

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

PRINTED: 09/29/2015
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 R 09/29/2015
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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} INITIAL COMMENTS

{F 000}

An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 09/01/15 as alleged.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

A Recertification Survey was conducted 08/11/15 through 08/13/15 with deficiencies cited at a highest Scope and Severity of an "E".

F 252 483.15(h)(1)

SS=E SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide a safe, clean, comfortable, and homelike environment as evidenced by dust observed in several residents' air vents and a bench in the courtyard heavily covered in bird droppings.

The findings include:

Review of the facility's policy titled, "Cleaning", revised February 2013, revealed the purpose of the policy was to ensure provision of a clean, attractive and antiseptic environment for residents to live in, as well as, provide a safe, clean, comfortable and homelike environment for all residents. Per the Policy, the procedure for the daily cleaning of residents' rooms was to dust all furniture, light fixtures, nightstands, tables, shelves, chairs, pictures and counter tops; however, there was no documentation related to the cleaning and/or dusting of the ceiling air vents

F 000 Preparation and execution of the response and plan of correction does not constitute an admission or agreement by this provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies.

F 252 The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

F252 483015(h)(1)

Safe/Clean/Comfortable/ Homelike Environment

After the survey was completed the Director Of Housekeeping, Maintenance Director and the Administrator took a tour of all Resident bathrooms and all vents were cleaned. This affected all residents who use the bathroom facilities. The benches with the bird droppings was cleaned as well that afternoon. All residents have the potential to be affected since even those residents who do not use the court yard look out the windows and would prefer not to view the bird droppings.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ken Uhlage

TITLE

Administrator

(X6) DATE

09/01/2015

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F 252 Continued From page 1
in the residents' bathrooms.

Observation during the initial tour on 08/11/15, beginning at 1:30 PM, revealed the ceiling air vents in the bathrooms in resident rooms: 1A, 4A, 7A, 13A, 1B, 2B, 3B, 7B, 9B, 11B, 13B, and 15B there was an approximately 1/2 inch to one inch layer of dust on the vents. In addition, observation on 08/13/15 at 1:00 PM, revealed in the resident courtyard, a bench which was heavily covered with multiple bird droppings (feces).

Interview with the Housekeeping/Laundry Supervisor on 08/13/15 at 1:30 PM, revealed it was her understanding the facility's maintenance workers were responsible for cleaning the air vents.

Interview with the Maintenance Supervisor on 08/13/15 at 2:00 PM, revealed it was his responsibility to maintain the outside environment of the facility, such as the benches; however he was not responsible for cleaning or dusting the ceiling air vents in residents' bathrooms. The Maintenance Supervisor revealed he would speak with the Housekeeping Supervisor and resolve the issue.

Interview with the Administrator on 08/13/15 at 3:00 PM, revealed he supervised the maintenance and housekeeping departments at the facility. Per interview, the ceiling vents should have been dusted and the courtyard bench cleaned of the bird droppings. The Administrator stated it was the goal of the facility to provide a clean, safe and homelike environment for the residents and their visitors, and he would be ensure this from now on.

F 252 Other residents will not be affected by the vents since all residents have the potential to be affected. Any resident who does not use the court yard or look out the window still could be affected when family or friends visit and could be affected. The vents will be checked weekly by Administrator, Director of Housekeeping And maintenance Director to insure the Vents remain clean. A policy for cleaning Vents has been written and attached. The benches have been moved away from the resident rooms that had the bird feeders outside their windows, in an effort to reduce the bird droppings. The benches are checked daily by maintenance (daily means morning and lunch times) during the week and cleaned if needed. During the evenings and on weekends or holidays housekeepers are assigned to check and clean as needed.

see addendum #1

Corrected
09/01/2015

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F 323 Continued From page 2
F 323 483.25(h) FREE OF ACCIDENT
SS=E HAZARDS/SUPERVISION/DEVICES

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible. Observation revealed scissors lying in view in resident rooms with the residents not present in room of Resident #8 and Unsampled Resident B. In addition, observations revealed exposed toilet bolts were observed in several resident bathrooms, and the pavement in the courtyard was uneven.

The findings include:
Review of the facility's policy titled "Cleaning", revised February 2013, revealed the daily cleaning of residents' rooms included cleaning the residents' bathrooms. Per the Policy, staff were to report all broken equipment to the facility's maintenance department. Further review revealed "yearly" cleaning procedures included removing hazards "to keep foot traffic areas safe".

The facility was unable to provide a policy related

F 323
F 323 F323 483.25(h) Free of Accident Hazard Supervision/Devices

This Tag was cited due to Scissors and pins found in two residents room. It was also cited for exposed bolts on the side of the toilets in residents room and for uneven concrete in the court yard. All residents are affected by each of these due to the broad reach of each of these items. Any one could wander into a resident room with unsafe items left unattended. Not only residents but visitors and staff could trip on the uneven concrete. The exposed bolts on the side of the toilets (also referred to as water closets) could affect all residents with a potential to fall.

Since it has been determined that all residents have the potential to be affected the following plan of correction will apply to not only residents but staff families and visitors as well.

The measures put in place to correct the Unsafe practices are as follows:
An article will be written and placed in the facility Newsletter "Lasting Impressions" Which is sent to all families and residents and distributed to all staff explaining, that safety is everyone's job. (Article Enclosed.)

see addendum #2

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F 323	<p>Continued From page 3</p> <p>to the use of scissors and sharp objects stored in residents' rooms by the end of the survey.</p> <p>Review of the facility's, "Wander Resident/Elopement Risk" list revealed there were seven (7) residents at risk of wandering and entering other residents' rooms.</p> <p>Observation during the initial tour of the facility on 08/11/15 at 1:30 PM, revealed exposed bolts at the base of the toilets in the bathrooms of resident rooms 1A, 5A, 7A, 11A, 13A, 1B, 3B, 9B, 11B, 13B and the Common Shower/Bathroom on the A-wing. Observation, on 08/11/15 at 2:30 PM, also during the initial tour of the facility, revealed Unsampled Resident B had a pair of pointed sewing scissors and several straight pins lying out in view on the overbed table in the resident's room when the resident was out of the room. Continued observations on 08/13/15 at 11:00 AM and at 1:10 PM revealed the scissors and the straight pins were again lying on the overbed table while Unsampled Resident B was was not in the room.</p> <p>Further observations revealed the exposed toilet bolts remained without coverings throughout the survey including the last day, 08/13/15. In addition, observation on 08/13/15 at 1:00 PM, revealed the concrete pavement, in front of a bench in the resident courtyard, was un-even.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 08/13/15 at 1:45 PM, on Unit B revealed the residents were not allowed to have scissors and sharp objects lying out in the open in their rooms when the resident was out of the room. Per interview, SRNA #1 was unaware Unsampled Resident B had sharp objects lying</p>	F 323	<p>A teaching moment will be given and reviewed by all staff to instruct them to be observant of any potential unsafe practice. Staff will notify the nurse on that unit and will insure that the item(s) are stored in a locked drawer in the room of the resident or taken to the nursing station to be locked in an appropriate place.</p> <p>The safety committee will do weekly rounds for the next month and monthly rounds thereafter to find any issue that might be a safety hazard and insure that the item(s) are locked up or corrected, depending on the nature of the unsafe practice or item.</p> <p>A policy has been written that expresses that residents may keep items in their rooms that may be unsafe for others, as long as the items kept locked up when not in use.</p>	<p>see addendum #3</p> <p>Corrected 09/01/2015</p>

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F 323 Continued From page 4
out in his/her room. Further interview revealed wandering residents could possibly enter the room and get hurt on the sharp objects lying out in the open.

Interview with Licensed Practical Nurse (LPN) #1 on 08/13/15 at 2:00 PM, revealed she did not think the residents were supposed to have scissors in their rooms and possibly someone brought the scissors in to Unsampld Resident B from outside the facility.

Interview with Registered Nurse (RN) #1 on 08/13/15 at 2:20 PM, revealed the facility did not have a policy for scissors and sharps, such as straight pins, being used in residents' rooms. RN #1 revealed she thought mentally competent residents should be able to have scissors and pins in their rooms, but should not leave them out lying out in the open when they left their rooms. Per interview, RN #1 was aware some residents did wander in and out of other residents' rooms throughout the facility.

Interview with the Housekeeping/Laundry Supervisor on 08/13/15 at 1:30 PM, revealed it was her understanding the facility's maintenance workers were responsible for maintaining the toilets, to include the toilet bolt coverings.

Interview with the Maintenance Supervisor on 08/13/15 at 2:00 PM, revealed it was his responsibility to maintain the toilets, in addition to the outside environment pavements and benches. The Maintenance Supervisor stated he made daily rounds in and around the facility; however, he had not noticed the missing toilet bolt covers at the base of the residents' toilets.

F 323

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F 323 Continued From page 5
Interview with the Administrator on 08/13/15 at 3:00 PM, revealed he provided the supervision for the facility's maintenance and housekeeping departments. He stated the toilet bolts should have been covered and the pavement level in the courtyard in order to prevent a possible injury. Continued interview with the Administrator on 08/13/15 at 5:00 PM, revealed it could be a problem if a wandering resident picked up a sharp object in another resident's room. Per interview, the facility needed to monitor the use of sharp objects to avoid residents from getting hurt.

F 323

Post-Certification Revisit Report

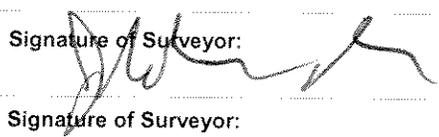
Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number: 185355
 (Y2) Multiple Construction: A. Building 01 - MAIN BUILDING 01, B. Wing
 (Y3) Date of Revisit: 9/8/2015

Name of Facility: RIVER VALLEY NURSING HOME
 Street Address, City, State, Zip Code: 305 TAYLOR STREET #402 BUTLER, KY 41006

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed 09/01/2015	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # NFPA 101 LSC K0062		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By: _____ Date: _____ Signature of Surveyor:  Date: 9-8-15
 State Agency: _____
 Reviewed By: _____ Date: _____ Signature of Surveyor: _____ Date: _____
 CMS RO: _____

Followup to Survey Completed on: 8/12/2015
 Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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{K 000} INITIAL COMMENTS

{K 000}

Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/01/15 as alleged.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 03/15/72

SURVEY UNDER: NFPA 101 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story with basement Type III (200)

SMOKE COMPARTMENTS: Four (4) smoke compartments

FIRE ALARM: Complete fire alarm system

SPRINKLER SYSTEM: Complete (wet) sprinkler system

GENERATOR: One (1) Type II Diesel generator.

A standard Life Safety Code Survey was conducted on 08/12/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

Deficiencies were cited with the highest deficiency identified at "D" level.

K 000: Preparation and execution of the response and plan of correction does not constitute an admission or agreement by this 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.

K062 NFPA 101 Life Safety Code Standard This standard has the potential to affect All Residents, since the sprinkler system is designed to extinguish a fire in the area affected. The action taken to correct this deficient practice was the sprinkler heads were relocated that are not located in the correct position and replace the corroded sprinkler heads as noted.

This building is fully sprinkled so all residents Have the potential to be affected if the System is not operating properly especially in resident occupied areas.

The facility will have the Safety Committee Perform monthly audits for 3 months and quarterly thereafter. (see names and positions on attached list) audit the sprinkler system for corroded or blocked sprinkler head.

Maintenance will also request that the company that does the quarterly inspections will note on the reports any sprinklers that they observe that require changing. (Currently that is The Cintas Company).

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 062

Completed
09/01/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ken Urloge

TITLE
Administrator

(X6) DATE
09/04/2015

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K 062 Continued From page 3
obstructions such as truss webs and chords,
pipes, columns, and fixtures.

Table 5-6.5.1.2 Positioning of Sprinklers to Avoid
Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to side of Obstruction
(A). Maximum Allowable Distance of Deflector
above Bottom of Obstruction (in.) (B)

Side of Obstruction (A)	Obstruction (in.) (B)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).

Reference: NFPA 25 (1998 Edition)

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.

Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.

K 062

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

PRINTED: 08/27/2015
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 08/12/2015
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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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Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.