025. She said anyone in the facility could put a work order in and it would be sent to maintenance and they would prioritize it. The Administrator reported the facility was still trying to phase out some of the old processes and initiate some new things to help the facility. She stated she expected all environmental issues to be addressed daily in the morning huddle meeting, which was (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her process for staying on top of issues. The Administrator explained, We use a system called TELS and anyone can place a work order (through it). She reported, My expectation is that work orders will get done in a timely manner, once they are reported to maintenance. The SSA Surveyor asked the Administrator if the facility used TELS for work orders, or the books that maintenance referenced, she stated, We do have both. But the TELS system is what is supposed to be utilized. She further stated she and the maintenance staff did a full walk through of the facility each month to identify anything needing to be fixed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to maintain an effective system for documenting the receipt, storage, disposition, and reconciliation of controlled medications in sufficient detail to allow accurate reconciliation for 1 of 25 sampled residents (Resident (R)11). The findings include: Review of facility policy titled, Clinical Medication Controlled Medication, dated [DATE], revealed controlled medications was to remain in the facility after the order had been discontinued or due to residents being discharged . Per review, the controlled medication was retained in the facility in a securely locked area with restricted access until destroyed by two nurse leaders and/or one nurse leader and a consultant pharmacist. Review of the policy, Consultant Pharmacist Services Provider Requirements, dated 01/2023, revealed the consultant was to assist the provider pharmacy to establish a system of records of receipt and disposition of all controlled substance. Per review, the established system produced an accurate reconciliation and account of controlled substance use on a periodic basis. Further review revealed the system assisted in the accounting, destruction and reconciliation of unused controlled substances and non-controlled substances as required by state and federal law. Observation on [DATE] at 9:20 AM, during inspection of the nursing storage room refrigerator located in the first-floor nurses' station, revealed a locked and chained black box contained one vial of Ativan injectable solution labeled for R11. During interview on [DATE] at 9:22 AM Registered Nurse (RN) 2 stated the Ativan medication order for R11 had been discontinued on [DATE]. RN 2 reported the medication should have been sent back to the pharmacy. The RN further stated if the medication had been given it could have caused harm, such as making the resident ill or being ineffective in controlling the resident's seizures. During interview on [DATE] at 9:30 AM, Unit Manager (UM) 8 stated discontinued medications were to be given to the Director of Nursing (DON). She further stated failure to remove discontinued and expired controlled medications created the potential for administration of those medications. She reported which might be ineffective or potentially harmful if given to a resident. In interview on [DATE] at 10:10AM, the DON stated the Ativan medication should have been given to her to put in a locked cabinet until the narcotic medication could have been destroyed as per facility policy. She reported discontinued and expired narcotic medication should not be given to residents, as if given, the medication could be less effective. The DON further stated if not given to her the narcotic medication could have been diverted from the facility. In interview on [DATE] at 10:50AM, UM 1 stated discontinued narcotic medication were to be discarded with two people signing the narcotic sheet and disposing of the medication. UM 1 further reported she was currently trying to get the policy and was not sure what the policy was for disposal of discontinued narcotic medications. She further stated R11's Ativan medication could have been given to another resident, or administered to the resident who could have experienced an adverse reaction because the medication was expired. She further stated the Ativan medication could have been taken out of the facility by someone. In interview, on [DATE] at 11:00AM, the Administrator stated she expected narcotic medication that were discontinued or expired to be destroyed. The Administrator further stated however, she was unaware of the facility's policy and exact time frames for holding and destroying medications. In interview, on [DATE] at 9:23AM, the Pharmacy Consultant (PC) stated he came to the facility monthly to spot check medication carts, medication storage room refrigerators and locked boxes. PC reported however, he did not know the last time he checked the narcotic box in the medication (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refrigerators. He further stated discontinued and expired narcotic medications were to be added to a control sheet and given to the DON for her to destroy in a reasonable amount of time.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and review of facility documentation, the facility failed to ensure menus were updated and accurately reflected the meals served and failed to ensure residents were informed of meal selections, for 4 of 25 sampled residents (Residents (Rs)4, 17, 48, and 101) and had the potential to affect all residents consuming meals in the facility. The findings include: On 02/17/2026 at 3:00 PM, the State Survey Agency (SSA) Surveyor asked the Administrator to provide a policy regarding menu posting and food substitutions; however, no such policy or procedure was provided. Review of the posted menu available for resident viewing revealed it was dated 07/14/2025 at 10:11 AM. Observation on 02/17/2026 at 10:45 AM, revealed menus were posted on the first-floor bulletin board across from the nurses' station and on hallway bulletin boards. Continued observation on 02/17/2026 at 10:50 AM, revealed the menus were posted on the second-floor bulletin board across from the nurses' station and on hallway bulletin boards. Further observation on 02/17/2026 at 10:55 AM, of the posted menus, revealed the lunch meal was listed as beef soft tacos with flour tortilla, shredded lettuce, diced tomatoes, and shredded cheese. In addition, observation of the menus revealed the alternative meal listed was garlic baked pork chop with sauteed peppers and onions, sliced parsley carrots, Mexican corn, potato wedges, dinner roll, and pineapple tidbits. However, further observation on 02/17/2026 at 11:02 AM, of the meal being served, revealed it was lasagna with meat sauce, cauliflower, dinner roll, and deluxe fruit salad. Continued observation revealed the alternative meal being served was breaded chicken on a bun with mayonnaise, lettuce, and tomato, oven browned potatoes, and deluxe fruit salad. Therefore, the posted menus did not reflect the meal being served on that date. 1). In interview on 02/16/2026 at 11:00 AM, R48, who was bedbound, stated she did not receive menus and was never informed by staff of what meals being served were. She further stated when she asked a Certified Nursing Assistant (CNA), she was always told, I don't know. 2). In interview on 02/16/2026 at 11:12 AM, R101's spouse stated she did not know where to find menus. She further stated she did not know what the meal being served to R101 until it was delivered. 3). In interview on 02/16/2026 at 11:18 AM, R4 stated she did not receive a menu; however, would like to know what the meals being served were before they were delivered to her room. 4). In interview on 02/17/2026 at 9:50 AM, R17 stated he was admitted in December 2025. R17 further stated what was listed on the posted menus were not always what was being served. In interview on 02/17/2026 at 11:35 AM, the Dietary Manager (DM) stated she was responsible for posting menus. She further stated, I am supposed to switch them, and I have not. I guess I just forgot. In interview on 02/17/2026 at 2:40 PM, the Regional Dietitian (RD) stated the facility did not rely on posted menus because department heads were informed of daily meals during the morning huddle. The RD said the unit managers (UMs) were expected to inform staff and residents of what was being served daily. The RD reported if the residents did not know what meals were being served it was because of a breakdown in communication due to staff being informed in the morning huddle. When the SSA Surveyor asked the RD why the correct menus had not been posted, the RD stated the current Dietary Manager (DM) had taken on that role in September 2025, and it was an oversight. In interview on 02/17/2026 at 4:00 PM, Registered Nurse (RN) 1, the Unit Manager (UM) stated she did not post menus on the unit. RN 1 reported she did inform residents sitting near the nurses' station of what the daily meals were. She stated however, she sometimes forgot to inform other nurses and CNAs of that information. She further stated therefore, some residents might not receive the information on the meals being served.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and facility policy review, the facility failed to ensure daily nurse staffing information was posted and updated daily as required. The findings include: Review of the facility policy titled, Posting of Nurse Staffing, last revised 01/31/2025, revealed the facility was to post nurse staffing information on a daily basis at the beginning of each shift. Per review of the policy, the posted information was to include the facility name, current date, resident census, and the total number and actual hours worked by registered nurses (RNs), licensed practical/vocational nurses, and certified nurse aides (CNAs) per shift. Policy review further revealed it was required for the nurse staffing information to be posted in a clear, readable format in a prominent location readily accessible to residents and visitors. Observation on 02/15/2026 at 11:26 AM, revealed the facility's posted daily staffing information was dated Wednesday, 02/11/2026 (four days prior), and did not reflect the current staffing for 02/15/2026. Continued observation revealed the daily nurse staffing sheets posted at the time clock, at the first-floor nurses' station, and the second-floor nurses' station, were all dated Wednesday, 02/11/2026. In interview, on 02/15/2026 at 11:31 AM, State Registered Nurse Aide (SRNA) 5 stated it was the responsibility of the Assistant Director of Nursing (ADON) or Director of Nursing (DON) to post the daily staffing schedules. In interview, on 02/15/2026 at 11:33 AM, RN 4 also stated it was the responsibility of the ADON or DON to post the daily staffing schedules. In interview, on 02/15/2026 at 11:47 AM, the DON stated she or the ADON were responsible for posting the daily staffing schedules. She reported however, the ADON had been off work the previous week so the responsibility had fallen solely on her to post the schedules. The DON further stated she was unsure when she last posted the daily nurse staffing. In interview, on 02/18/2026 at 10:38 AM, the ADON stated she was primarily responsible for posting the daily staffing information. She further stated however, she had been off the previous week and the DON would have been responsible for posting the daily nurse staffing schedule while she was off. In interview, on 02/18/2026 at 11:46 AM, the Administrator stated that she knew posting the daily nurse staffing schedule was a regulation. She stated she expected her staff to follow all policies and regulations. The Administrator further stated the staffing schedule should have been updated daily.		