

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2019
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1793 RIVERVIEW ROAD LINCOLNTON, NC 28092		
(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	
W 340	<p>NURSING SERVICES CFR(s): 483.460(c)(5)(i)</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, nursing services failed to ensure staff were trained to assure adequate hygiene related to client handwashing. The finding is:</p> <p>Observations in the group home on 2/4/19 at 4:25 PM revealed client #5 leaving the bathroom located on the hall of the home which includes the laundry room. Further observations revealed a staff member asking the client if he had washed his hands. Client #5 responded by indicating he had not due to no soap being available. The client then washed his hands in a different bathroom.</p> <p>Continued observations on 2/5/19 at 8:15 AM in the bathroom located on the hall with the laundry room, revealed a hand soap dispenser which was still empty. Interview with the group home manager at that time revealed it was an "oversight" and the home manager then re-filled the dispenser. Interview with the facility nurse on 2/5/19 confirmed that hand soap should be available in all bathrooms at all times to assure appropriate health and hygiene.</p>	W 340			

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.