

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

PRINTED: 04/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/13/2011
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NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey and an Abbreviated Survey Investigating ARO#KY00016295 and ARO#KY00016230 was initiated on 04/10/11 and concluded on 04/13/11. A Life Safety Code Survey was conducted on 04/11/11. Deficiencies were cited, with the highest scope and severity being an "F". ARO#KY00016295 was substantiated with no deficiencies. ARO#KY00016230 was substantiated with deficiencies cited.</p>	F 000		
F 241 88=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to promote care in a manner and environment that maintains or enhances dignity and respect for one (1) of fifteen (15) sampled residents (Resident #9). Observation revealed Resident #9 was left unclothed and uncovered for seven (7) minutes without staff attendance.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #9 on 01/03/11 with diagnoses which included Atrial Fibrillation, Hypertension, Renal Failure, Thyroid Disorder and Dementia.</p> <p>Observation on 04/11/11 at 10:55 AM revealed</p>	F 241	<p style="text-align: center;">RECEIVED MAY - 6 2011 BY: _____</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: <i>Kenneth W. Wolf</i>	TITLE <i>Administrator</i>	(X8) DATE <i>5/4/2011</i>
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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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to consult with the resident's physician for one (1) of fifteen (15) sampled residents. Resident #4 experienced a significant weight loss and the physician was not informed.</p> <p>The findings include:</p> <p>Review of Resident #4's Weights and Vitals Summary Record revealed on December 3, 2010 revealed the resident weighed two hundred sixteen and three tenths (216.3) pounds and on March 31, 2011 the resident weighed one hundred and ninety four (194) pounds a 10.3 % weight loss. Further review of the record revealed the resident continued to lose weight as evidenced by a weight of 189 pounds on April 8, 2011.</p> <p>Observation on 04/11/2011 at 3:00PM revealed the resident's weight to be 186 pounds.</p> <p>An interview with Resident #4's physician, Physician #1, on 04/12/11 at 3 PM revealed he was not made aware of Resident #4's weight loss. Physician #1 went on to state that it would have been appropriate for the facility to notify him when Resident #4's weight was taken in March.</p>	F 157		
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 2 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to promote care in a manner and environment that maintains or enhances dignity and respect for one (1) of fifteen (15) sampled residents(Resident #9). The findings include: Record review revealed the facility admitted Resident #9 on 01/03/11 with diagnoses which included Atrial Fibrillation, Hypertension, Renal Failure, Thyroid Disorder and Dementia. Observation on 04/11/11 at 10:55 AM revealed Resident #9 lying unclothed with no one in attendance on the bed. The privacy curtains, which had about eighteen inches of netting at the top, (which allowed this writer to observe the unclothed Resident #9), were pulled and bath items were on the bedside table. Certified Nursing Assistant, (CNA) #8, bathing the roommate stated that CNA #1 went to get the nurse to do the treatment before she finished bathing Resident #9. Interview with CNA #1 on 04/11/11 at 2:45 PM revealed she should not have completely uncovered the resident while bathing the resident nor should the resident have been left alone, unclothed, while she went to get the nurse.	F 241		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323	<p>Continued From page 3 HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the resident environment remained free of accident hazards for one (1) of fifteen (15) sampled residents. Resident #6 attempted consumption of a hazardous chemical.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Notification Form dated 03/18/11 revealed on 03/18/11 at 3:28 PM Resident #6 was observed by SRNA #6 to have a half-empty container of sani-wipes mixed with water to his/her mouth attempting to drink from it. Resident #6's face and clothing were observed by SRNA #6 to be wet. It was unclear whether or not Resident #6 had in fact consumed any liquid from the container, although according to the facility's Abuse Notification Form, poison control was contacted along with the MD and Resident #6's Power of Attorney (POA). Resident #6 was assessed by facility staff, but denied any symptoms associated with consumption of product.</p> <p>Resident #6 was admitted to the facility on</p>	F 323		
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F 323	<p>Continued From page 4</p> <p>12/05/06 with diagnoses including Dementia, Chronic Airway Obstruction NEC, and Unspecified Cerebrovascular Disease. In a Quarterly Minimum Data Set (MDS) dated 01/24/11 the facility assessed Resident #6 as moderately impaired in daily decision making.</p> <p>An interview with SRNA #6 on 04/12/11 at 2:50 PM revealed Resident #6 had a history of carrying around a plastic cup which he/she would fill with water from drinking fountains. Further interview revealed that Resident #6 had been placed on thickened liquids, and was no longer able to do this. SRNA #6 went on to reveal that Resident #6 was on contact precautions on 03/18/11 due to having MRSA in his/her urine. SRNA #6 was not aware of who left the container of sani-wipes in Resident #6's room, but expressed they were left due to contact precautions. SRNA #6 revealed she went into Resident #6's room on the afternoon of 03/18/11 and discovered him/her with a wet face and shirt, with a container of sani-wipes to his lips. As the container was half-full of liquid (normally less than 10% full), and the resident was near his/her sink, it was clear to SRNA #6 that Resident #6 had filled the container with water from the sink.</p> <p>An interview with the DON on 04/12/11 at 11:13 AM revealed she was at the nurses station when SRNA #6 brought the half-empty container of sani-wipes up and reported the incident. The DON revealed she assessed Resident #6 and could see no immediate reaction. The DON went on to state that she contacted poison control and followed the guidance provided, giving Resident #6 a glass of milk to consume and continuing to monitor him/her.</p>	F 323		

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F 323	Continued From page 5 An interview with the Director of Poison Control (DPC) on 04/13/11 at 10:10 AM revealed he recommended washing the chemical down into the stomach where the stomach acid would neutralize it, and went on to say that chemical burns to the lips or oral cavity would have been an unlikely possibility from the sani wipes. An interview with LPN #3 on 04/12/11 at 12 PM revealed there were no physical changes to Resident #6, and went on to confirm that staff continued to monitor Resident #6 following the incident.	F 323			
F 325	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure acceptable parameters of nutritional status were monitored for one (1) of fifteen (15) sampled residents (Resident # 4). Resident # 4 experienced a greater than 10.0% weight loss in (3) months. Resident # 4 lost twenty two and three tenths (22.3) pounds from December 3,	F 325			

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F 325	<p>Continued From page 6 2010 to March 31, 2011 a 10.3% loss.</p> <p>The findings include:</p> <p>Review of Resident #4's Weights and Vitals Summary Record revealed on December 3, 2010 revealed the resident weighed two hundred sixteen and three tenths (216.3) pounds and on March 31, 2011 the resident weighed one hundred and ninety four (194) pounds a 10.3 % weight loss. Further review of the record revealed the resident continued to lose weight as evidenced by a weight of 189 pounds on April 8, 2011.</p> <p>Observation on 04/11/2011 at 3:00PM revealed the resident's weight to be 186 pounds.</p> <p>An interview with the Registered Dietician (RD) on 04/11/11 At 11:45 AM revealed she was not aware that Resident #4 had such a severe weight loss. She further stated she was in the building on April 8th but he had not been weighed and was eating better at that point.</p> <p>Interview with Dietary Manager on 04/11/2011 at 11:00AM revealed she did not necessarily compare the weights on residents to previous months but would write down the numbers and pass them on to the Dietician.</p>	F 325		
F 371	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371		

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to prepare, distribute and serve food under sanitary conditions which included ice scoops in ice chests and improper hand sanitation and ill fitting window screens. The findings include: Review of the Facility's Hand Washing Sheet (no date), revealed it is the policy of the facility for all personnel to utilize good hand washing technique to "control and prevent the spread of microorganisms and nosocomial infections." Further observation of this sheet revealed all employees should wash hands when coming on duty and before leaving for home, before handling food or food trays and after blowing your nose or going to the bathroom. Observation during the initial kitchen tour on 04/10/11 at 9:50 AM, revealed a plastic cup containing red liquid, sitting on the third (3rd) shelf of a kitchen dry goods storage shelf, ladles were stored bowl up in a drawer and two (2) small serving bowls were stored wet. Further observation of the kitchen on 04/10/11 at 10:35 AM revealed a Dietary Aide returned from break and began washing dishes without washing her hands. Interview with the Dietary Aide on this date and time revealed she should have washed her hands when she returned from break.	F 371			

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F 371	<p>Continued From page 8</p> <p>Further observation at 10:50 AM revealed the Cook for the day returned from the dry storage tour with this writer, donned gloves and resumed food preparation without washing hands. Interview with the Cook revealed she should have washed her hands before she continued with food preparation. Continued observation on this date and time revealed the ice scoop was stored in the ice chest in the dining room. Observation on this date at 5:45 PM revealed (2) ice chests outside the Dietary Department had ice scoops stored on top of the ice.</p> <p>Kitchen observation on 04/11/11 at the noon meal service revealed Dietary Aide #2 to take the temperatures of hot tea and hot chocolate without sanitizing the thermometer between drinks. Further observation revealed Dietary Aide #2 did not wear gloves for transport of filled food trays to the A-line cart for meal service to the dining room. Interview with Dietary Aide #2 on 04/11/11 at 12:10 PM revealed she did not have to wear gloves because she did not have direct contact with food. Further observation on this day at 12:15 PM revealed an open window over the sink with an ill fitting screen that could allow for insect or rodent entry.</p> <p>Interview with Dietary Aides #3 and #4 on 04/11/11 at 3:00 PM revealed ladle bowls need to be stored bowl down, handle out, ice scoops should not be stored in the ice. Further interview with Dietary Aides #3 and #4 revealed that proper hand sanitation included, wash hands before beginning a task, the task should be finished, remove contaminated gloves, wash hands and don clean gloves if starting a new task.</p> <p>Interview with the Dietary Manager on 04/11/11 at</p>	F 371		
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F 371	Continued From page 9 3:45 PM, revealed all kitchen staff had been educated on on how utensils and serving dishes should be stored. Further interview revealed all staff had been educated on the facility's hand washing policy. The Dietary Manager stated that food service education begins upon hire and staff are educated throughout the year and as needed. Interview with the Maintenance Supervisor on 04/12/11 at 4:30 PM revealed he had been aware of the ill fitting screen and had an estimate for replacing the screen. Interview with the Facility Administrator on 04/13/11 at 3:45 PM revealed the facility was waiting for "good" weather before the screen was replaced.	F 371			
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441			

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F 441	<p>Continued From page 10</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of fifteen (15) sampled residents (Resident #2). Resident #2 was observed to be left unclothed for six (6) to seven (7) minutes while Certified Nursing Assistant was out of the room to get the assigned nurse to do a treatment.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #9 on 01/03/11 with diagnoses which included Atrial Fibrillation, Hypertension, Renal Failure, Thyroid Disorder and Dementia.</p>	F 441		

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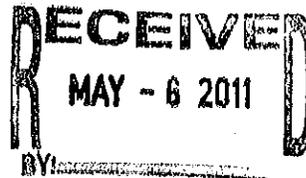
F 441	<p>Continued From page 11</p> <p>Observation on initial tour on 04/10/11 at 2:45 PM revealed Resident #9's oxygen (O2) concentrator filter to have numerous lint particles sticking all over it.</p> <p>Observation on 04/11/11 at 11:15 AM revealed Licensed Practical Nurse (LPN) #1 to do the wound care on Resident #9's buttocks without washing her hands before starting the treatment. Continued observation of wound care by LPN #1 revealed she applied ointment to Resident #9's peri-anal area then used the same gloves to apply ointment to the Resident #9's perineal area. Observation revealed there was no evidence the LPN washed her hands until she had completed the treatment.</p> <p>Interview with LPN #1 on 04/11/11 at 2:30 PM revealed she should have washed her hands, gloved, did the treatment to one (1) area, de-glove, wash hands, re-glove, do treatment on the other area, de-glove and wash hands. Further interview with LPN #1 revealed she had hand washing education upon hire and yearly or as needed.</p> <p>Review of the facility's "Hand Washing" sheet (no date), revealed staff should wash their hands when they come on duty and before they leave for home, before and after contact with wounds of any type and between contacts with different residents.</p>	F 441		
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- The maintenance department will keep a log of each item treated and the date it was treated.
- Completed June 15, 2011.

RESPONSE TO:

K 130 NFPA 101 MISCELLANEOUS OTHER LSC DEFECIENCY NOT ON 2786

- All residents have the potential to be affected by this deficient practice.
- The maintenance director has replaced the lights to insure lights work; new ones were purchased and installed.
- The maintenance director checked these lights according to code and this was not adequate to insure the lights worked when needed, there will now be weekly checks for the next month to insure the new lights continue to work properly. Monthly checks will be done after the first month to insure continued operation of the lights.
- Completed June 1, 2011



RESPONSE TO: F241 483.15(a) Dignity and Respect of Individuality: SS = D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- Resident #9 was affected by the deficient practice. Staff was provided with teaching moment to remind them that resident #9 needs to be dressed when in bed and that door and curtain are to be closed when given resident #9 care. New tracking will be hung along the ceiling (instead of on the soffit, where the curtain currently hangs). This will make the netting on the

curtains 12 inches closer to the ceiling. This has helped to protect resident #9's dignity and privacy. Resident #6 was started on the hydration program in March, 2011 with the goal being for resident #6 to consume at least an extra 240cc per day. Staff specifically was educated on offering resident #6 extra fluids.

- All resident charts were reviewed to identify other residents who have the potential to be affected. Determination was made to believe that all physically and cognitively impaired residents are at risk. However, all residents are at risk related to any resident has the potential of undressing/uncovering themselves. All resident rooms were assessed on 5/2/11 by the Administrator and the Maintenance Director for potential viewing through netting of curtains.
- All resident rooms have been checked and it was determined that rooms # A-1, A-2, A-3, A-4, A-5, A-6, A-7, A-8, A-10, and A-11 were affected. All of these rooms have new tracking hung along the ceiling (instead of on the soffit, where the curtain(s) currently hang). This has made the netting on the curtains 12 inches closer to the ceiling. Teaching moments have been written and hung up at both nurses station and at the time clock, to help educate staff on privacy, dignity, and respect of the residents. An in-service was held on 5/9/11 at 2pm, for all staff to discuss dignity, right to privacy and respect of the residents. All new hires are required to watch The University of North Carolina at Chapel Hill DVD titled: *Bathing Without a Battle* (see referencing below). The DVD focuses on simple practices to promote person-center care and dignity.
- The Director of Nursing (DON) and the QI/QA Nurse will do 4 random room checks per week for 4 weeks. Then the DON and QA/QI Nurse will do at least 1 random room check every 2 weeks for 4 weeks. Then the DON and QA/QI nurse will do at least 1 random room check per month during the next 3 quarters. Compliance will be maintained for dignity and respect of residents through random room checks with teaching moments provided when non-compliance has been noted by staff members.
- Compliance with F241 completed May 20, 2011.

References

Barrick, A. L., Rader, J., & Sloane, P. (2003). *Bathing without a battle*. North Carolina: University of North Carolina at Chapel Hill.

RESPONSE TO:

F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES: SS = D

(h)(1) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and (h)(2) each resident receives adequate supervision and assistance devices to prevent accidents.

- Resident #6 was affected by the deficient practice. On 3/18/11, after notified of possible consumption of water via sani-wipe container, a full assessment was conducted on resident #6. Poison control, MD, and POA were notified of resident found and possibly consuming water from sani-wipe container. All rooms were checked, with no other containers of sani-wipes found. Teaching moments regarding safety and proper storing of sani-wipes were hung at both A-Wing and B-Wing and by the time clock for staff to read, review, and sign. Resident #6 was given 240cc of milk by mouth at time of occurrence, based on Poison Control recommendation. Resident #6 was started on the hydration program on March 23, 2011. The program was implemented to help assure that resident #6 has fluid easily available. Resident #6's STNA care plan and Comprehensive care plan were updated to for the hydration program.
- All resident charts have been reviewed. All residents have the potential to be affected because a staff member had carried the sani-cloth wipes into resident #6's room. Residents who are at most risk for harm and/or injury include those who are cognitively impaired and those residents who are on thickened liquids.
- All resident rooms were checked to assure that no other containers of sani-cloth wipes were within resident reach. An in-service was held on 5/9/11 at

2pm, for staff to discuss F323 and to reeducate/reiterate the importance of keeping hazard materials locked up when not in use.

- On 3/23/11 a plan of correction for quality assurance was initiated. As a result of this incident, it was determined that the QA/QI nurse would monitor both wings and the nurses stations weekly times 4 weeks, then monthly times 3 months. Monitoring has been continued and has been increased to 5 times weekly times 1 week, then twice weekly times 1 monthly, and then at least once per month for the next 3 months. If sani-wipe containers are found outside of supply rooms (and not in use), teaching moments will immediately be provided to the staff responsible. A hydration program (**see attachment #2**) was initiated on March 23, 2011. All residents are offered at least 240cc of additional fluid per daily. This program was started to help increase fluid consumption for all residents and to make more fluid available to all residents. This program addresses individual residents who have been deemed as “potential for fluid volume deficit”. All residents’ are monitored and started on the hydration program, based on needs and determination is made by the nurses and/or interdepartmental team members. A policy for sani-cloth wipes (**see attachment #3**) was written and implemented on 3/30/11. This policy was placed at both nurse’s stations and by the time clock, to remind staff of the proper storage and use of the sani-cloth wipes.
- Compliance with F323 completed May 15, 2011.

RESPONSE TO:

F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY: SS = E

The facility must – (i)(1) Procure food from sources approved or considered satisfactory by federal, state, or local authorities; and (i)(2) Store, prepare, distribute, and serve food under sanitary conditions.

- No specific resident was cited in this deficient practice.
- All residents have the potential of being affected by the deficient practice. This was determined via review of citation and that all residents receive their meals via the dietary department.
- The facility has reviewed the CDC recommendations for proper hand washing. A new hand washing policy (**see attachment #4**) was implemented on 5/3/11 with the date placed on the footer of the policy. The policy does include proper technique of hand washing and that all staff must always wash their hands before handling food trays/dishes and before and after completing and starting any new task. An in-service was held on 5/20/11 for all dietary staff to discuss citations. The in-service discussed that no eating or drinking is allowed in the kitchen. The in-service also included proper storage of dry dishes, and proper infection control utilization (hand washing, ladle placement, thermometer cleaning between use, and importance of glove use). This was all discussed with dietary staff by the Dietary Manager. The in-service on 5/20/11 was conducted by the Dietician (who has been consulted throughout the whole recent survey process and citations). Some ladles were hung up on the pot and pan hanging holder. Other ladles have been thinned out of ladle drawer. Ladles that have been left in the drawer are positioned with the ladle bowl turned over and the handles facing out (this allows easy access and helps prevent contamination). A new policy (**see attachment #5**) was implemented regarding proper ice scoop storage and proper distribution of ice. New ice scoop holders were ordered for all of the ice chest (which included one in the dining room, one at A Wing nurses station, one at B Wing nurses station, and one in the employee break room. The two ice chest (which

includes the one in the dining room and the one in the break room will have the ice scoop holders mounted on the wall. Two new ice chest carts were ordered (which is for use on each of the two wings). These carts have ice scoop holders mounted to them. A teaching moment was initiated on 5/4/11 regarding proper sanitizing of the thermometer (after each use). A new policy (**see attachment #4**) was initiated regarding utilization of gloves when working in the dietary department. A new window with complete screen was ordered (with purchasing order on file) and was installed in kitchen by a contractor. The new window will help to prevent insect and/or rodent entry.

- Monitoring will be conducted through QA by the Dietary Manager. The Dietary Manager will monitor at least once weekly for one month on proper storage of dry dishes, proper hand washing, proper storage of ladles, and proper sanitation of thermometers. Then Dietary Manager will monitor the above list once biweekly for one month, then monthly times three months. The Dietary Manager will extend QA based on concerns noted. The Dietician will continue to observe and monitor for proper infection control compliance. The Dietician alerts the Dietary Manager, Administrator, and DON, when she finds concerns that need to be addressed. Personal teaching moments will be given and explained by the Dietary Manager as she observes any dietary staff not utilizing proper infection control practices.
- Compliance with F371 completed May 20, 2011.

RESPONSE TO:

F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS. SS = D

THE FACILITY MUST ESTABLISH AND MAINTAIN AN INFECTION CONTROL PROGRAM DESIGNED TO PROVIDE A SAFE, SANITARY AND COMFORTABLE ENVIRONMENT AND TO HELP PREVENT THE DEVELOPMENT AND TRANSMISSION OF DISEASE AND INFECTION.

(a) INFECTION CONTROL PROGRAM

THE FACILITY MUST ESTABLISH AN INFECTION CONTROL PROGRAM UNDER WHICH IT –

(1) INVESTIGATES, CONTROLS, AND PREVENTS INFECTIONS IN THE FACILITY;

(2) DECIDES WHAT PROCEDURES, SUCH AS ISOLATION, SHOULD BE APPLIED TO AN INDIVIDUAL RESIDENT;

(3) MAINTAINS A RECORD OF INCIDENTS AND CORRECTIVE ACTIONS RELATED TO INFECTIONS.

(b) PREVENTING SPREAD OF INFECTION

(1) WHEN THE INFECTION CONTROL PROGRAM DETERMINES THAT A RESIDENT NEEDS ISOLATION TO PREVENT THE SPREAD OF INFECTION, THE FACILITY MUST ISOLATE THE RESIDENT.

(2) THE FACILITY MUST PROHIBIT EMPLOYEES WITH A COMMUNICABLE DISEASE OR INFECTED SKIN LESIONS FROM DIRECT CONTACT WITH RESIDENTS OR THEIR FOOD, IF DIRECT CONTACT WILL TRANSMIT THE DISEASE.

(3) THE FACILITY MUST REQUIRE STAFF TO WASH THEIR HANDS AFTER EACH DIRECT RESIDENT CONTACT FOR WHICH HAND WASHING IS INDICATED BY ACCEPTED PROFESSIONAL PRACTICE.

(c) LINENS

PERSONNEL MUST HANDLE, STORE, PROCESS AND TRANSPORT LINENS SO AS TO PREVENT THE SPREAD OF INFECTION.

- Resident #9 was assessed; no change in mental or physical status noted to resident #9 and the medical record was reviewed for any changes in

condition need to alter treatment. LPN #1 was given a teaching moment regarding proper hand washing and wound care. A teaching moment was given to all nursing staff regarding proper hand washing technique.

- All residents were assessed and their medical records reviewed to determine if there were any nosocomial infections or communicable diseases noted. No incidents were identified that required reporting as related above. The hand washing policy has been updated with copies posted at each nursing station for the staff to read and sign for understanding. Staff has been instructed to ask question of the QA/QI nurse or DON, if there is any questions regarding the teaching moment on hand washing.
- The facility has developed an infection control team. The infection control team consist of the QA/QI Nurse, DON, Administrator, Medical Director, a staff nurse, and a staff STNA. The infection control committee will address any know infection control issues/concerns (at hand) on a monthly basis and then bi-monthly thereafter on second Tuesday of the month. All newly hired staff is required to watch the Mecomme Trainex: Blood borne Safety DVD. This video explains (and shows) proper hand washing techniques, Standard precautions, and Universal Precautions (**see referencing below**). In addition to this, all staff were in-serviced on hand washing and blood borne pathogens annually (according to OSHA standard/guideline: 1910.1030(g) (2) (ii) (B)). All staff were in-serviced on hand washing policy (**see attachment #4**) and random staff will demonstrate proper technique to infection control team with check off list placed in employee file. All staff were in-serviced on May 9, 2011 at 2pm. On May 6, 2011 at 2pm, nurses were in-serviced on proper infection control and wound care.
- The measures put into place in addition to those mentioned above will include: weekly review of infections at Interdisciplinary meeting and an audit on a quarterly basis by the Quality Assurance committee to ensure compliance. Random monitoring of nursing staff on wound care will be done weekly for 3 months then monthly for 3 months. Monitoring will be done by DON and/or QA/QI Nurse. Random use of glow-germ monthly on

employees will be done by DON and/or QA/QI Nurse. An in service was held on May 6, 2011 at 2pm. The in-service covered proper infection control and wound care. Another in service was held on May 9, 2011, to reeducate staff on proper infection control techniques specifically to include hand washing and wound care. Hand washing policy was reviewed by Interdepartmental team and Medical Director. Updates were made to policy based on CDC guidelines. Date for updating was placed on hand washing policy.

- Compliance with F441 completed May 15, 2011.

References

Unknown. (2003). *Blood borne safety: Universal precautions, standard precautions, and needle stick prevention in long term care*. Cypress, California: Medcomrn.

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.

902R 20:300-6(1) Section 6. Quality of Life: N113

(1) Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- Resident #9 was affected by the deficient practice. Staff was provided with teaching moment to remind them that resident #9 needs to be dressed when in bed and that door and curtain are to be closed when given resident #9 care. New tracking has been hung along the ceiling (instead of on the soffit, where the curtain currently hangs). This has made the netting on the curtains 12 inches closer to the ceiling. This has helped to protect resident #9's dignity and privacy. Resident #6 was started on the hydration program in March, 2011 with the goal being for resident #6 to consume at least an extra 240cc per day. Staff specifically was educated on offering resident #6 extra fluids.
- All resident charts were reviewed to identify other residents who have the potential to be affected. Determination was made to believe that all physically and cognitively impaired residents are at risk. However, all residents are at risk related to any resident has the potential of undressing/uncovering themselves. All resident rooms were assessed on 5/2/11 by the Administrator and the Maintenance Director for potential viewing through netting of curtains.
- All resident rooms have been checked and it was determined that rooms # A-1, A-2, A-3, A-4, A-5, A-6, A-7, A-8, A-10, and A-11 are affected. All of these rooms have new tracking hung along the ceiling (instead of on the

soffit, where the curtain(s) currently hang). This has made the netting on the curtains 12 inches closer to the ceiling. Teaching moments have been written and hung up at both nurses station and at the time clock, to help educate staff on privacy, dignity, and respect of the residents. An in-service was held on 5/9/11 at 2pm, for all staff to discuss dignity, right to privacy and respect of the residents. All new hires are required to watch The University of North Carolina at Chapel Hill DVD titled: *Bathing Without a Battle* (see referencing below). The DVD focuses on simple practices to promote person-center care and dignity.

- The Director of Nursing (DON) and the QI/QA Nurse will do 4 random room checks per week for 4 weeks. Then the DON and QA/QI Nurse will do at least 1 random room check every 2 weeks for 4 weeks. Then the DON and QA/QI nurse will do at least 1 random room check per month during the next 3 quarters. Compliance will be maintained for dignity and respect of residents through random room checks with teaching moments provided when non-compliance has been noted by staff members.
- 902 R 20:300-6(1) Section 6 completed May 20, 2011.

References

Barrick, A. L., Rader, J., & Sloane, P. (2003). *Bathing without a battle*. North Carolina: University of North Carolina at Chapel Hill.

902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life. N144

(7) Environment. (b) Infection control and communicable diseases. 2. The facility shall establish an infection control program which: a. Investigates, controls and prevents infections in the facility:

- Resident #9 was assessed; no change in mental or physical status noted to resident #9 and the medical record was reviewed for any changes in condition need to alter treatment. LPN #1 was given a teaching moment regarding proper hand washing and wound care. A teaching moment was given to all nursing staff regarding proper hand washing technique.
- All residents were assessed and their medical records reviewed to determine if there were any nosocomial infections or communicable diseases noted. No incidents were identified that required reporting as related above. The hand washing policy has been updated with copies posted at each nursing station for the staff to read and sign for understanding. Staff has been instructed to ask question of the QA/QI nurse or DON, if there is any questions regarding the teaching moment on hand washing.
- The facility has developed an infection control team. The infection control team consist of the QA/QI Nurse, DON, Administrator, Medical Director, a staff nurse, and a staff STNA. The infection control committee will address any know infection control issues/concerns (at hand) on a monthly basis and then bi-monthly thereafter on second Tuesday of the month. All newly hired staff is required to watch the Mecomme Trainex: Blood borne Safety DVD. This video explains (and shows) proper hand washing techniques, Standard precautions, and Universal Precautions (**see referencing below**). In addition to this, all staff are in-serviced on hand washing and blood borne pathogens annually (according to OSHA standard/guideline: 1910.1030(g) (2) (ii) (B)). All staff were in-serviced on hand washing policy (**see attachment #4**) and random staff will demonstrate proper technique to infection control team with check off list placed in employee file. All staff

were in-serviced on May 9, 2011 at 2pm. On May 6, 2011 at 2pm, nurses were in-serviced on proper infection control and wound care.

- The measures put into place in addition to those mentioned above will include: weekly review of infections at Interdisciplinary meeting and an audit on a quarterly basis by the Quality Assurance committee to ensure compliance. Random monitoring of nursing staff on wound care will be done weekly for 3 months then monthly for 3 months. Monitoring will be done by DON and/or QA/QI Nurse. Random use of glow-germ monthly on employees will be done by DON and/or QA/QI Nurse. An in service will be held on May 6, 2011 at 2pm on proper infection control and wound care. Another in service will be held May 9, 2011, to reeducate staff on proper infection control techniques specifically to include hand washing and wound care. Hand washing policy was reviewed by Interdepartmental team and Medical Director. Updates were made to policy based on CDC guidelines. Date for updating was placed on hand washing policy,
- Compliance with 902 KAR 20:300-6(7)(b)2.a. completed May 15, 2011.

References

Unknown. (2003). *Blood borne safety: Universal precautions, standard precautions, and needle stick prevention in long term care*. Cypress, California: Medcomrn.

902 KAR 20:300-8(7)(b) Section 8. Quality of Care. N220

(7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents.

- Resident #6 was affected by the deficient practice. On 3/18/11, after notified of possible consumption of water via sani-wipe container, a full assessment was conducted on resident #6. Poison control, MD, and POA were notified of resident found and possibly consuming water from sani-wipe container. All rooms were checked, with no other containers of sani-wipes found. Teaching moments regarding safety and proper storing of sani-wipes were hung at both A-Wing and B-Wing and by the time clock for staff to read, review, and sign. Resident #6 was given 240cc of milk by mouth at time of occurrence, based on Poison Control recommendation. Resident #6 was started on the hydration program on March 23, 2011. The program was implemented to help assure that resident #6 has fluid easily available. Resident #6's STNA care plan and Comprehensive care plan were updated to for the hydration program.
- All resident charts have been reviewed. All residents have the potential to be affected because a staff member had carried the sani-cloth wipes into resident #6's room. Residents who are at most risk for harm and/or injury include those who are cognitively impaired and those residents who are on thickened liquids.
- All resident rooms were checked to assure that no other containers of sani-cloth wipes were within resident reach. An in-service was held on 5/9/11 at 2pm, for staff to discuss F323 and to reeducate/reiterate the importance of keeping hazard materials locked up when not in use.
- On 3/23/11 a plan of correction for quality assurance was initiated. As a result of this incident, it was determined that the QA/QI nurse would monitor both wings and the nurses stations weekly times 4 weeks, then monthly times 3 months. Monitoring has been continued and has been increased to 5 times weekly times 1 week, then twice weekly times 1 monthly, and then at least once per month for the next 3 months. If sani-

wipe containers are found outside of supply rooms (and not in use), teaching moments will immediately be provided to the staff responsible. A hydration program (see attachment #2) was initiated on March 23, 2011. All residents are offered at least 240cc of additional fluid per daily. This program was started to help increase fluid consumption for all residents and to make more fluid available to all residents. This program addresses individual residents who have been deemed as "potential for fluid volume deficit". All residents' are monitored and started on the hydration program, based on needs and determination is made by the nurses and/or interdepartmental team members. A policy for sani-cloth wipes (see attachment #3) was written and implemented on 3/30/11. This policy was placed at both nurse's stations and by the time clock, to remind staff of the proper storage and use of the sani-cloth wipes.

- Compliance with 902 KAR 20:300-8(7)(b) Section 8 completed May 15, 2011.

902 KAR 20:300-10(8)(b) Section 10. Dietary Services. N283

(8) Sanitary conditions. The facility shall: (b) Store, prepare, distribute, and serve food under sanitary conditions;

- No specific resident was cited in this deficient practice.
- All residents have the potential of being affected by the deficient practice. This was determined via review of citation and that all residents receive their meals via the dietary department.
- The facility has reviewed the CDC recommendations for proper hand washing. A new hand washing policy (see attachment #4) was implemented on 5/3/11 with the date placed on the footer of the policy. The policy does include proper technique of hand washing and that all staff must always wash their hands before handling food trays/dishes and before and after completing and starting any new task. An in-service was held on 5/20/11 for all dietary staff to discuss citations. The in-service discussed

that no eating or drinking is allowed in the kitchen. The in-service also included proper storage of dry dishes, and proper infection control utilization (hand washing, ladle placement, thermometer cleaning between use, and importance of glove use). This was all discussed with dietary staff by the Dietary Manager. The in-service on 5/20/11 was conducted by the Dietician (who has been consulted throughout the whole recent survey process and citations). Some ladles were hung up on the pot and pan hanging holder. Other ladles have been thinned out of ladle drawer. Ladles that have been left in the drawer are positioned with the ladle bowl turned over and the handles facing out (this allows easy access and helps prevent contamination). A new policy (**see attachment #5**) was implemented regarding proper ice scoop storage and proper distribution of ice. New ice scoop holders were ordered for all of the ice chest (which included one in the dining room, one at A Wing nurses station, one at B Wing nurses station, and one in the employee break room. The two ice chest (which includes the one in the dining room and the one in the break room will have the ice scoop holders mounted on the wall. Two new ice chest carts were ordered (which is for use on each of the two wings). These carts have ice scoop holders mounted to them. A teaching moment was initiated on 5/4/11 regarding proper sanitizing of the thermometer (after each use). A new policy (**see attachment #4**) was initiated regarding utilization of gloves when working in the dietary department. A new window with complete screen was ordered (with purchasing order on file) and installed in kitchen by a contractor. The new window will help to prevent insect and/or rodent entry.

- Monitoring will be conducted through QA by the Dietary Manager. The Dietary Manager will monitor at least once weekly for one month on proper storage of dry dishes, proper hand washing, proper storage of ladles, and proper sanitation of thermometers. Then Dietary Manager will monitor the above list once biweekly for one month, then monthly times three months. The Dietary Manager will extend QA based on concerns noted. The Dietician will continue to observe and monitor for proper infection control compliance. The Dietician alerts the Dietary Manager, Administrator, and

DON, when she finds concerns that need to be addressed. Personal teaching moments will be given and explained by the Dietary Manager as she observes any dietary staff not utilizing proper infection control practices.

- Compliance with 902 KAR 20:300-10(8)(b) Section 10. completed May 20, 2011.

- The maintenance department will keep a log of each item treated and the date it was treated.
- K073 NFPA 101 completed May 17, 2011.

Received
5/28/11

RESPONSE TO:

K 130 NFPA 101 MISCELLANEOUS OTHER LSC DEFECIENCY NOT ON 2786

- All residents have the potential to be affected by this deficient practice.
- The maintenance director has replaced the lights to insure lights work; new ones were purchased and installed.
- The maintenance director checked these lights according to code and this was not adequate to insure the lights worked when needed, there will now be weekly checks for the next month to insure the new lights continue to work properly. Monthly checks will be done after the first month to insure continued operation of the lights.
- K130 NFPA 101 completed May 17, 2011.

5/20

RESPONSE TO: F241 483.15(a) Dignity and Respect of Individuality: SS = D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- Resident #9 was affected by the deficient practice. Staff was provided with teaching moment to remind them that resident #9 needs to be dressed when in bed and that door and curtain are to be closed when given resident #9 care. New tracking has been hung along the ceiling (instead of on the soffit, where the curtain currently hangs). This has made the netting on the

curtains 12 inches closer to the ceiling. This has helped to protect resident #9's dignity and privacy. Resident #6 was started on the hydration program in March, 2011 with the goal being for resident #6 to consume at least an extra 240cc per day. Staff specifically was educated on offering resident #6 extra fluids.

- All resident charts were reviewed to identify other residents who have the potential to be affected. Determination was made to believe that all physically and cognitively impaired residents are at risk. However, all residents are at risk related to any resident has the potential of undressing/uncovering themselves. All resident rooms were assessed on 5/2/11 by the Administrator and the Maintenance Director for potential viewing through netting of curtains.
- All resident rooms have been checked and it was determined that rooms # A-1, A-2, A-3, A-4, A-5, A-6, A-7, A-8, A-10, and A-11 were affected. All of these rooms have new tracking hung along the ceiling (instead of on the soffit, where the curtain(s) currently hang). This has made the netting on the curtains 12 inches closer to the ceiling. Teaching moments have been written and hung up at both nurses station and at the time clock, to help educate staff on privacy, dignity, and respect of the residents. An in-service was held on 5/9/11 at 2pm, for all staff to discuss dignity, right to privacy and respect of the residents. All new hires are required to watch The University of North Carolina at Chapel Hill DVD titled: *Bathing Without a Battle* (see referencing below). The DVD focuses on simple practices to promote person-center care and dignity.
- The Director of Nursing (DON) and the QI/QA Nurse will do 4 random room checks per week for 4 weeks. Then the DON and QA/QI Nurse will do at least 1 random room check every 2 weeks for 4 weeks. Then the DON and QA/QI nurse will do at least 1 random room check per month during the next 3 quarters. Compliance will be maintained for dignity and respect of residents through random room checks with teaching moments provided when non-compliance has been noted by staff members.
- Compliance with F241 completed May 20, 2011.

References

Barrick, A. L., Rader, J., & Sloane, P. (2003). *Bathing without a battle*. North Carolina: University of North Carolina at Chapel Hill.

3/15 **RESPONSE TO:**

F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES: SS = D

(h)(1) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and (h)(2) each resident receives adequate supervision and assistance devices to prevent accidents.

- Resident #6 was affected by the deficient practice. On 3/18/11, after notified of possible consumption of water via sani-wipe container, a full assessment was conducted on resident #6. Poison control, MD, and POA were notified of resident found and possibly consuming water from sani-wipe container. All rooms were checked, with no other containers of sani-wipes found. Teaching moments regarding safety and proper storing of sani-wipes were hung at both A-Wing and B-Wing and by the time clock for staff to read, review, and sign. Resident #6 was given 240cc of milk by mouth at time of occurrence, based on Poison Control recommendation. Resident #6 was started on the hydration program on March 23, 2011. The program was implemented to help assure that resident #6 has fluid easily available. Resident #6's STNA care plan and Comprehensive care plan were updated to for the hydration program.
- All resident charts have been reviewed. All residents have the potential to be affected because a staff member had carried the sani-cloth wipes into resident #6's room. Residents who are at most risk for harm and/or injury include those who are cognitively impaired and those residents who are on thickened liquids.
- All resident rooms were checked to assure that no other containers of sani-cloth wipes were within resident reach. An in-service was held on 5/9/11 at

2pm, for staff to discuss F323 and to reeducate/reiterate the importance of keeping hazard materials locked up when not in use.

- On 3/23/11 a plan of correction for quality assurance was initiated. As a result of this incident, it was determined that the QA/QI nurse would monitor both wings and the nurses stations weekly times 4 weeks, then monthly times 3 months. Monitoring has been continued and has been increased to 5 times weekly times 1 week, then twice weekly times 1 monthly, and then at least once per month for the next 3 months. If sani-wipe containers are found outside of supply rooms (and not in use), teaching moments will immediately be provided to the staff responsible. A hydration program (**see attachment #2**) was initiated on March 23, 2011. All residents are offered at least 240cc of additional fluid per daily. This program was started to help increase fluid consumption for all residents and to make more fluid available to all residents. This program addresses individual residents who have been deemed as "potential for fluid volume deficit". All residents' are monitored and started on the hydration program, based on needs and determination is made by the nurses and/or interdepartmental team members. A policy for sani-cloth wipes (**see attachment #3**) was written and implemented on 3/30/11. This policy was placed at both nurse's stations and by the time clock, to remind staff of the proper storage and use of the sani-cloth wipes.
- Compliance with F323 completed May 15, 2011.

9/20
RESPONSE TO:

F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY: SS = E

The facility must – (i)(1) Procure food from sources approved or considered satisfactory by federal, state, or local authorities; and (i)(2) Store, prepare, distribute, and serve food under sanitary conditions.

- No specific resident was cited in this deficient practice.
- All residents have the potential of being affected by the deficient practice. This was determined via review of citation and that all residents receive their meals via the dietary department.
- The facility has reviewed the CDC recommendations for proper hand washing. A new hand washing policy (**see attachment #4**) was implemented on 5/3/11 with the date placed on the footer of the policy. The policy does include proper technique of hand washing and that all staff must always wash their hands before handling food trays/dishes and before and after completing and starting any new task. An in-service was held on 5/20/11 for all dietary staff to discuss citations. The in-service discussed that no eating or drinking is allowed in the kitchen. The in-service also included proper storage of dry dishes, and proper infection control utilization (hand washing, ladle placement, thermometer cleaning between use, and importance of glove use). This was all discussed with dietary staff by the Dietary Manager. The in-service on 5/20/11 was conducted by the Dietician (who has been consulted throughout the whole recent survey process and citations). Some ladles were hung up on the pot and pan hanging holder. Other ladles have been thinned out of ladle drawer. Ladles that have been left in the drawer are positioned with the ladle bowl turned over and the handles facing out (this allows easy access and helps prevent contamination). A new policy (**see attachment #5**) was implemented regarding proper ice scoop storage and proper distribution of ice. New ice scoop holders were ordered for all of the ice chest (which included one in the dining room, one at A Wing nurses station, one at B Wing nurses station, and one in the employee break room. The two ice chest (which

includes the one in the dining room and the one in the break room will have the ice scoop holders mounted on the wall. Two new ice chest carts were ordered (which is for use on each of the two wings). These carts have ice scoop holders mounted to them. A teaching moment was initiated on 5/4/11 regarding proper sanitizing of the thermometer (after each use). A new policy (**see attachment #4**) was initiated regarding utilization of gloves when working in the dietary department. A new window with complete screen was ordered (with purchasing order on file) and was installed in kitchen by a contractor. The new window will help to prevent insect and/or rodent entry.

- Monitoring will be conducted through QA by the Dietary Manager. The Dietary Manager will monitor at least once weekly for one month on proper storage of dry dishes, proper hand washing, proper storage of ladles, and proper sanitation of thermometers. Then Dietary Manager will monitor the above list once biweekly for one month, then monthly times three months. The Dietary Manager will extend QA based on concerns noted. The Dietician will continue to observe and monitor for proper infection control compliance. The Dietician alerts the Dietary Manager, Administrator, and DON, when she finds concerns that need to be addressed. Personal teaching moments will be given and explained by the Dietary Manager as she observes any dietary staff not utilizing proper infection control practices.
- Compliance with F371 completed May 20, 2011.

5/15

RESPONSE TO:

F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS. SS = D

THE FACILITY MUST ESTABLISH AND MAINTAIN AN INFECTION CONTROL PROGRAM DESIGNED TO PROVIDE A SAFE, SANITARY AND COMFORTABLE ENVIRONMENT AND TO HELP PREVENT THE DEVELOPMENT AND TRANSMISSION OF DISEASE AND INFECTION.

(a) INFECTION CONTROL PROGRAM

THE FACILITY MUST ESTABLISH AN INFECTION CONTROL PROGRAM UNDER WHICH IT –

- (1) INVESTIGATES, CONTROLS, AND PREVENTS INFECTIONS IN THE FACILITY;**
- (2) DECIDES WHAT PROCEDURES, SUCH AS ISOLATION, SHOULD BE APPLIED TO AN INDIVIDUAL RESIDENT;**
- (3) MAINTAINS A RECORD OF INCIDENTS AND CORRECTIVE ACTIONS RELATED TO INFECTIONS.**

(b) PREVENTING SPREAD OF INFECTION

- (1) WHEN THE INFECTION CONTROL PROGRAM DETERMINES THAT A RESIDENT NEEDS ISOLATION TO PREVENT THE SPREAD OF INFECTION, THE FACILITY MUST ISOLATE THE RESIDENT.**
- (2) THE FACILITY MUST PROHIBIT EMPLOYEES WITH A COMMUNICABLE DISEASE OR INFECTED SKIN LESIONS FROM DIRECT CONTACT WITH RESIDENTS OR THEIR FOOD, IF DIRECT CONTACT WILL TRANSMIT THE DISEASE.**
- (3) THE FACILITY MUST REQUIRE STAFF TO WASH THEIR HANDS AFTER EACH DIRECT RESIDENT CONTACT FOR WHICH HAND WASHING IS INDICATED BY ACCEPTED PROFESSIONAL PRACTICE.**

(c) LINENS

PERSONNEL MUST HANDLE, STORE, PROCESS AND TRANSPORT LINENS SO AS TO PREVENT THE SPREAD OF INFECTION.

- Resident #9 was assessed; no change in mental or physical status noted to resident #9 and the medical record was reviewed for any changes in

condition need to alter treatment. LPN #1 was given a teaching moment regarding proper hand washing and wound care. A teaching moment was given to all nursing staff regarding proper hand washing technique.

- All residents were assessed and their medical records reviewed to determine if there were any nosocomial infections or communicable diseases noted. No incidents were identified that required reporting as related above. The hand washing policy has been updated with copies posted at each nursing station for the staff to read and sign for understanding. Staff has been instructed to ask question of the QA/QI nurse or DON, if there is any questions regarding the teaching moment on hand washing.
- The facility has developed an infection control team. The infection control team consist of the QA/QI Nurse, DON, Administrator, Medical Director, a staff nurse, and a staff STNA. The infection control committee will address any know infection control issues/concerns (at hand) on a monthly basis and then bi-monthly thereafter on second Tuesday of the month. All newly hired staff is required to watch the Mecom Trainex: Blood borne Safety DVD. This video explains (and shows) proper hand washing techniques, Standard precautions, and Universal Precautions (**see referencing below**). In addition to this, all staff were in-serviced on hand washing and blood borne pathogens annually (according to OSHA standard/guideline: 1910.1030(g) (2) (ii) (B)). All staff were in-serviced on hand washing policy (**see attachment #4**) and random staff will demonstrate proper technique to infection control team with check off list placed in employee file. All staff were in-serviced on May 9, 2011 at 2pm. On May 6, 2011 at 2pm, nurses were in-serviced on proper infection control and wound care.
- The measures put into place in addition to those mentioned above will include: weekly review of infections at Interdisciplinary meeting and an audit on a quarterly basis by the Quality Assurance committee to ensure compliance. Random monitoring of nursing staff on wound care will be done weekly for 3 months then monthly for 3 months. Monitoring will be done by DON and/or QA/QI Nurse. Random use of glow-germ monthly on

employees will be done by DON and/or QA/QI Nurse. An in service was held on May 6, 2011 at 2pm. The in-service covered proper infection control and wound care. Another in service was held on May 9, 2011, to reeducate staff on proper infection control techniques specifically to include hand washing and wound care. Hand washing policy was reviewed by Interdepartmental team and Medical Director. Updates were made to policy based on CDC guidelines. Date for updating was placed on hand washing policy.

- Compliance with F441 completed May 15, 2011.

References

Unknown. (2003). *Blood borne safety: Universal precautions, standard precautions, and needle stick prevention in long term care*. Cypress, California: Medcomrn.

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.

902R 20:300-6(1) Section 6. Quality of Life: N113

(1) Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- Resident #9 was affected by the deficient practice. Staff was provided with teaching moment to remind them that resident #9 needs to be dressed when in bed and that door and curtain are to be closed when given resident #9 care. New tracking has been hung along the ceiling (instead of on the soffit, where the curtain currently hangs). This has made the netting on the curtains 12 inches closer to the ceiling. This has helped to protect resident #9's dignity and privacy. Resident #6 was started on the hydration program in March, 2011 with the goal being for resident #6 to consume at least an extra 240cc per day. Staff specifically was educated on offering resident #6 extra fluids.
- All resident charts were reviewed to identify other residents who have the potential to be affected. Determination was made to believe that all physically and cognitively impaired residents are at risk. However, all residents are at risk related to any resident has the potential of undressing/uncovering themselves. All resident rooms were assessed on 5/2/11 by the Administrator and the Maintenance Director for potential viewing through netting of curtains.
- All resident rooms have been checked and it was determined that rooms # A-1, A-2, A-3, A-4, A-5, A-6, A-7, A-8, A-10, and A-11 are affected. All of these rooms have new tracking hung along the ceiling (instead of on the

soffit, where the curtain(s) currently hang). This has made the netting on the curtains 12 inches closer to the ceiling. Teaching moments have been written and hung up at both nurses station and at the time clock, to help educate staff on privacy, dignity, and respect of the residents. An in-service was held on 5/9/11 at 2pm, for all staff to discuss dignity, right to privacy and respect of the residents. All new hires are required to watch The University of North Carolina at Chapel Hill DVD titled: *Bathing Without a Battle* (see referencing below). The DVD focuses on simple practices to promote person-center care and dignity.

- The Director of Nursing (DON) and the QI/QA Nurse will do 4 random room checks per week for 4 weeks. Then the DON and QA/QI Nurse will do at least 1 random room check every 2 weeks for 4 weeks. Then the DON and QA/QI nurse will do at least 1 random room check per month during the next 3 quarters. Compliance will be maintained for dignity and respect of residents through random room checks with teaching moments provided when non-compliance has been noted by staff members.
- 902 R 20:300-6(1) Section 6 completed May 20, 2011.

References

Barrick, A. L., Rader, J., & Sloane, P. (2003). *Bathing without a battle*. North Carolina: University of North Carolina at Chapel Hill.

(7) Environment. (b) Infection control and communicable diseases. 2. The facility shall establish an infection control program which: a. Investigates, controls and prevents infections in the facility:

- Resident #9 was assessed; no change in mental or physical status noted to resident #9 and the medical record was reviewed for any changes in condition need to alter treatment. LPN #1 was given a teaching moment regarding proper hand washing and wound care. A teaching moment was given to all nursing staff regarding proper hand washing technique.
- All residents were assessed and their medical records reviewed to determine if there were any nosocomial infections or communicable diseases noted. No incidents were identified that required reporting as related above. The hand washing policy has been updated with copies posted at each nursing station for the staff to read and sign for understanding. Staff has been instructed to ask question of the QA/QI nurse or DON, if there is any questions regarding the teaching moment on hand washing.
- The facility has developed an infection control team. The infection control team consist of the QA/QI Nurse, DON, Administrator, Medical Director, a staff nurse, and a staff STNA. The infection control committee will address any know infection control issues/concerns (at hand) on a monthly basis and then bi-monthly thereafter on second Tuesday of the month. All newly hired staff is required to watch the Mecomme Trainex: Blood borne Safety DVD. This video explains (and shows) proper hand washing techniques, Standard precautions, and Universal Precautions (**see referencing below**). In addition to this, all staff are in-serviced on hand washing and blood borne pathogens annually (according to OSHA standard/guideline: 1910.1030(g) (2) (ii) (B)). All staff were in-serviced on hand washing policy (**see attachment #4**) and random staff will demonstrate proper technique to infection control team with check off list placed in employee file. All staff

were in-serviced on May 9, 2011 at 2pm. On May 6, 2011 at 2pm, nurses were in-serviced on proper infection control and wound care.

- The measures put into place in addition to those mentioned above will include: weekly review of infections at Interdisciplinary meeting and an audit on a quarterly basis by the Quality Assurance committee to ensure compliance. Random monitoring of nursing staff on wound care will be done weekly for 3 months then monthly for 3 months. Monitoring will be done by DON and/or QA/QI Nurse. Random use of glow-germ monthly on employees will be done by DON and/or QA/QI Nurse. An in service will be held on May 6, 2011 at 2pm on proper infection control and wound care. Another in service will be held May 9, 2011, to reeducate staff on proper infection control techniques specifically to include hand washing and wound care. Hand washing policy was reviewed by Interdepartmental team and Medical Director. Updates were made to policy based on CDC guidelines. Date for updating was placed on hand washing policy,
- Compliance with 902 KAR 20:300-6(7)(b)2.a. completed May 15, 2011.

References

Unknown. (2003). *Blood borne safety: Universal precautions, standard precautions, and needle stick prevention in long term care*. Cypress, California: Medcomrn.

902 KAR 20:300-8(7)(b) Section 8. Quality of Care. N220

(7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents.

- Resident #6 was affected by the deficient practice. On 3/18/11, after notified of possible consumption of water via sani-wipe container, a full assessment was conducted on resident #6. Poison control, MD, and POA were notified of resident found and possibly consuming water from sani-wipe container. All rooms were checked, with no other containers of sani-wipes found. Teaching moments regarding safety and proper storing of sani-wipes were hung at both A-Wing and B-Wing and by the time clock for staff to read, review, and sign. Resident #6 was given 240cc of milk by mouth at time of occurrence, based on Poison Control recommendation. Resident #6 was started on the hydration program on March 23, 2011. The program was implemented to help assure that resident #6 has fluid easily available. Resident #6's STNA care plan and Comprehensive care plan were updated to for the hydration program.
- All resident charts have been reviewed. All residents have the potential to be affected because a staff member had carried the sani-cloth wipes into resident #6's room. Residents who are at most risk for harm and/or injury include those who are cognitively impaired and those residents who are on thickened liquids.
- All resident rooms were checked to assure that no other containers of sani-cloth wipes were within resident reach. An in-service was held on 5/9/11 at 2pm, for staff to discuss F323 and to reeducate/reiterate the importance of keeping hazard materials locked up when not in use.
- On 3/23/11 a plan of correction for quality assurance was initiated. As a result of this incident, it was determined that the QA/QI nurse would monitor both wings and the nurses stations weekly times 4 weeks, then monthly times 3 months. Monitoring has been continued and has been increased to 5 times weekly times 1 week, then twice weekly times 1 monthly, and then at least once per month for the next 3 months. If sani-

that no eating or drinking is allowed in the kitchen. The in-service also included proper storage of dry dishes, and proper infection control utilization (hand washing, ladle placement, thermometer cleaning between use, and importance of glove use). This was all discussed with dietary staff by the Dietary Manager. The in-service on 5/20/11 was conducted by the Dietician (who has been consulted throughout the whole recent survey process and citations). Some ladles were hung up on the pot and pan hanging holder. Other ladles have been thinned out of ladle drawer. Ladles that have been left in the drawer are positioned with the ladle bowl turned over and the handles facing out (this allows easy access and helps prevent contamination). A new policy (**see attachment #5**) was implemented regarding proper ice scoop storage and proper distribution of ice. New ice scoop holders were ordered for all of the ice chest (which included one in the dining room, one at A Wing nurses station, one at B Wing nurses station, and one in the employee break room. The two ice chest (which includes the one in the dining room and the one in the break room will have the ice scoop holders mounted on the wall. Two new ice chest carts were ordered (which is for use on each of the two wings). These carts have ice scoop holders mounted to them. A teaching moment was initiated on 5/4/11 regarding proper sanitizing of the thermometer (after each use). A new policy (**see attachment #4**) was initiated regarding utilization of gloves when working in the dietary department. A new window with complete screen was ordered (with purchasing order on file) and installed in kitchen by a contractor. The new window will help to prevent insect and/or rodent entry.

- Monitoring will be conducted through QA by the Dietary Manager. The Dietary Manager will monitor at least once weekly for one month on proper storage of dry dishes, proper hand washing, proper storage of ladles, and proper sanitation of thermometers. Then Dietary Manager will monitor the above list once biweekly for one month, then monthly times three months. The Dietary Manager will extend QA based on concerns noted. The Dietician will continue to observe and monitor for proper infection control compliance. The Dietician alerts the Dietary Manager, Administrator, and

DON, when she finds concerns that need to be addressed. Personal teaching moments will be given and explained by the Dietary Manager as she observes any dietary staff not utilizing proper infection control practices.

- Compliance with 902 KAR 20:300-10(8)(b) Section 10. completed May 20, 2011.

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

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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 04/11/2011
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NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41008
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>K3 Building: 0101 K6 Plan Approval: 1970, 1995 K7 Survey under: 2000 existing K8 SNF Type of structure: One (1) story TYPE III (211) w/lt basement. Full automatic sprinkler system.</p> <p>A Life Safety Code Survey was initiated and concluded on 04/11/2011 for compliance with Title 42, Code of Federal Regulations, 483.70, and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 edition.</p>	K 000		
K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.8, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by:</p>	K 021	<p style="text-align: center;">RECEIVED MAY - 6 2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kenneth W. [Signature]</i>	TITLE Administrator	(X6) DATE 5/6/2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER 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 021	Continued From page 1 Based on observation and interview, it was determined the facility failed to ensure only proper hold open devices were used for hazardous areas. The findings include: Observation on 04/11/2011 at 11:45 AM, with the Maintenance Director, revealed two (2) storage rooms, located in the basement, were being propped open with dry goods. Interview on 04/11/2011 at 11:45, with the Maintenance Director, revealed staff would place items in front of the doors to keep them from closing while moving stock into the room. Reference: NFPA 101 (2000 edition) 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 021		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		

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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 029	<p>Continued From page 2</p> <p>other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The findings include: Observation on 04/11/2011 at 11:40 AM, with the Maintenance Director, revealed two (2) rooms, located in the basement, were being used for storage of combustible items (paper, plastic) in a hazardous quantity. Further observation revealed the doors did not have self closing devices. Interview on 04/11/2011 at 11:40 AM, with the Maintenance Director, revealed the rooms had originally been built as bathrooms and the facility had not identified the rooms as needing self closers when combustibles had been placed in the rooms. Observation on 04/11/2011 at 11:30 AM, with the Maintenance Director, revealed the room where the generator was located had a penetration in the wall and a section of rock wool located along the top of the wall was missing. Interview on 04/11/2011 at 11:30 AM, with the Maintenance Director, revealed he was not aware of the penetration or the missing rock wool. Observation on 04/11/2011 at 11:33 AM, with the Maintenance Director, revealed the Maintenance Shop had penetrations located in the wall. The</p>	K 029		

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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)	
K 029	<p>Continued From page 3</p> <p>penetrations were from metal conduit through the wall.</p> <p>Interview on 04/11/2011 at 11:33 AM, with the Maintenance Director, revealed he checks the for penetrations in walls of hazardous areas yearly and had not identified the penetrations located in the walls of the Maintenance Shop.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing.</p> <p>Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the 	K 029		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 029	Continued From page 4 authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency has the potential to affect all residents, staff and visitors. The findings include: Observation on 4/11/2011 at 12:00 PM with the Maintenance Director, revealed hanging decorations on the resident room doors numbered 3-A, 4-A, 8-A, 9-A, and 14-A on the A-Wing. And resident room doors numbered 3-B, 6-B, 7-B, 11-B, 12-B, and 14-B on the B-Wing. Interview with the Maintenance Director on 4/11/2011 at 12:00 PM, revealed the facility did not have a policy or system in place to ensure the	K 073		

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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 073	Continued From page 5 decorations were treated with a flame retardant material. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073			
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain lighting for the emergency generator according to National Fire Protection (NFPA) Standards. The findings include: Observation on 04/11/2011 at 11:28 AM, with the Maintenance Director, revealed the emergency lighting for the emergency generator would operate when tested. Interview on 04/11/2011 at 11:28 AM, with the Maintenance Director, reveals he tests the emergency lighting according to code and had not identified the emergency light as not working. Reference: NFPA 110 (1999 edition) 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 130			

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.

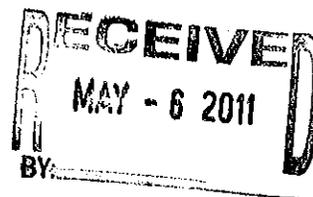
RESPONSE TO:

K 021 NFPA 101 Life Safety code Standard: SS=D

Any door in an exit Passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: (a) the required manual fire alarm system;

(b) local smoke detectors, (c) the automatic sprinkler system,

- All residents have the potential to be affected by this deficient practice. All staff that utilizes these areas has been instructed to not prop doors open, as this constitutes a danger to all residents, families, staff and visitors. These doors are storage areas which should remain locked at all times unless staff are putting items in or removing items from these areas.
- The measures put into place will include;
Signs on the door indicating that the door is not to be propped open for any reason and two staff will be required to be open the areas so that, one can open the door while the other can place items in or remove items from these areas.
- The maintenance director will monitor these areas daily for two weeks and at least once a week for the next three weeks to insure compliance, thereafter the area will be monitored monthly to verify the problem is not recurring. An In-Service on this issue will be conducted on May 9, 2011.
- Completed June 1, 2011



RESPONSE TO:

K 029 NFPA 101 Life safety Code Standard: SS=E

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic for extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas.

- This deficiency has the potential to affect all residents, families, staff and visitors,
- The areas used for storage have had self closing devices installed to insure the doors remain closed. Staff that use this area have been instructed to keep doors closed. The area in the generator room and in the maintenance shop where the penetration of the fire wall were noted have been repaired and filled with fire proof materials.
- The Maintenance director will now do Quarterly inspections of these areas to insure penetrations in the fire wall are resolved on a timelier basis.
- Corrected May 5, 2011

RESPONSE TO;

K073 NFPA 101 Life Safety Code Standard NFPA: SS=D

**No Furnishings or decorations of highly flammable character are used.
19.7.5.2, 19.7.5.3, 19.7.5.4**

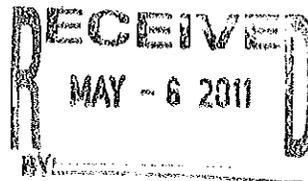
- All residents having decorations hanging on their doors and other residents who may want to hang decorations are directly affected. All residents have the potential to be affected by this deficient practice.
- A new policy has been written and given to all residents and families. See Attachment (Policy on resident room decorative materials) In addition this policy will be included in all future admission packets so the family and residents are aware that all decorations must be of a non-combustible material or have a flame retardant applied by the maintenance department.

- The maintenance department will keep a log of each item treated and the date it was treated.
- Completed June 15, 2011.

RESPONSE TO:

K 130 NFPA 101 MISCELLANEOUS OTHER LSC DEFECIENCY NOT ON 2786

- All residents have the potential to be affected by this deficient practice.
- The maintenance director has replaced the lights to insure lights work; new ones were purchased and installed.
- The maintenance director checked these lights according to code and this was not adequate to insure the lights worked when needed, there will now be weekly checks for the next month to insure the new lights continue to work properly. Monthly checks will be done after the first month to insure continued operation of the lights.
- Completed June 1, 2011



RESPONSE TO: F241 483.15(a) Dignity and Respect of Individuality: SS = D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- Resident #9 was affected by the deficient practice. Staff was provided with teaching moment to remind them that resident #9 needs to be dressed when in bed and that door and curtain are to be closed when given resident #9 care. New tracking will be hung along the ceiling (instead of on the soffit, where the curtain currently hangs). This will make the netting on the