

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

PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 7 by providing and documenting the responsible party has been notified of fall. No other residents were identified concerning this tag. 2. Facility residents that have a fall have the potential to be affected by this same alleged deficient practice; an audit of residents with a fall has been done per Director of Nursing and/or Restorative Nurse to ensure that all responsible parties have been notified and documented. When necessary, Director of Nursing and/or Restorative Nurse notified responsible party and/or MD as needed. Risk Management tab in our electronic medication record system reviewed 2 x/ week per Director of Nursing and/or Restorative Nurse to ensure licensed nursing staff notified MD and responsible party of any falls. The results demonstrated compliance.	

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

Renwick W. [Signature]

TITLE

Administrator

(X6) DATE

8/12/13

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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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to notify the resident's legal representative of one (1) of fifteen (15) sampled residents (Resident #7) after a fall experienced at the facility. The facility failed to provide evidence indicating the resident's responsible party was notified after Resident #7's fall on 07/08/13. The findings Include: Review of the facility's policy, "Fall Response", revised 05/30/12, revealed in section (b) the Physician, Director of Nursing, and Supervisor and resident's family should be notified following a resident's fall. Review of Resident #7's medical record revealed the facility admitted the resident on 06/06/13 with diagnoses which included Dementia, Dehydration, Pressure Ulcer, History of Falls, and many other medical concerns. Review of the 06/12/13 admission Minimum Data Set (MDS) Assessment revealed the facility assess the resident to have severe cogitative impairment. In addition, the resident experienced one (1) fall within the last six (6) months which incurred fractures related to the fall, one (1) fall within the last two (2) to six (6) months, and one (fall) last month. Further review of the record revealed Resident #7 fell on 07/08/13 at 3:15 AM. Documentation, located within the fall report,	F 157	3. Measures put into place to ensure alleged deficient practice does not recur include: Teaching Moment done on July 11, 2013 educating staff on F Tag 157, In-Service for licensed nursing staff held on July 31, 2013 by the Director of Nursing regarding F Tag 157 emphasizing on notifying responsible party of all falls and documenting notification. Director of Nursing, Quality Assurance/Process Improvement Nurse and/or Nursing Supervisor will review 24 hour report and nurses notes daily to ensure any change in condition i.e.: fall that MD and responsible party were notified and documented. 4. The facility plans to monitor compliance performance by the Quality Assurance/Process Improvement Nurse will complete daily audits (Monday-Friday) X 4 weeks, then weekly X 4 weeks and monthly X 3 months to ensure notification of change in resident condition has been completed and documented on QA Audit tool. Director of Nursing and/or Restorative Nurse to complete random chart audits (Monday-Friday) X 2 weeks then weekly X 2 weeks then monthly X 3 months to ensure notification of change in resident condition has been completed and documented on QA Audit tool. Findings from QA audits will be presented in monthly safety meeting.	

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F 157	<p>Continued From page 2</p> <p>revealed the resident was eased to the floor. Resident #7's vitals were taken, the Physician was notified, and a note was put on the twenty-four (24) hour report which stated, "Please inform family"; however, staff could not verify family was notified.</p> <p>Interview, with Registered Nurse (RN) #1, on 07/11/13 at 11:25 AM, revealed Resident #7 was eased to the floor, it was not a complete fall. RN #1 reported the resident was assisted by an aide. RN #1 revealed she checked Resident #7's vitals, questioned the resident, checked for Range of Motion, and notified the resident's Physician. RN#1 revealed she informed the morning shift about the incident that occurred and would have expected the oncoming nurse to have responded to the twenty-four (24) hour report, which requested for family to be notified of the incident. RN #1 revealed she was not certain if family was notified.</p> <p>Interview with Resident #7's son, on 07/11/13 at 1:30 PM, revealed he was not informed about Resident #7's fall, which occurred on 07/08/13, until the morning of 07/11/13.</p> <p>Interview, with Restorative Nurse, on 07/10/13 at approximately 4:35 PM, revealed that after a fall, residents vitals would be taken for a period of seventy-two (72) hours. She further revealed the residents physician and family would be notified. The Restorative Nurse stated she would then update the residents care plan. In the case of Resident #7, the Restorative Nurse revealed she did not know if a message was left for the following shift to contact Resident #7's family. She added that since the fall occurred so early in</p>	F 157	<p>Safety Committee consists of Administrator, Infection Control Nurse, Maintenance Director and Housekeeping/Dietary representative. Issues concerning notification of changes to responsible party/MD will be reviewed at the monthly safety meeting.</p> <p>The Quality Assurance/Process Improvement (QAPI) Committee, consisting of Director of Nursing, Physician and at least three other members of the facility staff will review safety committee findings X 3 months then quarterly thereafter to determine the need for additional education and/or monitoring.</p>	08/01/13

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F 157	Continued From page 3 the morning, the procedure would be to notify the family in the morning, if no major injuries occurred. The Restorative Nurse revealed she was not certain if resident's family was notified, but added family should have been notified of resident's fall. Interview with the Assistant Director of Nursing (ADON), on 07/10/13 at 4:10 PM, revealed Resident #7's family was not notified when resident fell on 07/08/13. She stated the twenty-four (24) hour/change of condition report revealed Resident #7's family should have been notified the following morning; however, the ADON could not locate any documented evidence the family was notified. The ADON stated the family, "absolutely", should have been notified.	F 157		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the resident environment remained free of accident hazards. Observation of water	F 323	<ul style="list-style-type: none"> On the day of survey any resident who had used the sinks with the temperature above 110o degrees had the potential to be affected. The sinks that had temperatures higher than 110 degrees were immediately adjusted to get temperature at or below 110 degrees. The residents who reside in the affected rooms and any other resident or visitor had the potential to be affected by the temperatures if their exposure would have been for a prolonged period. 	

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F 323	Continued From page 4 temperatures in resident rooms on 07/11/13 revealed temperatures of 118 degrees Fahrenheit in two resident rooms, Room #1 and Room #7. The findings include: Water temperatures observed during the environmental walk-through with the Maintenance Director, on 07/11/13 between 10:35 AM and 11:15 AM revealed water temperatures taken by the Maintenance Director in the sink of Resident Room #7 at 10:47 AM was 118 degrees Fahrenheit. A water temperature taken in the sink of Resident Room #1 at 10:51 AM was also 118 degrees Fahrenheit. A review of water temperature logs maintained weekly by the Maintenance Director revealed no recorded temperatures above 110 degrees Fahrenheit. Interview with the Maintenance Director, on 07/11/13 at 10:53 AM, revealed his goal was to maintain temperatures around 110 degrees Fahrenheit, 112 degrees Fahrenheit at most. He further revealed he had heard temperatures of 115 degrees Fahrenheit were safe. While the Maintenance Director did state temperatures of 118 degrees Fahrenheit were "a little high," he believed they were not sufficient to cause burns. The Maintenance Director revealed, in addition to weekly monitoring, he would adjust the water temperatures based on information provided by staff indicating they were cold or hot. The Maintenance Director revealed no one had reported to him water temperatures were too hot.	F 323	The maintenance director has monitored the temperatures daily and will continue to do so for the next month to insure the water temperatures remain at or below 110 degrees. Safety committee will monitor the maintenance temperature reports for next three (3) months. The QAPI committee will review Safety committee minutes for the next three quarters to insure continued compliance. In addition the Safety committee which is comprised of Administrator, Infection control nurse, Maintenance, Housekeeping and dietary representative team members, will be charged with the following process each month at the meeting. 1. Audit and identify any environmental hazards and residents at risk. 2. Evaluate and analyze any risk, hazard, or potential accident. 3. Implement appropriate interventions and or corrections, (and where appropriate care plan(s)). 4. Monitor and modify interventions and report findings to the administrator and others to insure compliance. All staff will be required to complete a course which corresponds to federal regulations: F323 on line course through Care2Learn University. Staff will complete by August 30, 2013(See Attached course description) Corrected on August 31, 2013	08/31/13	

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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 Type III (200) SMOKE COMPARTMENTS: Three (3) 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 07/10/13. River Valley Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds with a census of one fifty-nine (59) on the day of the survey. 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	K 000	This deficient practice could affect all residents due to this being a system for Fire alarm which is designed to give everyone an early warning in case fire is detected. All Residents, Staff, Visitors and volunteers can be affected if the Fire alarm system is not functioning properly, due to not being properly and regularly inspected. The Maintenance Director and Administrators have marked each of their calendars for the dates that the inspections of all systems are due, to insure these inspections are not missed and are done timely. The Safety Committee which is chaired by the Restorative Nurse and has members from each department will review and maintain a list of all system inspections and the dates these are due. At the monthly meetings of the Safety Committee the inspection reports will be documented by the Maintenance Director and given to the committee to verify timeliness and completion. Completion date August 31, 2013	8/25/13 08/31/13 per TO E K. Ullage 8/15/13 3 pm
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RECEIVED
AUG 12 2013
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kenneth W. Ullage</i>	TITLE Administrator	DATE 8/2/13
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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 03/15/72</p> <p>SURVEY UNDER: NFPA 101 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story Type III (200)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system</p> <p>SPRINKLER SYSTEM: Complete (wet) sprinkler system</p> <p>GENERATOR: One (1) Type II Diesel generator.</p> <p>A standard Life Safety Code survey was conducted on 07/10/13. River Valley Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds with a census of one fifty-nine (59) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000	<ul style="list-style-type: none"> This deficient practice could affect all residents due to this being a system for Fire alarm which is designed to give everyone an early warning in case fire is detected. All Residents, Staff, Visitors and volunteers can be affected if the Fire alarm system is not functioning properly, due to not being properly and regularly inspected. The Maintenance Director and Administrators have marked each of their calendars for the dates that the inspections of all systems are due, to insure these inspections are not missed and are done timely. The Safety Committee which is chaired by the Restorative Nurse and has members from each department will review and maintain a list of all system inspections and the dates these are due. At the monthly meetings of the Safety Committee the inspection reports will be documented by the Maintenance Director and given to the committee to verify timeliness and completion. Completion date August 25, 2013 	08/25/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K 000	Continued From page 1	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection record review, it was determined the facility failed to test and maintain the fire alarm system per NFPA standards. The deficiency had the potential to affect all compartments, all residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty-nine (59) on the day of the survey. The findings include: Fire alarm inspection record review, on 07/10/13 at 11:15 AM, with the Maintenance Director, revealed the facility failed to provide documentation to show the fire alarm system inspection had been completed the first quarter of	K 052		

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K 052	<p>Continued From page 2</p> <p>2013. Documentation of Fire Alarm quarterly inspections on 06/03/13, 11/28/12, and 09/07/12 revealed the system was in compliance and in working order.</p> <p>Interview, on 07/10/13 at 11:15 AM, with the Maintenance Director revealed he was unaware that the contractor had not completed the quarterly inspection.</p> <p>Interview, on 07/10/13 at 12:00 PM, with the Administrator revealed he was unaware of the Fire Alarm inspection not completed but would start monitoring the quarterly required inspections for compliance.</p> <p>NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p>	K 052		
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