

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

PRINTED: 05/27/2010
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 308 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 000	INITIAL COMMENTS	F.000		
F 157 SS-D	<p>A Recertification Survey was conducted 05/11/10 through 05/13/10, and a Life Safety Code Survey was conducted on 05/13/10. Deficiencies were cited with the highest scope and severity of a "F".</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin W. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE 6/4/2010
--	-------------------------------	------------------------------

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: 05/27/2010
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 05/13/2010
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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the Physician was notified of a change in condition that may have warranted a need to alter treatment for one (1) of sixteen (16) sampled residents (Resident #5). Resident #5 exhibited behaviors towards female residents review revealed no documented evidence the Physician was notified of the resident's pattern of behaviors. In addition, there was no evidence Resident #5's responsible party was notified of all of the residents behaviors.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #5's clinical record revealed diagnoses which included Dementia. Review of the Annual Minimum Data Set (MDS) Assessment dated 04/10/10 revealed the facility assessed the resident as having short term memory loss, and moderate impairment in cognitive skills for decision making. The MDS revealed the facility assessed the resident as requiring extensive assistance to transfer, as being unable to ambulate, and as requiring extensive assistance with dressing, and hygiene <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 04/16/10 revealed Resident #5 was hard of hearing and was alert and oriented to self only. The RAPS further stated the resident could propel the wheelchair on the unit and required extensive assistance with most Activities of Daily Living (ADLs).</p> <p>Review of the Plan of Care dated 04/10/10</p>	F 157			

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157	<p>Continued From page 2</p> <p>revealed Resident #5 had inappropriate physical and sexual behaviors related to an attempt to hit another resident and sexual advances to another resident. The goal stated the resident would have less than one episode of behavior the next month. The interventions included; calmly redirecting and providing another location to redirect behavior, documenting behaviors every shift, and notifying the interdisciplinary team as needed.</p> <p>Review of the Nurse's Notes dated 11/10/09 at 8:00 PM revealed Resident #5 was observed touching another resident inappropriately. Review of the Nurse's Notes dated 11/17/09 at 1:30 PM revealed Resident #5 was noted touching another resident inappropriately, and smiled when redirected.</p> <p>Review of the Nurse's Notes dated 11/26/09 at 9:00 PM revealed Resident #5 was seen in the hallway by an aide, reaching hands up a female residents skirt. The Note further stated Resident #5 was spoken to and told it was disrespectful and inappropriate and the resident stated, "Ok, I'm sorry, I won't do it again".</p> <p>Interview on 05/13/10 at 12:00 PM with LPN #3 revealed she had documented the entry on 11/26/10. She stated, she documented the incidents in the chart and did not feel the need to notify the physician.</p> <p>Review of the Nurses' Notes dated 11/28/09 at 4:00 PM revealed it was reported by an aide, the resident was in the hallway with hands between a female residents legs. The Note further stated, staff intervened and separated the residents. The resident was spoken to regarding behavior and a call was placed to a POA (Power of Attorney) and</p>	F 157		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157	<p>Continued From page 3</p> <p>a message was left. The Note further stated, would notify the Physician of behaviors.</p> <p>Interview on 05/13/10 at 10:45 PM with LPN #4 revealed she was the Nurse Manager on the unit at the time she witnessed the incident on 11/28/09. She stated, she left a message for the Physician on 11/28/09 related to Resident #5's behavior and notified the Physician on 12/01/10. Further review of the medical record revealed LPN #4 sent a communication sheet to the Physician to inform him of the residents behaviors on 12/01/09.</p> <p>Review of the Nurse's Notes dated 11/30/09 at 9:20 PM revealed the resident had one episode of inappropriate behaviors sexually. "Aide seen resident putting hands on a female residents legs rubbing them. Told it was not appropriate. Resident stated "OK, it won't happen again".</p> <p>Further interview on 05/13/10 at 11:00 AM with LPN #3 revealed Resident #5 was rubbing a female residents thigh on 11/30. She stated, she documented the incidents in the chart and did not feel the need to notify the physician of the behaviors. She stated she just notified the families of the residents of the incidents; however, there was no documented evidence Resident #5's family was notified.</p> <p>Review of the Nurse's Notes dated 02/21/10 at 3:00 PM revealed the resident was groping a female resident, and redirection was effective. The Note further stated the female resident was visibly upset.</p> <p>Interview on 05/13/10 at 5:20 PM with LPN #2, revealed she had documented the incident on</p>	F 157		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
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 157	Continued From page 4 02/21/10. She stated Resident #11 got upset and was making a moaning sound. The LPN stated she did not notify the Physician or responsible parties. Interview on 05/12/10 at 10:00 AM with the Director of Nursing (DON), revealed she was aware of the incidents on 11/26 related to Resident #5's behavior. She further stated she had witnessed the incident on 11/30/09 related to Resident #5's behavior towards Resident #11. Continued interview, revealed she thought the Physician had been notified a few times related to Resident #5's behaviors; however, may not be aware of all the behaviors. The DON indicated the resident was being followed by Psychiatric Services; however, after reviewing the medical record there was no evidence of the resident receiving a Psychiatric Consult. Interview on 05/13/10 at 2:30 PM with the Attending Physician/Medical Director revealed he was aware of some incidents related to Resident #5's behavior towards female residents; however was unaware of all the residents behaviors. He stated, if he had been notified of all Resident #5's behaviors, he would have attempted to obtain behavioral counseling for the resident.	F 157		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	<p>Continued From page 5</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse, or injuries of unknown source were reported immediately to the Administrator of the facility and to State Agencies in accordance with state law. Also, the facility failed to have an effective system to ensure allegations of abuse</p>	F 225		

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

PRINTED: 05/27/2010
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 05/13/2010
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 225	<p>Continued From page 6</p> <p>were thoroughly investigated and/or to ensure protection of residents from potential abuse while the investigation was in progress for four (4) of sixteen (16) sampled residents (Residents #5, #11, #12, and #14).</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Reporting abuse, Neglect and Misappropriation", dated 05/01/06 revealed "it is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management". "In a case of any allegation or reasonable suspicion of resident abuse, neglect, or misappropriation of resident property, the Administrator or designee will prepare and submit the findings to the State Survey Agency and law enforcement agencies".</p> <p>1. Record review for Resident #5 revealed diagnoses which included Dementia, Left Above the Knee Amputation, and Intracranial Hemorrhage. Review of the Annual Minimum Data Set (MDS) dated 04/10/10 revealed the facility assessed the resident as having short term memory loss, and moderate impairment in cognitive skills for decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance to transfer, as being unable to ambulate, and as requiring extensive assistance with dressing, and hygiene</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 04/16/10 revealed</p>	F 225		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	<p>Continued From page 7</p> <p>Resident #5 was hard of hearing and was alert and oriented to self only. The RAPS further stated the resident could propel the wheelchair on the unit and required extensive assistance with most Activities of Daily Living (ADLs).</p> <p>Review of the Plan of Care dated 04/10/10 revealed Resident #5 had inappropriate physical and sexual behaviors related to an attempt to hit another resident and sexual advances to another resident. The goal stated the resident would have less than one episode of behavior the next month. The interventions included; calmly redirecting and providing another location to redirect behavior, documenting behaviors every shift, and notifying the interdisciplinary team as needed.</p> <p>Review of the Nurse's Notes dated 11/26/09 at 9:00 PM revealed Resident #5 was seen in the hallway by an aide, reaching hands up a female residents skirt. The Note further stated Resident #5 was spoken to and told it was disrespectful and inappropriate and the resident stated, "Ok, I'm sorry, I won't do it again".</p> <p>Interview on 05/12/10 at 9:00 AM with Certified Nursing Assistant #1 revealed she had witnessed Resident #5 to place his/her hand up Resident #14's skirt on 11/26/10. She stated she reported the incident to the nurse and removed Resident #5 from the situation. She stated the resident could be inappropriate with female residents and some staff. She further stated the incident could have been considered sexual harassment or abuse; however, she was unsure if the act was intentional due to the residents confusion.</p> <p>Interview on 05/13/10 at 12:00 PM with LPN #3 revealed she had documented the entry on</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	<p>Continued From page 8</p> <p>11/26/10. She stated Resident #5 was rubbing a female residents leg under her skirt. She stated the female resident had on a long skirt and Resident #5's hand was on the female resident's knee; however, she could not remember which female resident was involved. She stated she was unsure if the incident would be considered sexual harassment or sexual abuse and did not feel the need to notify the physician or the Administrator.</p> <p>Review of the Nurses' Notes dated 11/28/09 at 4:00 PM revealed it was reported by an aide, the resident was in the hallway with hands between a female residents legs. The Note further stated, staff intervened and separated the residents. The resident was spoken to regarding behavior and a call was placed to a POA (Power of Attorney) and a message was left and would notify the Physician of the behaviors.</p> <p>Interview on 05/13/10 at 10:45 PM with LPN #4 revealed she was the Nurse Manager on the unit at the time she witnessed the incident on 11/28/09. She stated Resident #5 had his/her hand on Resident #11's thigh. She stated she wrote up an Unusual Occurrence Report and handed it to the previous Director of Nursing for further investigation and also verbally reported the incident to the previous DON. She further stated, she left a message for the Physician on 11/28/09 related to Resident #5's behavior and notified the Physician on 12/01/10. Continued interview revealed she felt the incident could be considered abuse, and if abuse was witnessed a Report was to be written up and the Director of Nursing (DON) and Administrator were to be notified.</p> <p>Review of the Nurse's Notes dated 11/30/09 at</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010	
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 225	<p>Continued From page 9</p> <p>9:20 PM revealed the resident had one episode of inappropriate behaviors sexually. "Aide seen resident putting hands on a female residents legs rubbing them. Told it was not appropriate. Resident stated "OK, it won't happen again".</p> <p>Further interview on 05/13/10 at 11:00 AM with LPN #3 revealed Resident #5 was rubbing a female residents thigh on 11/30; however, the LPN could not recall which female resident. She stated Resident #5 was easily redirected and she did not remember the female resident getting upset. She stated she was unsure if this incident would be considered sexual harassment or sexual abuse. LPN #3 stated she documented the incidents in the chart and did not notify the physician or Administration of the incident.</p> <p>Review of the Nurse's Notes dated 02/21/10 at 3:00 PM revealed the resident was groping a female resident, and redirection was effective. The Note further stated the female resident was visibly upset.</p> <p>Interview on 05/13/10 at 5:20 PM with LPN #2, revealed she had documented the incident on 02/21/10. She stated Resident #5 had his/her hand on Resident #11's thigh. She stated Resident #11 got upset and was making a moaning sound. She further stated Resident #11 was very confused and the nurse comforted the resident. She stated she did not feel the incident was sexual harassment or sexual abuse because of Resident #5's confusion. She stated she did not notify the DON or Administrator because she did not feel the incident was intentional or that Resident #5 was seeking out Resident #11.</p> <p>Interview with Resident #5 was attempted on</p>	F 225		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	<p>Continued From page 10 05/13/10 at 3:00 PM. However, the interview was unsuccessful due to the resident's hearing loss.</p> <p>Interview on 05/12/10 at 10:00 AM with the Director of Nursing (DON), revealed she was aware of the incidents on 11/26 related to Resident #5's behavior towards Resident #14. She further stated she had witnessed the incident on 11/30/09 related to Resident #5's behavior towards Resident #11. She stated she was the Assistant DON at the time of the incidents and she thought she had notified the previous DON of Resident #5's behaviors. She further stated she had notified the staff two to three (2-3) months ago to watch Resident #5 for behaviors. Continued interview revealed Resident #5 was confused and did not intentionally "pick out" certain residents. Further interview indicated the DON was unsure if the incidents should have been called into state agencies due to the resident being easily redirected. Continued interview revealed she was unaware of the residents behaviors on 11/28/10, and 02/21/10. Further interview revealed these behaviors should have been documented on the twenty-four hour report to ensure communication between nurses and Administration.</p> <p>Further interview with the DON on 05/13/10 at 9:50 AM revealed the Social Services Director (SS Director) was in charge of abuse and was to be notified of any behavior problems. She stated the communication from nursing to social services was to post a note on the SS Directors door, by word of mouth, or by phone. Continued interview, revealed falls, behaviors and other incidents were discussed daily except Wednesdays in the Stand Up Meetings and weekly in the Interdisciplinary Team Meetings</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/19/2010
--	---	--	---

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 225	<p>Continued From page 11 (IDT's). She stated, she and the Social Services Director attended the IDT Meetings and the Stand Up Meetings.</p> <p>Interview on 05/12/10 at 10:30 AM with the SS Director revealed she attended the IDT Meetings, and Stand Up meetings and was unaware of Resident #5's behaviors towards female residents. She stated Resident #5's, #11's, and #14's Plan of Care should have been revised to include thirty (30) minute checks for protection of the residents after the incidents. In addition, she stated Resident #5 should have had a Psychiatric consult done related to behaviors towards female residents. Continued interview, revealed she and the Administrator should have been notified of each incident. She stated she would have investigated the allegations and notified state agencies within twenty-four hours of the alleged abuse. Continued interview revealed, to touch another resident without permission could be considered sexual abuse or sexual harassment.</p> <p>Interview on 05/13/10 at 2:30 PM with the attending Physician/Medical Director revealed he was aware of some incidents related to Resident #5's behavior towards female residents; however was unaware of all the residents behaviors. He stated, if he had been notified of all Resident #5's behaviors, he would have attempted to obtain behavioral counseling for the resident. He stated he was not sure if Resident #5's behaviors towards the female residents would be considered abuse. Continued interview revealed nursing should ensure Administration was aware of any alleged abuse, and Administration should notify the state agencies. He was unaware there was a problem with the facility following the abuse policy.</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	<p>Continued From page 12</p> <p>2. Review of Resident #12's medical record revealed diagnoses which included Dementia. Review of the Annual Minimum Data Set Assessment dated 02/26/10 revealed the facility assessed the resident as having both short and long term memory loss and as being moderately impaired in cognitive skills for decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance with Activities of Daily Living (ADLs) and as being unable to ambulate.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 02/26/10 revealed the resident was confused to time and place, had difficulty finding words or finishing thoughts and received antidepressant medication for depression.</p> <p>Review of the Plan of Care dated 02/26/10 revealed the resident had confusion to time and place and was tearful at times. The interventions included giving reassurance and support during tearful confused episodes.</p> <p>Review of the Nurse's Notes dated 02/07/10 revealed Resident #12's daughter reported bruises of unknown origin on the resident's left hand and right forearm. The Note further stated, there was a large ecchymotic site to the right forearm. Continued review of the Note revealed the daughter reported Resident #12 was upset due to someone running into the resident on purpose. "No recent incidents documented. No treatment required. Will monitor for safety".</p> <p>Interview on 05/13/10 at 12:00 PM with Registered Nurse (RN) #1 revealed she had</p>	F 225		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	<p>Continued From page 13</p> <p>documented the entry on 02/07/10. She stated if there was an injury of unknown source she would monitor for pain and call the Physician for an x-ray or treatment if needed. She further stated, Resident #12's bruises were large; however she did not measure the bruises. Continued interview revealed she did not remember reporting or investigating the bruises and "abuse wouldn't come to mind".</p> <p>Interview with the DON on 05/13/10 at 10:00 AM revealed she was unaware of the incident related to the bruising on 02/07/10, and also unaware of Resident #12 slapping another resident on 02/10/10. She stated there were no investigations completed related to the incidents; however, the abuse policy should have been implemented.</p> <p>Interview on 05/13/10 at 11:40 AM with the SS Director revealed she was also unaware of the incidents related to Resident #12 on 02/07/10 and 02/10/10. She further stated she should have been notified of both incidents, and the incidents should have been reported to state agencies and investigated as alleged abuse.</p> <p>Interview on 05/13/10 at 3:00 PM with the Administrator revealed he was unaware of Resident #5's behaviors towards Residents #11 and #14. He stated he considered the incidents related to Resident #5 placing his/her hand up a residents skirt or between a residents legs as sexual abuse. He stated he was not notified of these incidents. Further interview revealed he was not notified of the injury of unknown source related to Resident #12, and was not notified of Resident #12 slapping another resident. He stated the staff were expected to notify the DON,</p>	F 225		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 225	Continued From page 14 the SS Director, or himself of any alleged abuse. Further interview revealed the staff needed to be educated to notify Administration of any alleged abuse. Continued interview, revealed there was no system in place to monitor to ensure abuse violations were followed per policy.	F 225		
F 226 SS=E	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 and record review, it was determined the facility failed to implement their Abuse Policy and Procedures regarding protecting residents after an allegation of abuse was received, thoroughly investigating the alleged abuse, and reporting the alleged abuse to the Administrator and state agencies for four (4) of sixteen (16) sampled residents (Residents #5, #11, #12, and #14). In addition, there was no evidence the facility staff identified abuse when it occurred, and no evidence of an effective system to ensure the policy was implemented. Allegations of abuse were reported to the nursing staff involving Residents #5, #11, #12, and #14. However, there was no evidence the facility identified, investigated and reported alleged abuse to the Administrator and state agencies. The facility's failure to implement the Abuse Policy and Procedures, all residents were at risk for further mistreatment, neglect, and abuse.	F 226		

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

PRINTED: 05/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	---	--	---

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	<p>Continued From page 15</p> <p>The findings include:</p> <p>Review of the facility "Resident to Resident Abuse" policy revealed "should a resident be observed/ accused of abusing another resident, our facility will implement the following actions:", remove the transgressor from the situation, counsel the resident to determine the cause of the behavior, evaluate the circumstances leading up to the incident, inform all staff involved in the care of the resident of the care plan and to promptly report behavioral changes to the charge nurse, document in the residents record all interventions and their effectiveness, complete an incident report and document findings and any corrective actions taken, report incidents, findings, and corrective measures to appropriate agencies.</p> <p>Review of the facility's "Abuse Policy and Procedures" revealed employees, consultants and/ or physicians must report any suspected abuse or incidents of abuse to the administrator immediately or to the the Director of Nursing (DON), Unit Manager Social Worker, Nursing Supervisor or Employees Department Manager. The facility Administrator or designee would be responsible to ensure a thorough and immediate investigation was conducted. The Policy further stated, the Administrator or designee would prepare and submit the findings to the State Survey Agency.</p> <p>1. Review of the Nurse's Notes dated 11/26/09 at 9:00 PM revealed Resident #5 was seen in the hallway by an aide, reaching hands up a female residents skirt. Interview on 05/13/10 at 12:00 PM with LPN #3 revealed she was unsure if the incident would be considered sexual harassment</p>	F 226		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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	<p>Continued From page 16</p> <p>or sexual abuse and she did not remember reporting it to the Administrator. She stated, she documented the incidents in the chart and did not feel the need to notify the physician.</p> <p>Review of the Nurses' Notes dated 11/28/09 at 4:00 PM revealed it was reported by an aide, the resident was in the hallway with hands between a female residents legs. Interview on 05/13/10 at 10:45 PM with LPN #4 revealed she witnessed the incident on 11/28/09 and wrote up an Unusual Occurrence Report and handed it to the previous Director of Nursing (DON) for further investigation and also verbally reported the incident to the previous DON. Continued interview revealed she felt the incident could be considered abuse, and if abuse was witnessed a Report was to be written up and the DON and Administrator were to be notified. However, interview with the Administrator on 05/13/10 at 3:00 PM revealed he was unaware of the incident.</p> <p>Review of the Nurse's Notes dated 11/30/09 at 9:20 PM revealed the resident had one episode of inappropriate behaviors sexually. Interview on 05/13/10 at 11:00 AM with LPN #3 revealed she was unsure if the incidents on 11/30 and 11/26 would be considered sexual harassment or sexual abuse and did not recall reporting the incident to Administration.</p> <p>Review of the Nurse's Notes dated 02/21/10 at 3:00 PM revealed the resident was groping a female resident, and redirection was effective. The Note further stated the female resident was visibly upset. Interview on 05/13/10 at 5:20 PM with LPN #2, revealed she did not feel the incident was sexual harassment or sexual abuse because of Resident #5's confusion. She stated</p>	F 226		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	<p>Continued From page 17</p> <p>she did not notify the DON or Administrator because she did not feel the incident was intentional.</p> <p>Interview on 05/12/10 at 10:00 AM with the Director of Nursing (DON), revealed she was aware of the incidents on 11/26 related to Resident #5;s behavior towards Resident #14. She further stated she had witnessed the incident on 11/30/09 related to Resident #5's behavior towards Resident #11. Continued interview revealed, she was the Assistant DON at the time and thought the incidents had been reported to the previous DON for investigation. Further interview, revealed the DON was unsure if the incidents should have been called into state agencies due to the resident being easily redirected. Continued interview revealed she was unaware of the residents behaviors on 11/10/09, 11/17/09, 11/28/10, and 02/21/10.</p> <p>Interview on 05/12/10 at 10:30 AM with the Social Service Director (SS Director) revealed she was unaware of Resident #5's behaviors towards female residents. She stated Resident #5's, #11's, and #14's Plan of Care should have been revised to include thirty (30) minute checks for protection of the residents after the incidents. In addition, she stated Resident #5 should have had a Psychiatric consult done related to behaviors towards female residents. Continued interview, revealed she and the Administrator should have been notified of each incident. She stated she would have investigated the allegations and notified state agencies within twenty-four hours of the alleged abuse.</p> <p>Interview on 05/13/10 at 2:30 PM with the attending Physician/Medical Director revealed he</p>	F 226		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
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	<p>Continued From page 18</p> <p>was aware of some incidents related to Resident #5's behavior towards female residents; however was unaware of all the residents behaviors and the allegations of abuse. He stated, if he had been notified of all Resident #5's behaviors, he would have attempted to obtain behavioral counseling for the resident. Continued interview, revealed the Medical Director was unaware there was a problem with the facility following the abuse policy.</p> <p>2. Review of the Nurse's Notes dated 02/07/10 revealed Resident #12's daughter reported bruises of unknown origin on the resident's left hand and right forearm. The Note further stated, there was a large ecchymotic site to the right forearm. Continued review of the Note revealed the daughter reported Resident #12 was upset due to someone running into the resident on purpose. Interview on 05/13/10 at 12:00 PM with Registered Nurse (RN) #1 revealed she did not remember reporting or investigating the bruises and "abuse wouldn't come to mind". Continued interview revealed she did not remember having abuse training at the facility.</p> <p>Interview with the DON on 05/13/10 at 10:00 AM revealed she was unaware of the incident related to the bruising on 02/07/10. She stated there were no investigations completed related to the incident; however, the abuse policy should have been implemented.</p> <p>Interview on 05/13/10 at 11:40 AM with the SS Director revealed she was also unaware of the incident related to Resident #12 on 02/07/10. She further stated she should have been notified of the incident, and the incident should have been reported to state agencies and investigated as</p>	F 226		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 19 alleged abuse.	F 226		
F 250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure medically-related social services to assure the highest practicable physical, mental, and psychosocial well-being of residents was attained and/or maintained for four (4) of sixteen (16) sampled residents (Resident #5, #11, #12, and #14). Resident #5 displayed sexual behaviors towards female residents; however, the facility failed to provide Resident #5 with social service. Additionally, there was no documented evidence medically related social services were provided to the residents in which Resident #5 displayed</p>	F 250		

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

PRINTED: 05/27/2010
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 05/13/2010
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 250	<p>Continued From page 20</p> <p>sexual behaviors toward (Resident #11, and #14). Also, there was no documented evidence Resident #12 received medically related social services after the resident's daughter reported the resident bruises of unknown origin and the possibility that someone had purposely run into the resident.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Resident to Resident Abuse" revealed, should a resident be observed/ accused of abusing another resident, the facility would implement the following actions: consult psychiatric services for assistance in assessing the resident and developing a care plan for intervention and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team.</p> <p>1. Review of the Nurse's Notes dated 11/26/09 at 9:00 PM revealed Resident #5 was seen by an aide, reaching hands up a female residents skirt. Interview on 05/12/10 at 9:00 AM with Certified Nursing Assistant #1 revealed she had witnessed Resident #5 to place his/ her hand up Resident #14's skirt on 11/26/10.</p> <p>Review of the Nurses' Notes dated 11/28/09 at 4:00 PM revealed it was reported by an aide, the resident was in the hallway with hands between a female residents legs. Interview on 05/13/10 at 10:45 PM with LPN #4 revealed Resident #5's hand was on Resident #11's thigh.</p> <p>Review of the Nurse's Notes dated 11/30/09 at 9:20 PM revealed the resident had one episode of inappropriate behaviors sexually. "Aide seen</p>	F 250		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 250	<p>Continued From page 21</p> <p>resident putting hands on a female residents legs rubbing them. Interview on 05/13/10 at 11:00 AM with LPN #3 revealed Resident #5 was rubbing a female residents thigh on 11/30; however, the LPN could not recall which female resident.</p> <p>Review of the Nurse's Notes dated 02/21/10 at 3:00 PM revealed the resident was groping a female resident, and redirection was effective. The Note further stated the female resident was visibly upset. Interview on 05/13/10 at 5:20 PM with LPN #2, revealed she had documented the incident on 02/21/10. She stated Resident #5 had his/ her hand on Resident #11's thigh. She stated Resident #11 got upset and was making a moaning sound.</p> <p>Review of Resident #5's Plan of Care dated 04/10/10 revealed the resident had inappropriate physical and sexual behaviors related to an attempt to hit another resident and sexual advances to another resident. The goal stated the resident would have less than one episode of behavior the next month. The interventions included; calmly redirecting and providing another location to redirect behavior, documenting behaviors every shift, and notifying the interdisciplinary team as needed.</p> <p>Interview on 05/12/10 at 10:00 AM and 05/13/10 at 9:50 AM with the Director of Nursing (DON), revealed she was aware of the incidents on 11/26/09 and 11/30/09 and thought the incidents had been reported to the previous Director of Nursing. She stated she had notified the staff two to three (2-3) months ago to watch Resident #5 for behaviors. Continued interview revealed she was unaware of the residents behaviors on 11/28/10, and 02/21/10. She stated Resident</p>	F 250		
-------	--	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 250	<p>Continued From page 22</p> <p>#5's behaviors should have been documented on the twenty-four hour report and on an Incident Report to ensure communication between nurses and Administration.</p> <p>Further interview with the DON revealed the Social Services Director was to be notified of any behavior problems. She stated the communication from nursing to social services was to post a note on the SS Directors door, by word of mouth, or by phone. Continued interview, revealed there was no behavior monitoring except to document behaviors in the Nursing Progress Notes. She stated the Unit Mangers were to review the Nurses Progress Notes on a regular basis; however, the previous Unit Manager for Resident #5's Unit had not been reviewing the Progress Notes. Continue interview, revealed falls, behaviors and other incidents were discussed daily except Wednesdays in the Stand Up Meetings and weekly on Wednesdays in the Interdisciplinary Team Meetings (IDT's). She stated, she and the Social Services Director attended the IDT Meetings and the Stand Up Meetings.</p> <p>Interview on 05/12/10 at 10:30 AM with the SS Director revealed she attended the IDT Meetings, Stand Up meetings, and Care Plan Meetings and communicated with nursing related to behavior problems in the meetings. She stated she was unaware of Resident #5's behaviors towards female residents and she only read the Nurse's Progress Notes thirty (30) days prior to when the Minimum Data Set (MDS) was due. Further interview revealed, Resident #5's, #11's, and #14's Plan of Care should have been revised to include thirty (30) minute checks for protection of the residents after the incidents, and the female</p>	F 250		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 250	<p>Continued From page 23</p> <p>residents should have received comfort and observation for mood/behavior changes. She further stated, Resident #5 should have had a Psychiatric consult done related to behaviors towards female residents. Continued interview, revealed she should have been notified of each incident. She stated, to touch another resident without permission could be considered sexual abuse or sexual harassment.</p> <p>Interview on 05/13/10 at 4:45 PM with the Safety Committee Chairman, revealed she reviewed the IDT Meeting Notes and found no information related to Resident #5's behaviors.</p> <p>Interview was attempted with Resident #11 on 05/13/10 at 4:40 PM; however the resident was unable to communicate. Record Review for Resident #11 revealed there were no entries related to the incidents which occurred on 11/28/09 and 02/21/10.</p> <p>Review of the closed record for Resident #14 revealed there were no entries related to the incident which occurred on 11/26//09.</p> <p>2. Review of Resident #12's medical record a Nurse's Notes dated 02/07/10 which stated Resident #12's daughter reported bruises of unknown origin on the left hand and right forearm. Further review of the Note revealed, there was a large ecchymotic site to the right forearm. The Note further stated, the daughter reported Resident #12 was upset due to someone running into the resident on purpose. Interview on 05/13/10 at 12:00 PM with Registered Nurse (RN) #1 revealed she did not remember reporting or investigating the bruises and "abuse wouldn't come to mind".</p>	F 250		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
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 250	<p>Continued From page 24</p> <p>Further review of the record, revealed a Nurse's Note dated 02/10/10 at 4:00 PM, which revealed Resident #12 slapped another resident at a social.</p> <p>Interview with the DON on 05/13/10 at 10:00 AM revealed she had not been notified of the bruising of unknown origin on 02/07/10 for Resident #12, or that Resident #12 slapped another resident on 05/13/10.</p> <p>Interview on 05/13/10 at 11:40 AM with the SS Director revealed she was unaware of the incidents related to Resident #12 on 02/07/10 and 02/10/10. She stated she should have been notified of both incidents, and the incidents should have been reported to state agencies and investigated as alleged abuse.</p> <p>Interview on 05/13/10 at 3:00 PM with the Administrator revealed he was unaware of Resident #5's behaviors towards Residents #11 and #14 and stated he had not been notified of the incidents. He stated he considered the incidents related to Resident #5 placing his/her hand up a residents skirt or between a residents legs as sexual abuse. Further interview revealed he was not notified of the injury of unknown source related to Resident #12, and was not notified of Resident #12 slapping another resident. The Administrator stated, the staff were expected to notify the DON, the SS Director, or himself of any alleged abuse. Further interview revealed the staff needed to be educated to notify Administration of any alleged abuse.</p> <p>There was no documented evidence of an effective system in place to monitor behaviors,</p>	F 250		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 250	Continued From page 25 and communicate behavior changes or alleged abuse to the Director of Nursing, Social Services or the Administrator in order for residents to receive medically related social services. In addition, there was no documented evidence Resident #5, 11, #12, and #14 received medically related social services after allegations of alleged abuse.	F 250		
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the Plan of Care was revised for one (1) of sixteen (16) sampled residents (Residents #5). Resident #5	F 280		

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

PRINTED: 05/27/2010
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 05/13/2010
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 280	<p>Continued From page 26</p> <p>was observed by staff to have episodes of inappropriate behaviors towards female residents. There was no documented evidence the Plan of Care was reviewed and revised to ensure the interventions were effective.</p> <p>The findings include:</p> <p>1. Review of Resident #5's clinical record revealed diagnoses which included Dementia, Left Above the Knee Amputation, and Intracranial Hemorrhage. Review of the Annual Minimum Data Set (MDS) Assessment dated 04/10/10 revealed the facility assessed the resident as having short term memory loss, and moderate impairment in cognitive skills for decision making.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 04/16/10 revealed Resident #5 was hard of hearing and was alert and oriented to self only. The RAPS further stated the resident could propel the wheelchair on the unit and required extensive assistance with most Activities of Daily Living (ADL's).</p> <p>Review of the Plan of Care dated 11/17/09 revealed the resident had inappropriate sexual behaviors. The goal stated the inappropriate sexual behaviors would decrease or stop by 12/17/09. The interventions included monitoring the resident when around other residents, redirecting the resident if behaviors were noted, document any behaviors, and notify social services and Administration. The Plan was discontinued with a note stating no further episodes. There was no date for discontinuation of the Plan of Care.</p> <p>Review of the medical record revealed</p>	F 280		

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

PRINTED: 05/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185955	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	---	--	---

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 280	<p>Continued From page 27</p> <p>inappropriate sexual behaviors were noted on 11/26/10, 11/28/10, 11/30/10, and 02/21/10 (Refer to F-225). There was no evidence the Plan of Care dated 11/17/09 had been reviewed or revised when inappropriate sexual behaviors were noted by staff.</p> <p>Interview with the DON on 05/13/10 at 9:50 AM revealed the Plan of Care should have been updated to include all behaviors and revised as needed with new interventions. She stated, the nurse who received a Physician's Order or finds a concern was responsible for revising the Plans of Care. She further stated the Unit Managers were responsible for reviewing the Nurse's Progress Notes and Plans of Care to ensure they had been revised appropriately; however, the Unit Manager on Resident #5' unit was new and had not had a chance to complete the reviews, and the prior Unit Manager was unable to ensure tasks were completed.</p> <p>Review of the Plan of Care dated 04/10/10 revealed Resident #5 had inappropriate physical and sexual behaviors related to an attempt to hit another resident and sexual advances to another resident. The goal stated the resident would have less than one episode of behavior the next month.</p> <p>The interventions included; calmly redirecting and providing another location to redirect behavior, documenting behaviors every shift, and notifying the interdisciplinary team as needed</p> <p>Further interview with the DON on 05/13/10 at 9:50 AM revealed the Plans of Care dated 11/17/09 and 04/10/10 included redirection which meant to take the resident to the resident's room and offer coffee and tobacco which the resident</p>	F 280		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 280	Continued From page 28 enjoyed. However, there were no specific individualized interventions on the Plans of Care related to re-direction. Interview with the SS Director on 05/12/10 at 10:30 AM and 05/13/10 at 11:40 AM revealed she completed the Minimum Data Set (MDS) Assessments and Plan of Care related to Mood and Behavior. She stated she read the Nurse's Notes for thirty days prior to completing the MDS; however, did not read Nurse's Notes on a regular basis. She stated she attended the IDT Meetings, and Stand Up meetings; however was unaware of Resident #5's behaviors towards female residents. She stated Resident #5's Plan of Care dated 11/17/09 and 04/10/10 should have been revised to include thirty (30) minute checks for protection of the residents after incidents of inappropriate behavior. In addition, she stated Resident #5's Plan of Care should have had an intervention for a Psychiatric consult done related to behaviors towards female residents. She further stated the Plan of Care should have been monitored and revised when interventions were noted to be ineffective.	F 280		
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:	F 323		

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

PRINTED: 05/27/2010
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 05/13/2010
--	---	--	---

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 29</p> <p>Based on observation, interview, and record review it was determined the facility failed to provide a safe environment related to items left unattended which could pose a danger to the residents.</p> <p>The findings include:</p> <p>Observation on initial tour on 05/11/10 at 12:45 PM revealed the general bathroom on the B wing had an unlocked cabinet which contained a tube of Calmoseptine Ointment. The label on the Ointment stated, keep out of reach of children and if ingested contact physician or Poison control. The unlocked cabinet also contained a can of Pantene Hairspray with a label which stated, keep out of the reach of children.</p> <p>Continued observation on initial tour on 05/11/10 at 12:50 PM revealed the general bathroom on the A wing had an unlocked cabinet positioned low over the toilet on the wall which contained a disposable razor and a sharps container containing disposable razors. The unlocked cabinet also contained a bottle of baby oil and a can of shave cream which both contained labels stating, keep out of the reach of children.</p> <p>Further observation while on initial tour on 05/11/10 at 12:55 PM revealed the Beauty Salon door was unlocked. There was a bottle of Barbicide Disinfectant on top of the counter. Review of the Material Safety Data Sheet (MSDS) for Barbicide revealed, avoid ingestion and eye contact and keep out of the reach of children. If ingested drink one to two (1-2) glasses of water and if symptoms persist seek medical attention. Ingestion of large quantities of (greater than fifty milliliters (50 ml's)) can cause circulatory shock,</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 05/27/2010
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 05/13/2010
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 30 seek medical attention. Interview on 05/11/10 at 4:30 PM with the Director of Nursing revealed the Calmoseptine Ointment should have been in the treatment cart, and the toiletries and razors should have been in the locked cabinet in the hall. Further interview revealed the sharps container should have been up on the wall and not in the unlocked cabinet. Continued interview revealed the Beauty Shop was to stay locked. She stated the Beautician was only in the shop on Thursdays and was to lock the shop when she left. She further stated the Department Heads were to check to ensure the shop was locked periodically when passing by the door. The DON stated there was one resident in particular which was confused and wandered the halls.	F 323			

- Completed June 1, 2010.

RECEIVED
JUL - 3 2010
BY: _____

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions federal and state law.

RESPONSE TO:
F157 483.10 (b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC): SS=D

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is –

(B) A significant change is the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications.

- **#1 Resident #5 was assessed and the medical record was reviewed for any changes in condition or need to alter treatment. No additional behaviors or changes in condition were identified. Resident #5 will have a new care plan to address behavioral concerns. Resident #5 was started on 15 minute safety checks, to assure that resident #5 has been visualized by a staff member at least every 15 minutes. Once resident #5 has had a psychiatric consult, the interdepartmental team will discuss decreasing the 15 minute safety checks, based on current behavioral symptoms regarding resident #5. The safety checks will be decreased to hourly times two weeks and then discontinued, if resident #5 is not exhibiting inappropriate behaviors. The Nursing Staff has been re-educated the importance of notifying the MD of any significant condition changes. The nurses have been instructed to chart the name of the MD contacted when notification of condition changes occurs. Nurses have also been re-educated on requirements to notify the resident, legal representative and other family of behavioral changes or with any other significant change in condition for this resident. Resident #5 will be monitored for effectiveness of the planned interventions per plan of care.**
- **#2 All resident records were reviewed and there was no identification of accidents resulting in injury that require physician intervention, nor significant change in any residents' physical, mental or psychosocial status or need to alter treatment significantly that required physician notification. All cognitively impaired residents have the potential to be affected by this deficient practice. A review of care plans has been completed on all residents who have psychiatric services involved. The nurse's 24-hour reports are utilized to alert staff to cognitive declines and/or behavioral problems.**
- **#3 The nursing staff will monitor for condition changes, record and report the changes identified. This will be accomplished by the following: shift to shift nursing reporting of resident change in condition or need to alter treatments to be performed by the licensed nurses on duty each shift. A "24 hour" report form will be utilized by nurses to record behavior and**

condition changes, physician contacts and physician direction received as well as responsible party/family notification made. This information will be entered into the medical record. These forms will be reviewed daily by the Nursing Managers or designee and any necessary follow up will be performed. The Nursing Staff has been reeducated and reminded by in-service and individual instruction of the importance of communication to the physician of any significant condition changes. The professional nursing staff has been individually educated on charting the name of the physician who was contacted. Nurses have also been re-educated on the importance of notifying families and or legal guardians of accidents with injuries, significant condition changes or a need to alter treatments.

- #4 Any resident identified as exhibiting behaviors will be reviewed by the Interdisciplinary Team monthly and plans of care updated as indicated. Effectiveness of the behavior management program will be evaluated by the Interdisciplinary Team. A 25% review of all resident records monitoring for condition or behavior changes, need to alter treatment and presence of physician and or family notifications will be conducted. The Interdisciplinary team members will be assigned records to audit by the DON. The DON will supervise the audit process. Any noted concerns will be addressed promptly at the direction of the DON and/or Administrator. The Quality Assurance Committee will review results of the record audits, note that appropriate notification was made and make any additional necessary recommendations at the quarterly meetings.
- #5 Compliance with F157 completed June 25, 2010.

RESPONSE TO:
F225 483.13(c)(1)(ii)-(iii), (c)(2) -- (4) INVESTIGATE/REPORT
ALLEGATIONS/INDIVIDUALS: SS=E



The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

- #1 Residents' #5, #11, and #12 have all been assessed thoroughly, which included a review of the medical record. Resident #14's medical records were not reviewed related to resident #14 expired on 3/12/10. Resident #5 will have a new care plan to address behavioral concerns. Resident #5 will have a psychiatric consult on June 29, 2010. Resident #5 was started on 15 minute safety checks, to assure that resident #5 has been visualized by a staff member at least every 15 minutes. Once resident #5 has had a psychiatric consult, the interdepartmental team will discuss decreasing the 15 minute safety checks, based on current behavioral symptoms regarding resident #5. The safety checks will be decreased to hourly times two weeks and then discontinued, if resident #5 is not exhibiting inappropriate behaviors. Nurses have been re-educated on requirements to notify the Administrator, DON or Social Services Director, Physician and family of resident behavioral changes. Nursing staff have been educated on completion of the resident, abuse, neglect, misappropriation and investigation form for any incident of suspected abuse including sexual abuse. (Form is attachment#1). All staff completed an abuse policy and procedure review and a quiz was completed to assure their knowledge of the P&P. Episodes of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be thoroughly investigated and reported to the proper agencies. Staff will be instructed to notify the Administrator, Social Service Director, and DON immediately, which is as soon as is practical or within the first three hours of a report of an incident. Residents #11, and #12 were thoroughly assessed for any signs of emotional distress or behavioral changes and no signs of emotional distress were noted as a result of the

incidents involving resident #5. Resident #12 was assessed in relation to the resident to resident incident and for the presence of any additional bruising. Resident #12 received a review of her behavior by the interdisciplinary team and the plan of care revised to include monitoring for behavior changes and a referral for psychological services if indicated. No additional bruising of unidentified origin was noted and continued routine observation of skin condition will continue per plan of care.

- **#2 All residents were assessed and their medical records reviewed to determine if there were any examples of not reporting of allegations of abuse to the Administrator, DON or Social Service Director and state agencies, of failure to protect the residents, and absence of investigating allegations of abuse and failure to report the findings to state agencies. No incidents were identified that required reporting as related above. All cognitively impaired or verbally impaired residents are particularly at risk and their plans of care have been revised to include appropriate monitoring for changes in their behavior (sadness, signs and symptoms of depression etc) which could indicate a concern they are unable to express. Routine (every shift and per individual plan of care) visual monitoring of these residents will occur. All alert and oriented residents are encouraged to report any negative incidents that they experience. This information will be reviewed in Resident Council meetings. All potential employees are screened prior to hire. This screening includes criminal background checks, nurse aide abuse registry checks and previous employment checks. No potential employee with a history of abuse is employed and no individual is knowingly hired who has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime. The Administrator reviews all applicants to ensure that the appropriate background checks have been performed prior to hire.**
- **#3 All new employees are oriented to the Abuse Policy and Procedure and an in-service on this policy and procedures is conducted annually for all employees. The measures put into place in addition to those mentioned above will include: Questioning of staff on the Abuse Policy and Procedure to be completed at least twice per day for the first week and at least once on each shift for one month by the Administrator**

and/or Director of Nursing and Social Services to insure all incidents of this type are reported and that the proper investigation is started/completed and the proper agencies are notified. Reports of alleged or suspected abuse are investigated by the Social Service Director. If the Social Service Director is not available the DON or Administrator will conduct the investigation.

#4 An in-service was held on June 15, 2010, to re-educate staff which was videotaped to assure all employees will receive this instruction. The DON, Social Service Director, and Safety committee Chairman conducted the in-service. (Agenda of In-service is included as an attachment). An audit will be performed on a quarterly basis by members of the Interdisciplinary Team assigned by the DON to complete a 25% review of all records to identify if appropriate reporting and investigation has occurred. Results of the audit will be reviewed by the Quality Assurance Committee for recommendations. The QA committee meets quarterly.

- #5 -Compliance with F225 to be completed by 6/25/2010.**

RESPONSE TO:
F226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC
POLICIES SS=E

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property abuse of residents and misappropriation of resident property.

- **#1 Residents' #5, 11, and 12 were assessed, medical records reviewed and their plan of care revised. Resident #14's medical record was not reviewed related to resident #14 expired on 3/12/10. Residents will receive counseling where necessary with appropriate interventions for each of the residents identified.**
- **#2 All residents' records have been reviewed to ensure there were no incidences of not reporting allegations of abuse to the Social Service Director, DON, Administrator and state agencies immediately. There were not other incidences identified upon this audit of failure to report, failure to protect, failure to thoroughly investigate allegations of abuse or report to the state agencies. Measures are taken to protect all residents which includes' the procedure followed in hiring employees. All potential employees are screened prior to hire. This screening includes criminal background checks, nurse aide abuse registry checks and previous employment checks. No potential employee with a history of abuse is employed and no individual is knowingly hired who has been convicted of a felony offence related to theft; abuse or sale of illegal drugs; abuse; neglect; or exploitation of an adult; or a sexual crime. The Administrator reviews all applicants to ensure that the appropriate background checks have been performed prior to hire. All new employees are oriented to the Abuse Policy and Procedure and an in-service on this policy and procedures is conducted annually for all employees.**
- **#3 The facility policy (Internal and External Communication of Resident Behavior Changes and Incidents of Unknown Origin) has been updated with copies posted on both nursing units for the staff to read and sign for understanding. The facility has re-implemented a facility wide tool called: Abuse Notification Form. All nursing staff has been trained on the use of form. This form requires that the**

Administrator, the Director of Nursing and Social Services Director, all to be notified within 3 hours of the occurrence, with date and time to be indicated on the form. If one of these individuals is not available the other two are responsible to notify that individual when they become available. The investigation will be started on the next day, not to exceed 24 hours. Once any of these individuals are notified, an investigation will begin and the proper agencies will be notified. The review of the policies indicated no changes were needed however the procedures for implementation needed to be adhered to and on a timely basis. All staff completed an abuse review and quiz. Episodes of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be investigated and reported to the proper agencies. An in-service will be held on June 15, 2010, to re-educate staff. All staff will complete a pre-test and a post-test to insure their understanding of the policies/procedures and the tags, which have been cited in the Form 2567. Any employee not receiving a passing grade of at least 90% on the post-test will receive individual "teaching moments", until understanding has been reached.

#4 The measures put into place in addition to those mentioned above will include: questioning of staff to be completed at least twice per day for the first week and at least once on each shift, for one month by the Administrator and or Director of Nursing and Social Service Director, to insure no incidents have gone unreported. An audit of 25% of all medical records will be performed on a quarterly basis by an assigned Quality Assurance committee member to assure that the policy and procedure to prohibit mistreatment, neglect, abuse of residents and misappropriation of their property has been appropriately implemented. This audit will occur quarterly for one year then twice per year thereafter, until assurance is verified through the Quality Assurance Committee. The DON will be responsible for assuring that the audits are completed.

#5 Compliance with F226 to be completed by June 25, 2010.

RESPONSE TO:

F250 483.15(G)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

SS=E

The facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

- **#1 Resident #5, #11, and #12 were assessed and records reviewed. Care Plans for resident #5, #11, and #12 were reviewed, evaluated and revised by the Care planning team. Resident #5 will have a psychiatric consult during the next scheduled visit that is due on June 29, 2010 to ensure compliance with the care plan(s) as written. Resident #12 received care and treatment for the bruised areas as per physician direction. Resident #12 is monitored for signs of distress or depression. A referral for counseling will be made should resident #12 demonstrate adverse emotional signs or symptoms.**
- **#2 All residents were assessed to identify any incidences where the resident's highest practicable, mental and psychosocial well being was affected. No incidences were identified. Residents will continue to be assessed by the Social Service Director per their MDS assessment schedule or upon referral to social services to identify issues that may require medically-related social services for any resident.**
- **#3 The Social Services Director will review any residents' chart that has a change of physical, mental and/or psychosocial change; in addition the Social Services Director will audit at least four charts a week to insure no changes go unreported. The Social Service Director will review the medical records every week for the first quarter and then monthly thereafter, until**

compliance has been verified by the Quality Assurance Committee. If any changes are reported or found during audits the Care planning team would be notified and any medically related services would be requested from the physician.

- **#4 The Quality Assurance Committee will review 25% of the records of all residents to identify that residents who have a change of status received the necessary intervention by Social Services and that the interventions are appropriate and timely. The QA Committee will perform this review quarterly for four quarters then semiannually until compliance is assured. Residents will be assessed as per their MDS assessment schedule by the Social Services Director to assure that change of status is identified timely as well. The 24 hour report forms are monitored by the Nursing Managers and DON daily for status changes and will alert the Social Services Director for additional assessment and intervention. A mandatory in-service has been scheduled for June 15, 2010. The Social Services Director will cover the requirements of F250 with all employees.**
- **#5 Compliance with F250 to be completed by June 25, 2010.**

RESPONSE TO:

F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING
CARE-REVICE CP SS=F

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.

- **#1 Resident #5, #11, and #12's medical records were reviewed. Care Plans for resident #5, #11, and #12 were reviewed, evaluated and revised by the Care planning team. Resident #14's medical record was not reviewed related to resident #14 expired on March 12, 2010. Resident #5 will have a psychiatric consult on June 29, 2010, during the next scheduled visit to ensure compliance with the care plan(s) as written.**
- **#2 All residents were assessed for changes in condition or behavior that would necessitate updating of plans of care as indicated by a change in the resident's physical, mental or psychosocial well-being.**
- **#3 The Social Services Director will review any residents' chart that has a change of physical, mental and/or psychosocial change upon referral or upon becoming knowledgeable of changes. Nursing 24 hour reports will be utilized to notify team members of changes in the residents' condition and to identify medical records to review. In addition the Social Services Director will audit at least four charts a week for the next quarter to insure no changes identifying care planning or SS needs/interventions go unreported or unidentified. If any changes are reported or found during audits the Care planning team would be notified and any medically related services would be requested from the physician relative to physical, mental, and/or psychosocial issues and the plan of care then revised.**
- **#4 The Quality Assurance committee will review 25% of all resident records to monitor for appropriate updates in the plans of care based on documentation in the record. The focus will be on resident change of status to verify intervention by Social Services is appropriate and timely. This audit will occur quarterly for four quarters then semiannually until compliance is assured. A mandatory in-service was held on June 15, 2010.**

The Social Services Director covered the requirements of F280 with all employees.

- #5 Compliance with F280 to be completed by June 25, 2010.

RESPONSE TO:

**F323 483.25 (h) FREE OF ACCIDENT HAZARDS/
SUPERVISION/DEVICES;**

SS=E

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.

- #1 There was no specific residents shown to be at risk for environmental safety hazards.
- #2 All residents who are deemed to be cognitively impaired, through the MDS assessment process, have the potential to be at risk for environmental safety hazards.
- #3 Actions taken to correct the deficient practice include, the following: Signs were posted in the Shower rooms on A & B wing reminding staff that personal items and potentially dangerous items (e.g. razors, Calmoseptine Ointment, hairspray etc.) are to be put away

and locked up after resident's shower. The signs were hung up on June 25, 2010. An in-service was held on June 15, 2010 to remind staff of the safety regulations and of providing a safe environment for the residents. The staffs were educated on the importance of locking all doors and cabinets. All sharp containers have been properly mounted on the wall and not in the locked cabinet.

- **#4 The safety committee and floor housekeepers will monitor the shower rooms and beauty shop daily for two weeks and then weekly thereafter to insure compliance. The housekeeping staff is to report any findings to the nurse on duty. The Nursing department will be notified of any hazards supplies/items that have been found in the shower rooms, and will be responsible for re-educating the staff, and for removing the items. The Restorative Nurse is monitoring F323 citations on a weekly basis. The Restorative Nurse is reporting any findings on a weekly basis at the Interdepartmental team meetings. Each nurse who administers treatments and utilizes the treatment cart is responsible for monitoring that all ointments are properly locked in the treatment carts. All sharp containers have been properly mounted on the wall and not in the locked cabinet. An in-service was held on June 15, 2010, with all staff concerning safety regulations and providing a safe environment for the residents. The Quality Assurance Committee will review the results of the monitoring of the treatment carts being properly locked on a quarterly basis for the next 2 quarters and then once per year to assure continued compliance. The DON will be responsible for assurance of the audits being done.**
- #5 Compliance with F323 to be completed by June 25, 2010.**

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

PRINTED: 05/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106385	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	--	--	--

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)	(X6) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on 05/13/2010. The facility was found not to meet the minimal requirements with 42 code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F."</p>	K 000		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain sprinkler heads according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 05/13/10 at 10:02 AM revealed two dirty sprinkler heads which were located in the laundry area. The Director of Maintenance was present during the observation.</p> <p>An interview with the Director of Maintenance on 05/13/10 at 10:02 AM revealed the he was unaware of the dirty sprinkler heads. The Director of Maintenance stated the sprinkler heads were cleaned monthly but in the future he would check the laundry room more frequent.</p> <p>Reference: NFPA 25 (1999 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of</p>	K 062		

RECEIVED
JUN 14 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Renee W. Deje</i>	TITLE <i>Administrator</i>	(X8) DATE <i>6/4/2010</i>
---	-------------------------------	------------------------------

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: 05/24/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	---	---	---

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
K 062 K 066 SS=F	<p>Continued From page 1</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview</p>	K 062 K 066		

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

PRINTED: 05/24/2010
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2010
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	
K 066	<p>Continued From page 2</p> <p>conducted on 05-13-2010, the facility failed to maintain a smoking policy according to NFPA standards.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 05-13-2010 at 10:43 AM, with the Director of Maintenance, observation at that time revealed that there were no metal containers with self-closing cover devices into which ashtrays could be emptied, located in the smoking areas. The smoking areas were located at the front entrance, the outside near the rear of the basement, and in the enclosed porch area.</p> <p>An interview with the Maintenance Director on 05-13-2010 at 10:43 AM revealed that Director of Maintenance was unaware of the requirements for the metal containers with self-closing devices.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited.</p>	K 066			

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

PRINTED: 05/24/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	---	---	---

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
K 066	Continued From page 3 Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 05-13-2010, the facility failed to maintain electrical wiring according to NFPA standards. The findings include:</p> <p>During the Life Safety Code survey on 05-13-2010 at 10:05 AM, with the Director of Maintenance, observation at that time revealed two electrical junction boxes in the boiler room were uncovered. An interview with the Maintenance Director on 05-13-2010 at 10:05 AM revealed that Director of Maintenance was unaware of the uncovered electrical junction boxes. Director of Maintenance stated that he would correct the problem right away.</p> <p>Refer to NFPA 70 (1999 Edition).</p>	K 147		

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

PRINTED: 05/24/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
--	---	---	---

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
K 147	Continued From page 4 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22,	K 147		

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

RESPONSE TO:

K 062 NFPA 101 Life Safety code Standard:

SS=D

Required automatic sprinkler systems are continuously maintained in a reliable operating condition and are inspected and tested periodically.

- All residents have the potential to be affected by this deficient practice.
- In addition to the Director of Maintenance checking these sprinklers on a monthly basis the Directors of Dietary and Housekeeping/Laundry will also check the sprinkler heads in their departments on a monthly basis. This will be done on a form that will be given to the Administrator and Director of Maintenance. Any sprinkler head noted out of compliance will be cleaned as soon as possible.
- The measures put into place in addition to those mentioned above will include; audit on a quarterly basis by the safety committee to insure compliance.
- Completed June 1, 2010

RECEIVED
JUN - 4 2010
BY: _____

RESPONSE TO:

**K 066 NFPA 101 Life safety Code Standard 19.7.4*Smoking
SS=F**

There were no metal containers with self-closing cover devices into which ashtrays could be emptied, located in the smoking areas.

- **This deficiency has the potential to affect all residents, staff and visitors,**
- **The proper metal containers with self-closing cover devices were ordered and have been received and are now in use where residents, staff or visitors smoke.**
- **Additional self-closing ashtrays have been ordered to replace any that may be stolen, damaged or needed in addition to those already in place. The safety committee will review to insure continued compliance and will monitor this on a monthly basis.**
- **Corrected June 1, 2010**

**RESPONSE TO;
K147 NFPA 101 Life Safety Code Standard NFPA Code 70,
National Electrical Code.9.1.2 370.28(c) Covers.**

SS=D

All pull boxes, junction boxes, and conduit bodies shall be provided with covers.

- **All residents have the potential to be affected by this deficient practice.**
- **The proper cover has been put into place by the maintenance staff. The Safety Committee will monitor this thru monthly/quarterly inspections and rounds to verify compliance.**
- **Completed June 1, 2010.**

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions federal and state law.