

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
APR 12 2013
02/14/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006	
(X4) IO 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 AMENDED An Abbreviated Survey investigating KY#00019775 and KY#00019776 was initiated on 02/13/13 and completed on 02/14/13. KY#00019776 was substantiated with no deficient practice identified. KY#00019775 was substantiated with deficiencies cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The facility failed to implement their abuse policy and procedures to protect residents from potential further abuse and failed to immediately examine (1) of three (3) sampled residents (Resident #1) after receiving an alleged report of physical abuse. The facility received an allegation of physical abuse toward Resident #1 on 02/07/13 at 11:30 AM. A physical examination of Resident #1 was not performed until 02/08/13 at 1:44 PM.	F 226	1. Resident #1 was affected by the deficient practice because the facility failed to perform physical examination day of alleged abuse. A physical examination was done on Resident #1 on 2/8/13 at 1:44 pm by LPN; the findings were a deep purple discoloration to the right interior wrist. 2. All residents who report alleged abuse have the potential to be affected by deficient practice if facility fails to follow abuse policy by not performing physical examination on day of alleged abuse. On February 8th, 2013 the Director of Nursing conducted a teaching moment to licensed nurses. The purpose of the teaching moment was to inform staff that the facility did not follow its policy and procedure on doing a skin assessment immediately after an allegation of physical or sexual abuse. 3. In-service was held on February 28, 2013 by the Director of Nursing to licensed nurses; this in-service included the facility abuse policy and re-education on doing a skin assessment immediately when an alleged physical or sexual abuse has been reported. The Director of Nursing provided re-education to those licensed nurses who was unable to attend the in-service on February 28, 2013.	4/12/2013 4/12/2013 4/12/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *4/12/2013*

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.

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006	
(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 226	Continued From page 1 The findings include: Review of the facility's policy titled "Reporting Abuse, Neglect & Misappropriation", updated July 2012, Section Seven (7), revealed upon the facility receiving reports of physical or sexual abuse, a licensed nurse (or physician) shall immediately examine the resident. Further review revealed the findings of the examination must be recorded in the resident's medical record. Additionally, the policy revealed that in the event of an occurrence of abuse or neglect, the facility's first responsibility was to provide medical intervention and support to stabilize the resident's health and provide reassurance. Review of the medical record revealed the facility admitted Resident #1 on 06/28/06 with diagnoses which included Mild Cognitive Impairment, Anxiety State, Depressive Disorder Obscuring Vision after Cataract Surgery, Urinary Tract Infection, Dysphagia, Anorexia and Difficulty in Walking. Review of the Minimum Data Set (MDS) Assessment, date 01/29/13 revealed the facility assessed Resident #1 with a Brief Interview for Mental Status Score of six (6) out of fifteen (15) indicating the resident was cognitively impaired. Review of the facility's reported incident report, dated 02/07/13 at 11:30 AM, revealed Resident #1 reported to Occupational Therapist #1 that he/she did not want to shower that morning but was made to shower anyway. Resident #1 further reported that the staff twisted her hand when they tried to do nail care that he/she also did not want done. Resident #1 reported that it hurt his/her hand and they mistreated him/her. Continued review revealed an examination of Resident #1	F 226	4. The facility Abuse Notification Form has been revised to prompt staff when an alleged physical or sexual report is made a skin assessment is required immediately. (See attached revised Abuse Notification Form). The Administrator, Director of Nursing, and/or the Social Service Director will conduct a review with the staff member initiating the notifications to ensure the form/assessment/proper/notifications/other duties have been completed timely and the investigation has been initiated. The Social Service Director reports during quarterly QA meetings the number of self-reports the facility has made and the compliance with this requirement.	4/12/2013

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 2 was not performed until 02/08/13 at 1:44 PM. Interview with Licensed Practical Nurse (LPN) #1, on 02/13/13 at 5:00 PM, revealed the facility's policy was to examine the resident immediately after receiving a report of alleged abuse. Interview with Registered Nurse (RN) #1, on 02/13/13 at 5:30 PM, revealed the procedure was to examine the resident for injuries immediately after receiving the alleged reports of abuse and to keep the resident safe. Interview with the Director of Nursing (DON), on 02/14/13 at 12:00 PM, revealed the facility's policy and procedure was to immediately examine the resident after receiving a report of alleged abuse and to record and document the findings in the medical record.	F 226			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy brochure "Residents' Rights for	F 242	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." 1. Resident #1 is being allowed to make individual choices related to her care to include having her preference honored to receive showers/bed bath on scheduled shower days or upon her request. Resident #1 was asked by a State Trained Nursing Assistant what her bathing preferences were. Resident #1 prefers a bath, morning or evening, two-three times per week. Resident #1 care plan was reviewed by the Inter Disciplinary Team, the care plan was revised to reflect her potential for resistive/refusal of care. The three State Trained Nursing Assistants involved in the incident with Resident #1 were terminated February 12th, 2013. 2. All current residents have the potential to be affected by the deficient practice. 10% of the current residents were interviewed by	4/12/2013	4/12/2013

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	<p>Continued From page 3</p> <p>Residents in Kentucky Long-Term Care Facilities", it was determined the facility failed to ensure the resident had the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; and make choices about aspects of his or her life in the facility that are significant to the resident for one (1) of three (3) sampled residents (Resident #1). It was reported, on 02/07/13 at approximately 10:00 AM, Resident #1 was taken to the shower room for a shower. It was reported that Resident #1 did not want a shower and verbalized this to the care giver; however, Resident #1 was not given the choice and received a shower. The facility failed to create an environment that was respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life.</p> <p>The findings include:</p> <p>Review of the facility's policy brochure "Resident's Rights For Residents in Kentucky Long-Term Care Facilities", undated, Section: Federal Resident Rights, revealed the facility shall protect and promote the rights of each resident, including the right to a dignified existence and self-determination.</p> <p>Review of the medical record revealed the facility admitted Resident #1 originally on 06/28/06 with diagnoses which included Mild Cognitive Impairment, Anxiety State, Depressive Disorder Obscuring Vision after Cataract Surgery, Urinary Tract Infection, Dysphagia, Anorexia and Difficulty in Walking. Review of the Minimum Data Set (MDS) Assessment, date 01/29/13 revealed</p>	F 242	<p>the Director of Nursing and/or Social Services Director regarding self-determination-right to make choices. The resident shower schedule has been updated to prompt the Certified Nursing Assistant/ State Trained Nursing Assistant to offer another means of bathing i.e. whirlpool/sponge bath should the resident refuse their stated preference (see attached). The revised schedule was completed by the Director of Nursing. The restorative nurse audit/review residents' shower preferences upon admission/quarterly/annually/significant change. A specific resident right(s) is addressed at every resident council meeting, which are held the second Wednesday of every month.</p> <p>On April 10th, 2013, the Social Service Director addressed residents rights #5 and #10 under the Federal Resident's Rights. Resident Right #5 the resident has the right to refuse treatment and to refuse to participate in experimental research. Resident Right # 10 the resident has the right to participate in planning his or her care and treatment unless adjudged incompetent or otherwise found to be incapacitated under law of the State. The Social Service Director will review Resident Rights with each resident/responsible party upon admission/quarterly/annual/significant change assessment.</p> <p>3. On February 27th and 28th the Social Services Director held in-services for staff on Resident Rights for Residents in Kentucky Long-term Care Facilities (see attached). This in-service was mandatory for all disciplines. Staff who did not attend the in-services completed Care2Learn, a web-based training/educational training specifically for Long-Term Care Facilities; this was mandatory as well; completion of this was March 12, 2013.</p>	4/12/2013

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	<p>Continued From page 4</p> <p>the facility assessed Resident #1 with a Brief Interview for Mental Status Score (BIMS) of six (6) out of fifteen (15) indicating the resident was cognitively impaired. Review of Resident #1's care plan, initiated 12/24/12, revealed the facility should provide this resident encouragement/assistance/support to maintain as much independence and control as possible. This resident's strengths are: can ask for help and can express feelings. Further review revealed a care plan intervention initiated on 12/27/12, which stated the facility should allow Resident #1 to make decisions about treatment regime to provide a sense of control.</p> <p>Review of an abuse notification form dated 02/07/13 at 11:30 AM, revealed Resident #1 reported to Occupational Therapist (OT) #1 that he/she did not want a shower that morning and told the Certified Nursing Assistant (CNA). It was reported that Resident #1 received a shower anyway. It was reported by Resident #1 that they mistreated him/her and made him/her cry. Further review of the Abuse Notification Form revealed Resident #1 told OT #1 that in general, he/she did not want to take showers because he/she always got sick or got a headache.</p> <p>Interview with Resident #1, on 02/13/13 at 2:45 PM, revealed he/she did not like to take showers at the facility due to the temperatures in the shower room. Resident #1 stated he/she got too cold. Resident #1 stated that he/she told the Certified Nursing Assistant (CNA) he/she did not want a shower. Resident #1 revealed that he/she was not given the choice to shower or not and was not given the choice of a bed bath.</p>	F 242	<p>4. The Director of Nursing, Quality Assurance Nurse, Social Services Director and/or Administrator will perform weekly audits of at least 10% of residents to ensure residents are being offered choices related to baths; type and frequency 2 x's weekly for 1 month then 1x weekly for 2 months. The Quality Assurance Nurse will monitor results of the audit and report findings of to the Quality Assurance Committee monthly x3 months. The Social Service Director and/or Administrator will orient/ educate employees about Resident Rights upon hire, annually and as needed.</p>	4/12/2013	

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41008		
(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 242	Continued From page 5 Interview with Certified Nursing Assistant (CNA) #1, on 02/14/13 at 9:45 AM, revealed she was the care giver for Resident #1 on that date. CNA#1 stated she continued to ask the resident to shower until the resident relented. Further interview revealed after Resident #1 was undressed and on the shower chair, prior to the actual shower, Resident #1 stated to CNA #1 he/she did not want a shower. Continued interview revealed she advised the Resident she was almost done and continued to give the shower. CNA #1 stated Resident #1 used to not be bad about taking his/her showers but anymore he/she just didn't want to be bothered. Interview with the Director of Nursing (DON), on 02/14/13 at 12:00 PM, revealed Resident #1, as well as all the facility's residents, should have a choice to shower or not. Further interview revealed an in-service was conducted to re-educate the staff regarding Resident Rights.	F 242			
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 and review of the manufactures's recommendations, it was	F 323	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."		

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006	
(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 6</p> <p>determined the facility failed to ensure that the resident environment remains as free of accident hazards as is possible. The facility failed to identify an electrical space heater plugged into a wall outlet in the shower room to be a potential electrical hazard for the facility's residents.</p> <p>The findings include:</p> <p>Review of the manufacture's recommendations for a Truman Infrared Heater revealed the heater was not intended for bathrooms. Under the "Warning" section the manufacturer stated to use the heater only as described in the manual. Further stating that any other use was not recommended by the manufacturer and may cause fire, electric shock, or injury to persons.</p> <p>Observation on initial tour, on 02/13/13 at 9:20 AM and 02/14/13 at 12:05 PM, revealed an electrical space heater plugged into a wall outlet in the residents' community shower room. Located above the electrical space heater was a sign posted that stated "Attention All Employees Due to Safety Hazards Electrical Heaters are not Permitted in the Shower Rooms".</p> <p>Interview with the Director of Nursing (DON), on 02/14/13 at 1:20 PM, revealed the facility did not have a policy on electrical heaters in the residents' shower rooms. The DON further revealed she did not know if it would be a safety hazard.</p> <p>Interview with the Director of Maintenance, on 02/14/13 at 2:50 PM, revealed he had the Truman Infrared Heater original box in his office. Observation of the original box revealed a</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> 1. The facility immediately removed the heater from the shower room to ensure the safety of residents and staff. 2. All residents on the unit and others who use the shower room had the potential to be affected by the heater while it was in the shower room. 3. Bids are currently being received to completely renovate this shower room. The upgrade will include a heating and ventilation system to ensure the comfort and safety of all residents who use this shower room. Lighting and plumbing will also be changed to ensure resident and staff safety. 4. Once all contractors and subcontractors have completed work this will result in greater safety and comfort for residents and staff. The Administrator will perform random audits of at least 10% of residents to ensure residents are being offered choices related to baths; type and frequency 2x weekly for one month, then one time weekly for 2 months. The Quality Assurance Nurse will monitor the results of the audits, update bath schedules as needed and report findings to the Quality Assurance Committee monthly x3 months. 	<p>4/15/2013</p> <p>4/15/2013</p> <p>4/15/2013</p> <p>4/15/2013</p>

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(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 7 warning label stating "Warning Potential for Electrical Shock" and "not to be used in moist or wet areas". Further interview with the Director of Maintenance at 3:10 PM, revealed the heater could be an electrical hazard when used in the shower room.	F 323			



Abuse Notification Form

Name of Resident/Victim: DOB SS# Rm# Primary Diagnosis

Name of Person(s) Accused DOB SS# Rm# Primary Diagnosis

Date of Incident: Time of Incident: Location of Incident:

Type Incident/Allegation (check all that apply)

- Type of Abuse: Verbal Physical Sexual Mental Neglect
- Involuntary Seclusion Injury of unknown origin Misappropriation of resident's property

***All Allegations of physical or sexual abuse require a skin assessment by a licensed nurse immediately**

Date: _____ Signature: _____ Time: _____

Summary of Incident: Include the names and positions of persons who witnessed the incidents, dates, shifts, descriptions of misappropriated property, evident of abuse/neglect/misappropriation, specifics of the type of abuse (attach additional sheets if necessary).

Actions taken to protect resident from further abuse/neglect/misappropriation, etc. Attach additional sheets if necessary) **Do we need to separate residents, send employee or visitor home?**

Notify the Physician: Date: _____ Time: _____ DR. Name _____

Notify the POA Date _____ Time _____ POA Name _____

Signature and title of person completing this report:

 X _____ Report Date and Time: _____

Call All Three Department Managers Immediately

ADMINISTRATOR DATE _____ TIME _____

DIRECTOR OF NURSING DATE _____ TIME _____

SOCIAL SERVICE DIR. DATE _____ TIME _____

B-Wing Shower Schedule

Date _____

Tuesday

Day Shift (7a-3p)

4B-2	Lena Wells	Shower
4B-1	Sandy Harrison	Shower
16B-1	Louise Green	Shower
14B-1	Louise Kelly	Shower
11B-1	Wanda Clark	Shower
11B-2	Evelyn Wallace	Shower
6B-1	Roberta Robers	Prefers Bed Bath

Evening Shift (3p-11p)

5B-1	M. Hutchinson	Shower
7B-1	J. Szelkowski	Shower
13B-2	Millie Durham	Prefers Bed Bath
12B-2	Carolyn Brown	Bath
10B-2	Allen Rue	Shower

***Report immediately to nurse if resident refuses their shower!**

**** Did you offer an alternative? whirlpool or bed bath?**

B-Wing Shower Schedule

Date _____

Saturday

Day Shift (7a-3p)

8B-1	Linda Coleman	Shower
9B-1		
1B	Patty Yelton	Bed Bath Only
3B2	Pat Wolf	Bed Bath Only

Evening Shift (3p-11p)

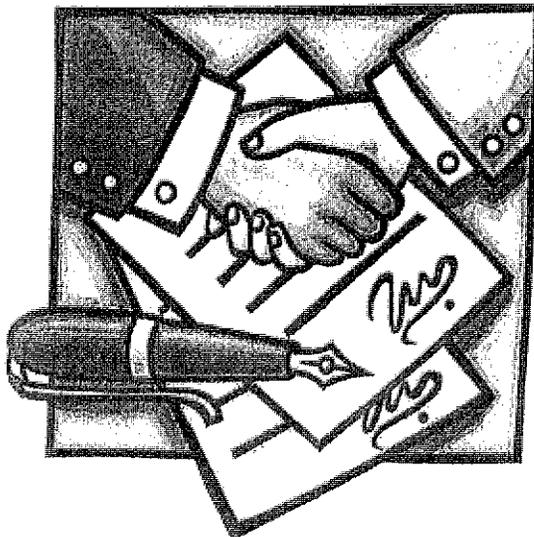
3B-1	Rosella Lemming	Shower
13B-2	Millie Durham	Prefers Bed Baths
15B-2	Mary Ann Dean	Bath/Shower

***Report immediately to nurse if resident refuses their shower!**

**** Did you offer an alternative? whirlpool or bed bath?**

Residents'
Rights
For Residents in
Kentucky
Long-Term Care
Facilities

This document combines both Federal and Kentucky statutes, as well as information from the National Citizens' Coalition for Nursing Home Reform at www.nccnhr.com



Residents' Rights

- Residents' Rights were part of the Nursing Home Reform Law enacted in 1987 by the U.S. Congress.
- Residents' Rights are also incorporated into Kentucky Regulatory Statutes.
 - These laws require nursing homes and other long-term care health facilities to promote and protect the rights of each resident;
 - These are their rights as residents of the facility, and as citizens of the United States, and the Commonwealth of Kentucky.
 - These rights place a strong emphasis on individual dignity and self-determination.
 - Nursing homes must meet residents' rights requirements to participate in Medicare and/or Medicaid.

Kentucky State Resident Rights

Every resident in a long-term care facility shall have at least the following rights:

1. Before admission to a long-term care facility, the resident and the responsible party or his responsible family member or his guardian shall be fully informed in writing, as evidenced by the resident's written acknowledgment and that of the responsible party or his responsible family member or his guardian, of all services available at the long-term care facility. Every long-term care facility shall keep the original document of each written acknowledgment in the residents' personal file.
2. Before admission to a long-term care facility, the resident and the responsible party or his responsible family member or his guardian shall be fully informed in writing, as evidenced by the

resident's written acknowledgment and that of the responsible party or his responsible family member or his guardian, of all resident's responsibilities and rights as defined in this section and KRS 216.520 and 216.530. Every long-term care facility shall keep the original document of each written acknowledgment in the residents' personal file.

3. The resident and the responsible party or his responsible family member or his guardian shall be fully informed in writing, as evidenced by the resident's written acknowledgment and that of the responsible party or his responsible family member, or his guardian, prior to or at the time of admission and quarterly during the resident's stay at the facility, of all service charges for which the resident or his responsible family member or his guardian is responsible for paying. The resident and the responsible party or his responsible family member or his guardian shall have the right to file complaints concerning charges which they deem unjustified to appropriate local and state consumer protection agencies. Every long-term care facility shall keep the original document of each written acknowledgment in the residents' personal file.
4. The resident shall be transferred or discharged only for medical reasons, or his own welfare, or that of the other residents, or for nonpayment, except where prohibited by law or administrative regulation. Reasonable notice of such action shall be given to the resident and the responsible party or his responsible family member or his guardian.
5. All residents shall be encouraged and assisted throughout their periods of stay in long-term care facilities to exercise their rights as a resident and a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of their choice, free

from restraint, interference, coercion, discrimination, or reprisal.

6. All residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a physician for a specified and limited period of time and documented in the residents' medical record.
7. All residents shall have confidential treatment of their medical and personal records. Each resident or his responsible family member or his guardian shall approve or refuse the release of such records to any individuals outside the facility, except as otherwise specified by statute or administrative regulation.
8. Each resident may manage the use of his personal funds. If the facility accepts the responsibility for managing the resident's personal funds as evidenced by the facility's written acknowledgment, proper accounting and monitoring of such funds shall be made. This shall include each facility giving quarterly itemized or his responsible family member or his guardian which detail the status of the resident's personal funds and any transactions in which such funds have been received or disbursed. The facility shall return to the resident his valuables, personal possessions, and any unused balance of moneys from his account at the time of his transfer or discharge from the facility. In case of death or for valid reasons when he is transferred or discharged, the resident's valuables, personal possessions and funds that the facility are not liable for shall be promptly returned to the resident's responsible party or family member, or his guardian, or his executor.

9. If a resident is married, privacy shall be assured for the spouse's visits and if they are both residents in the facility, they may share the same room unless they are in different levels of care or unless medically contraindicated and documented by a physician in the resident's medical record.
10. Residents shall not be required to perform services for the facility that are not included for therapeutic purposes in their plan of care.
11. Residents may associate and communicate privately with persons of their choice and send and receive personal mail unopened.
12. Residents may retain the use of their personal clothing unless it would infringe upon the rights of others.
13. No responsible resident shall be detained against his will. Residents shall be permitted and encouraged to go outdoors and leave the premises as they wish unless a legitimate reason can be shown and documented for refusing such activity.
14. Residents shall be permitted to participate in activities of social, religious, and community groups at their discretion.
15. Residents shall be assured of at least visual privacy in multi-bed rooms and in tub, shower, and toilet rooms.
16. The resident and the responsible party or his responsible family member or his guardian shall be permitted the choice of a physician.

17. If the resident is adjudicated mentally disabled in accordance with state law, the resident's guardian shall act on the resident's behalf in order that his rights be implemented.
18. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.
19. Every resident and the responsible party or his responsible family member or his guardian has the right to be fully informed of the resident's medical condition unless medically contraindicated and documented by a physician in the resident's medical record.
20. Residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming.
21. Residents shall have access to a telephone at a convenient location within the facility for making and receiving telephone calls.
22. The resident's responsible party or family member or his guardian shall be notified immediately of any accident, sudden illness, disease, unexplained absence, or anything unusual involving the resident.
23. Residents have the right to have private meetings with appropriate long-term care facility inspectors from the Cabinet for Health and Family Services.
24. Each resident and the responsible party or his responsible family member or his guardian has the right to have access to all inspection reports on the facility.

25. The above stated rights shall apply in all cases unless medically contraindicated and documented by a physician in writing in the resident's medical record.
26. Any resident whose rights as specified in this section are deprived or infringed upon shall have a cause of action against any facility responsible for the violation. The action may be brought by the resident or his guardian. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any deprivation or infringement on the rights of a resident.

Any plaintiff who prevails in such action against the facility may be entitled to recover reasonable attorney's fees, costs of the action, and damages, unless the court finds the plaintiff has acted in bad faith, with malicious purpose, or that there was a complete absence of justifiable issue of either law or fact. Prevailing defendants may be entitled to recover reasonable attorney's fees. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a resident and to the Cabinet.

Federal Resident Rights

All residents have rights under federal law. Each state has outlined specific rights as well.

The facility shall protect and promote the rights of each Resident, including each of the following rights:

1. The Resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the facility.

2. The Resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
3. The Resident has the right to be free of interference, coercion, discrimination or reprisal from the facility in exercising his or her rights.
4. The Resident has the right to be fully informed, in a language he or she can understand, of his or her total health status, including, but not limited to, his or her medical condition.
5. The Resident has the right to refuse treatment and to refuse to participate in experimental research.
6. The Resident has the right to exercise his or her legal rights, including filing a grievance with the Office of the Inspector General concerning resident abuse, neglect and misappropriation of resident property in the facility.
7. The Resident has the right to manage his or her financial affairs.
8. The Resident has the right to choose an attending physician.
9. The Resident has a right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the resident's well-being.
10. The Resident has a right to participate in planning his or her care and treatment or changes in care and treatment unless adjudged incompetent or otherwise found to be incapacitated under laws of the State.

11. The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
12. The Resident or Legal Representative has the right upon oral or written request, to access all records pertaining to himself or herself, including clinical records, within twenty-four hours. After receipt of his or her records, the resident or legal representative has the right to purchase (at a cost not to exceed the community standard) photocopies of the records or any portions of them upon request and with two days' advance notice to the facility.
13. The Resident may approve or refuse the release of personal and clinical records to any individual outside the facility except then:
 - a. The resident is transferred to another health care institution.
 - b. Record release is required by law or a third-party payment contract.
14. The Resident has a right to voice grievances with respect to treatment or care that fails to be furnished without discrimination or reprisal for voicing grievances.
15. The Resident has a right to prompt efforts by the facility to resolve grievances, including those with respect to the behavior of other residents.
16. The Resident has a right to examine the results of the most recent survey of the facility conducted by Federal or

State surveyors and any plan of correction in effect with respect to the facility.

17. The Resident has a right to receive information from agencies acting as client advocates and be afforded the opportunity to contact such agencies.

If you have questions or concerns, please contact:

Connie Murphy

District Long-Term Care Ombudsman

1032 Madison Ave

Covington, KY 41011

859-292-7962 – B

Kimberly Baker

State Long-Term Care Ombudsman

275 East Main Street, 3 E-E

Frankfort, KY 40621

502-564-6930 – B

1-800-372-2991 Hotline

Office of the Inspector General

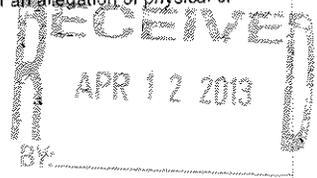
275 East Main Street, 5 E-A

Frankfort, KY 40621

502-564-2888 – B

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(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) COMPLETE DATE
N 000	INITIAL COMMENTS AMENDED A Complaint Survey investigating KY#00019775 and KY#00019776 was initiated on 02/13/13 and completed on 02/14/13. KY#00019776 was substantiated with no deficient practice identified. KY#00019775 was substantiated with deficiencies cited.	N 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
N 105	902 KAR 20:300-5(3) Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The facility failed to implement their abuse policy and procedures to protect residents from potential further abuse and failed to immediately examine (1) of three (3) sampled residents (Resident #1) after receiving an alleged report of physical abuse. The facility received an allegation of physical abuse toward Resident #1 on 02/07/13 at 11:30 AM. A physical examination of Resident #1 was not performed until 02/08/13 at 1:44 PM. The findings include: Review of the facility's policy titled "Reporting Abuse, Neglect & Misappropriation", updated July 2012, Section Seven (7), revealed upon the facility receiving reports of physical or sexual	N 105	1. Resident #1 was affected by the deficient practice because the facility failed to perform a physical examination day of alleged abuse. A physical examination was done on Resident #1 on 2/8/13 at 1:44 pm by LPN; the findings were a deep purple discoloration to the right interior wrist. 2. All residents who report alleged abuse have the potential to be affected by deficient practice if facility fails to follow abuse policy by not performing physical examination on day of alleged abuse. On February 8th, 2013 the Director of Nursing conducted a teaching moment to licensed nurses. The purpose of the teaching moment was to inform staff that the facility did not follow its policy and procedure on doing a skin assessment immediately after an allegation of physical or sexual abuse.	4/12/2013 4/12/2013



Ken Jeff
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 1099

TITLE *Administrator* (X6) DATE *4/12/2013*

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(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) COMPLETE DATE
N 105	Continued From page 1 abuse, a licensed nurse (or physician) shall immediately examine the resident. Further review revealed the findings of the examination must be recorded in the resident's medical record. Additionally, the policy revealed that in the event of an occurrence of abuse or neglect, the facility's first responsibility was to provide medical intervention and support to stabilize the resident's health and provide reassurance. Review of the medical record revealed the facility admitted Resident #1 on 06/28/06 with diagnoses which included Mild Cognitive impairment, Anxiety State, Depressive Disorder Obscuring Vision after Cataract Surgery, Urinary Tract Infection, Dysphagia, Anorexia and Difficulty In Walking. Review of the Minimum Data Set (MDS) Assessment, date 01/29/13 revealed the facility assessed Resident #1 with a Brief Interview for Mental Status Score of six (6) out of fifteen (15) indicating the resident was cognitively impaired. Review of the facility's reported incident report, dated 02/07/13 at 11:30 AM, revealed Resident #1 reported to Occupational Therapist #1 that he/she did not want to shower that morning but was made to shower anyway. Resident #1 further reported that the staff twisted her hand when they tried to do nail care that he/she also did not want done. Resident #1 reported that it hurt his/her hand and they mistreated him/her. Continued review revealed an examination of Resident #1 was not performed until 02/08/13 at 1:44 PM. Interview with Licensed Practical Nurse (LPN) #1, on 02/13/13 at 5:00 PM, revealed the facility's policy was to examine the resident immediately after receiving a report of alleged abuse. Interview with Registered Nurse (RN) #1, on	N 105	3. In-service was held on February 28, 2013 by the Director of Nursing to licensed nurses; this in-service included the facility abuse policy and re-education on doing a skin assessment immediately when an alleged physical or sexual abuse is reported. The Director of Nursing provided re-education to those licensed nurses who did not attend the In-service on February 28, 2013. 4. The facility Abuse Notification Form has been revised to prompt staff when an alleged physical or sexual report is made a skin assessment is required immediately. (See attached revised Abuse Notification Form). The Administrator, Director of Nursing, and/or Social Service Director will conduct a review with the staff member initiating the notification to ensure the form/assessment/proper notifications/other duties have been completed timely and the investigation has been initiated. The Social Service Director reports during the quarterly QA meetings the number of self-reports the facility has made and the compliance with this requirement.	4/12/2013 4/12/2013

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41008	
(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) COMPLETE DATE
N 105	Continued From page 2 02/13/13 at 5:30 PM, revealed the procedure was to examine the resident for injuries immediately after receiving the alleged reports of abuse and to keep the resident safe. Interview with the Director of Nursing (DON), on 02/14/13 at 12:00 PM, revealed the facility's policy and procedure was to immediately examine the resident after receiving a report of alleged abuse and to record and document the findings in the medical record.	N 105	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
N 114	902 KAR 20:300-6(2)(a) Section 6. Quality Of Life (2) Self-determination and participation. The resident shall have the right to: (a) Choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care: This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy brochure "Residents' Rights for Residents in Kentucky Long-Term Care Facilities", it was determined the facility failed to ensure the resident had the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; and make choices about aspects of his or her life in the facility that are significant to the resident for one (1) of three (3) sampled residents (Resident #1). It was reported, on 02/07/13 at approximately 10:00 AM, resident #1 was taken to the shower room for a shower. It was reported that Resident #1 did not want a shower and verbalized this to the care giver, however Resident #1 was not given the choice and received a shower. The facility failed to create an environment that was respectful of the right of each resident to exercise his or her autonomy	N 114	N 114 1. Resident #1 is being allowed to make individual choices related to her care to include having her preference honored to receive showers/bed bath on scheduled shower days. Resident # 1 was asked by a State Trained Nursing Assistant what her bathing preferences were. Resident # 1 prefers a bath, morning or evening, two-three times a week. Resident #1 care plan was reviewed by the Inter Disciplinary Team, the care plan was revised to reflect her potential for resistive/refusal of care. The three State Trained Nursing Assistants involved in the incident with Resident # 1 were terminated February 12th, 2013. 2. All current residents have the potential to be affected by the deficient practice. 10% of the current residents were interviewed by the Director of Nursing and/or Social Services Director regarding self-determination-right to make choices. The resident shower schedule has been updated to prompt the Certified Nursing Assistant/ State Trained Nursing Assistanl to offer another means of bathing i.e. whirlpool/sponge bath should the resident refuse their stated preference (see attached). The revised schedule was completed by the Director of Nursing. The restorative nurse audit/review residents' shower preferences upon admission/quarterly/annually/significant change. A specific resident right(s) is addressed at every	4/12/2013

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(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) COMPLETE DATE
N 114	<p>Continued From page 4</p> <p>told the Certified Nursing Assistant (CNA). It was reported that Resident #1 received a shower anyway. It was reported by Resident #1 that they mistreated him/her and made him/her cry. Further review of the Abuse Notification Form revealed Resident #1 told OT #1 that in general, he/she did not want to take showers because he/she always got sick or got a headache.</p> <p>Interview with Resident #1, on 02/13/13 at 2:45 PM, revealed he/she did not like to take showers at the facility due to the temperatures in the shower room, Resident #1 stated he/she got too cold. Resident #1 stated that he/she told the Certified Nursing Assistant (CNA) he/she did not want a shower. Resident #1 revealed that he/she was not given the choice to shower or not and was not given the choice of a bed bath.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 02/14/13 at 9:45 AM, revealed she was the care giver for Resident #1 on that date. CNA#1 stated she continued to ask the resident to shower until the resident relented. Further interview revealed after Resident #1 was undressed and on the shower chair, prior to the actual shower, Resident #1 stated to CNA #1 he/she did not want a shower. Continued interview revealed she advised the Resident she was almost done and continued to give the shower. CNA #1 stated Resident #1 used to not be bad about taking his/her showers but anymore he/she just didn't want to be bothered.</p> <p>Interview with the Director of Nursing (DON), on 02/14/13 at 12:00 PM, revealed Resident #1, as well as all the facility's residents, should have a choice to shower or not. Further interview revealed an in-service was conducted to re-educate the staff regarding Resident Rights.</p>	N 114		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(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) COMPLETE DATE
N 219	<p>902 KAR 20:300-8(7)(a) Section 8. Quality of Care</p> <p>(7) Accidents. The facility shall ensure that: (a) The resident environment remains as free of accident hazards as is possible; and</p> <p>This requirement is not met as evidenced by: Based on observation, interview and review of the manufacturer's recommendations, it was determined the facility failed to ensure that the resident environment remains as free of accident hazards as is possible. The facility failed to identify an electrical space heater plugged into a wall outlet in the shower room to be a potential electrical hazard for the facility's residents.</p> <p>The findings include:</p> <p>Review of the manufacturer's recommendations for a Truman Infrared Heater revealed the heater was not intended for bathrooms. Under the "Warning" section the manufacturer stated to use the heater only as described in the manual. Further stating that any other use was not recommended by the manufacturer and may cause fire, electric shock, or injury to persons.</p> <p>Observation on initial tour, on 02/13/13 at 9:20 AM and 02/14/13 at 12:05 PM, revealed an electrical space heater plugged into a wall outlet in the residents' community shower room. Located above the electrical space heater was a sign posted that stated "Attention All Employees Due to Safety Hazards Electrical Heaters are not Permitted in the Shower Rooms".</p> <p>Interview with the Director of Nursing (DON), on 02/14/13 at 1:20 PM, revealed the facility did not have a policy on electrical heaters in the</p>	N 219	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>N219</p> <ol style="list-style-type: none"> 1. The facility immediately removed the heater from the shower room to ensure the safety of residents and staff. 2. All residents on the unit and others who use the shower room had the potential to be affected by the heater while it was in the shower room. 3. Bids are currently being received to completely renovate this shower room. The upgrade will include a heating and ventilation system to ensure the comfort and safety of all residents who use this shower room. Lighting and plumbing will also be changed to ensure resident and staff safety. 4. Once all contractors and subcontractors have completed work this will result in greater safety and comfort for residents and staff. The Administrator will perform random audits of at least 10% of residents to ensure residents are being offered choices related to baths; type and frequency 2 x's weekly for 1 month then 1x weekly for 2 months. The Quality Assurance Nurse will monitor results of the audit, update bath schedules as needed and report findings of to the Quality Assurance Committee monthly x3 months. 	<p>4/15/2013</p> <p>4/15/2013</p> <p>4/15/2013</p> <p>4/15/2013</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/14/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006		
(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) COMPLETE DATE
N 219	Continued From page 6 residents' shower rooms. The DON further revealed she did not know if it would be a safety hazard. Interview with the Director of Maintenance, on 02/14/13 at 2:50 PM, revealed he had the Truman Infrared Heater original box in his office. Observation of the original box revealed a warning label stating "Warning Potential for Electrical Shock" and "not to be used in moist or wet areas". Further interview with the Director of Maintenance at 3:10 PM, revealed the heater could be an electrical hazard when used in the shower room.	N 219		