

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

PRINTED: 09/18/2014  
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  09/05/2014
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  A Recertification Survey was initiated on 09/02/14 and concluded on 09/05/14 with deficient practice cited at the highest scope and severity of an "E".	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 the form exists, nor does the center admit to any statement, 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 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS  Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.  The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)  The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.  The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.  The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159	As stated in the deficiency, The Resident funds 10/01/2014 of 54 residents out of 59 were not in an interest bearing account. This was a decision made by this Administrator to comply with what he felt was the intent of the regulation. Having to take more fees out than was earned on the interest was thought to be a misappropriation of funds by regulation.  The bank has been contacted to start the interest bearing account with monthly fees starting October 1, 2014.  Other residents who have money placed with the facility would be affected by this practice and this could be Medicaid recipients as well as private pay residents who wish to have money available at the facility through this account.  The measures put into place to insure this will not recur are that this Administrator will pay the monthly fees so that the residents will not have their money reduce. This Administrator will also be contacting the Members of Congress to notify them of this regulation that has the potential to take money away from the residents contrary to the intent of the regulation. When this regulation was was instituted, it was not anticipated that interest rates would be less than the fees charged by the banks on these accounts below the \$20,000.00 average balance per month. (See attached letter from Fifth Third Bank statement showing interest earned for the year.)	10/01/2014

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

*Kim Dalg...*

TITLE

Administrator

(X5) DATE

9/26/2014

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 159 Continued From page 1

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:  
Based on record review and interview, it was determined the facility failed to deposit resident personal funds in excess of \$50 in an interest bearing account for fifty-four (54) of fifty-nine (59) facility residents.

The findings include:

Record review of recent resident accounting statements revealed no evidence of the resident account bearing interest.

Interview with the Facility Accountant, on 09/05/14 at 11:30 AM, revealed throughout last year resident funds only earned forty cents (\$.40) interest. The Facility Accountant went on to reveal an interest-bearing account was not financially beneficial to residents, as there was a fee of twenty-five dollars (\$25.00) a month on interest bearing accounts with less than twenty-five thousand dollars (\$25,000.00) in them.

F 159 continued from page 1

The facility will have the members of the Compliance and Integrity Committee monitor this account on a monthly basis to insure that interest is accruing and posted to the residents as prescribed by this regulation. This monitoring will continue until the regulation is changed or the interest rate is more than the bank charges.  
(This committee is composed of the Administrator, the Social Services Director, the Business Office Manager and the Facility Accountant.)

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F 159 Continued From page 2

Interview with the Administrator, on 09/05/14 at 12:00 PM, revealed he had checked with other financial institutions and had not found one that would not charge them to have an interest-bearing account. The Administrator went on to state if the facility had to pass along a charge of twenty-five dollars (\$25.00) a month on residents with accounts, residents would actually be losing money instead of earning money.

F 252 SS=E 483.15(h)(1) 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 and interview, it was determined the facility failed to provide a clean, comfortable and homelike environment for residents. Observation of unit bathrooms revealed dark stains on the grout between shower tiles, cracked and missing tiles, chipped paint on pipes and fixtures, and scrapes on the walls.

The findings include:  
Observation, on 09/02/14 at 11:50 AM, of the Unit A shower room revealed a dark stains between tiles in the shower, more pronounced near the lower walls of the shower and on the floor of the shower. Broken and missing tiles were observed

F 159

F 252 This deficiency is for Safe/Clean/Comfortable/Homelike Environment which was based on observations of Stain on Grout, cracked and or missing tiles, chipped paint on pipes and fixtures and scrapes on the walls of the shower rooms used by all residents. As indicated to the surveyor, at the time of the tour this had already been noted and bids were being requested prior to the survey. Bids were received within a few days of the survey being completed. The bids for the tile work has been approved and started in the "A" wing shower room where all tile is being replaced because it cannot be matched with current tiles. The walls have been painted and the scrapes have been repaired. Pipes and fixtures have been repaired, replaced or repainted depending on what was needed. Once the tile work has been complete, the paint will be touched up if required.

10/10/2014

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F 252 Continued From page 3

on the wall to the right of the shower. Chipped paint was observed on pipes near the toilet and beneath the sink. A scrape was observed to the left of the toilet down to the concrete, approximately one foot (1') in length, eighteen inches (18") off the floor. Additionally, paint was observed missing from the radiator vent and rust spots were observed on the radiator vent.

Observation, on 09/02/14 at 12:05 PM, of the Unit B shower room revealed dark stains between tiles in the shower, with stains being more pronounced near the lower walls of the shower and on the floor of the shower.

Interview during tour with the Environmental Services Supervisor (ESS), on 09/04/14 at 10:15 AM, revealed shower rooms were cleaned daily by housekeeping staff and after each use by nursing staff. The ESS went on to reveal she believed the dark stains between tiles were where bleach had settled and discolored the grout. Regarding the wall scrape, missing paint, and broken or missing tilework, the ESS agreed it did not promote a homelike environment, and stated she would not want her bathroom at home to look like that.

Additionally, observation during tour of resident bathrooms on Unit B, specifically the bathroom shared by rooms five (5) and six (6), and the bathroom shared by room seven (7) and eight (8) revealed the appearance of bubbled and missing paint on toilet seats. This was pointed out to the ESS, who revealed she replaced toilet seats in resident bathrooms when they looked like that, and she had not been aware of these. The ESS was unable to recall the last time toilet seats had been replaced.

F 252 The toilet seats in all rooms that were sited plus several others have been replaced. The grout has been scraped out and replaced as needed to correct the problems of stains that could not be cleaned.

A homelike environment is required for all residents and affects a their feeling of "home" if it is not properly cleaned and maintained. This has the potential to affect all the residents who currently use the shower rooms and any residents who might need to use these shower rooms which means that all residents have the potential to be affected.

New tile and grout are being installed, new toilet seats have been installed, the pipes and fixtures have been replaced or repaired and the Safety Committee will be required to take a tour of the facility every month to review the shower rooms and other areas for needed repairs and work orders will be completed to notify Maintenance of the issues.

The Safety Committee will bring minutes of their monthly meeting to the Quality Assurance Meeting scheduled for October 29, 2014 for discussion and further action, if needed. The Quality Assurance Committee is made up of the Medical Director, Administrator, Director of Nursing, Social Services, Director, Activities Director, Dietary Manager, Environmental Service Director, Restorative Nurse, Quality Assurance/Infection Control Nurse and representatives from Pharmacy and Laboratory Services.

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F 252	Continued From page 4  Interview and tour with the Administrator, on 09/04/14 at 10:25 AM, revealed both Unit A and Unit B shower rooms were in use. The Surveyor provided Administrator a description of the concerns, and Administrator shared unit bathrooms had been identified as a concern, and they had been taking bids to have them redone. The Administrator was agreeable he would not want a bathroom at home to look like that, and whether it was clean or not he would be concerned if it didn't look clean. The Administrator went on to say housekeeping may need to spend more time cleaning resident shower rooms, and maintenance may need to scrape up and reapply grout more often to keep bathrooms looking cleaner.	F 252	In addition to the Safety Committee making monthly rounds, the President of the Board and/or the Administrator will make a tour of the facility at least monthly and review the condition of the facilities physical plant to insure the homelike environment is maintained.		
F 441 SS=D	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	F441	1. Resident #3 was assessed; no change in mental or physical status noted to resident #3 and the medical record was reviewed for any changes in condition which required a need to alter treatment. Corrective action has been accomplished for the alleged deficient practice in regards to CNA #2. CNA #2 completed a teaching moment and Care2Learn, Education Unit Course on Infection Control dated 09/25/2014. See attachment #. 2. Facility residents that require peri-care and/or who who are incontinent of bowel and bladder have the potential to be affected by the same alleged deficient practice. The Director of Nursing and the Minimum Data Survey Coordinator have identified those residents who have the potential to be affected by examining medical records and Minimum Data Survey assessments.	10/08/2014	

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F 441 Continued From page 5  
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.

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 maintain an Infection Control Program designated to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for one (1) of fifteen (15) sampled residents (Resident #3).

The findings include:  
Review of the facility's policy titled "Hand Washing Procedure, Infection Control", revised 05/04/11, revealed its purpose was to control and prevent the spread of microorganisms from one resident to another through utilization of proper hand washing technique.

F 441 continued from page 5  
3. Measures put into place to ensure the alleged deficient practice does not recur includes: An in-service will be provided by the Director of Nursing education staff on F Tag 441. All nursing personnel, in addition to newly hired staff, will be required to complete a Care2Learn Education Course on Infection Control. A teaching moment which includes a copy of the updated Incontinent and Perinea Care Policy will be given to each nursing staff member to read and sign for understanding. Staff has been instructed to ask the Director of Nursing or Quality Assurance/Infection Control Nurse if there are any questions regarding the Incontinent and Perinea Care Policy. Individual reeducation will occur if concerns are noted.  
4. The facility plans to monitor its performance to ensure that solutions are sustained by: The Director of Nursing and/or Quality Assurance/Infection Control Nurse will perform weekly audits of at least 10% of residents to ensure compliance has been completed and documented on the Incontinent and Perinea Care Audit Tool 2 times weekly for 1 month then 1 time weekly for 2 months. The Director of Nursing or Quality Assurance/Infection Control Nurse will monitor results of the audit and report findings to the Quality Assurance Committee/Interdisciplinary Team monthly for 3 months. The Director of Nursing or Quality Assurance/Infection Control Nurse will determine the need for additional education and/or monitoring as needed.

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F 441 Continued From page 6  
Record review revealed Resident #3 was admitted to the facility on 12/07/12 with diagnoses which included Diabetes, Breast Cancer, Atrial Fibrillation, Aphasia, Dysphagia, Seizure Disorder, Depression and Anxiety.

Observation, on 09/04/14 at 9:35 AM, revealed Certified Nurse Assistant (CNA) #2 washed hands and donned gloves to perform perineal care. Continued observation revealed, after providing perineal care to Resident #3 CNA #2, without removing the contaminated gloves and washing hands, repositioned the resident and touched the bed linens.

Interview, on 09/04/14 at 9:45 AM, with CNA #2 revealed she should have removed the gloves and washed her hands before touching or repositioning the resident.

Interview, on 09/04/14 at 10:00 AM, with License Practical Nurse (LPN) #3 revealed CNA #2 should have removed her gloves and washed her hands before touching the resident.

Interview, on 09/04/14 at 10:50 AM, with Director of Nursing (DON) revealed CNA #2 should have removed the gloves and washed her hands and then repositioned the resident in the bed.

F 441

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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 09/02/14. The facility 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 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 deficiency identified at "F" level.</p>	K 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this plan of Correction, River Valley Nursing Home does not admit that the deficiency listed on the form exists, nor does the center admit to any statement, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ken Delg TITLE: Administrator (X6) DATE: 9/29/2014

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K 025 SS=F NFWA 101 LIFE SAFETY CODE STANDARD

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, sixty (60) residents, staff and visitors.

The findings included:

Observations on 09/08/2014 between 12:20 PM and 12:30 PM, with the Maintenance Director, revealed the smoke barrier wall located in the attic above rooms 15B and 14B had unsealed penetrations around two (2) pieces of metal conduit and an unsealed penetration around one (1) piece of flexible conduit. Further observations revealed the smoke barrier wall located in the attic above rooms 2B and 1B had four (4) open pieces of metal conduit that were not sealed.

Interview with the Maintenance Director, on

K 025 1. This alleged deficient practice could affect all residents due to the three (3) of four (4) smoke compartments failed to have maintained proper fire resistance or holes filled which would allow the fire and or smoke to penetrate into other areas.

2. All staff, visitors, family members and volunteers have the ability to be affected if the smoke barriers are not maintained properly. If the barriers are not maintained, the smoke and or fire has the potential to penetrate into other areas.

3. The Maintenance Director has completed the repairs or installed the "Proper" fire resistance material to insure that the smoke or fire does not penetrate into other areas. The Maintenance Director also completed an inspection of other areas to make sure all penetrations were filled to the proper fire rating with the proper material.

4. The Maintenance Director has been instructed to log any repairs done to these areas so that the Administrator can verify that the repairs can be inspected upon completion and that all penetrations are filled properly at the time to insure the safety of all residents, staff, families and volunteers.

5. The repairs were completed on 09/22/2014.

09/22/2014

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K 025	<p>Continued From page 2</p> <p>09/08/14 at 12:20 PM, revealed he was not educated on maintaining smoke barriers when he was hired at the facility.</p> <p>Observation on 09/08/2014 at 12:40 PM, with the Maintenance Director, revealed the block wall that served as a smoke barrier wall above room 1A had unsealed penetrations around two (2) pipes and an opening in the block wall.</p> <p>The findings were confirmed with the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 edition) 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p>	K 025	
(X5) COMPLETION DATE			

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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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K 025 Continued From page 3

(3) \*Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:

- a. The material shall be capable of maintaining the fire resistance of the fire barrier.
- b. The material shall be protected by an approved device that is designed for the specific purpose.

(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:

- a. It shall be made on either side of the fire barrier.
- b. It shall be made by an approved device that is designed for the specific purpose.

8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:

(1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions:

- a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.
- b. It shall be protected by an approved device that is designed for the specific purpose.

(2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one

K 025

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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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K 025 Continued From page 4 of the following conditions:

a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.

b. It shall be protected by an approved device that is designed for the specific purpose.

(3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:

a. It shall be made on either side of the smoke barrier.

b. It shall be made by an approved device that is designed for the specific purpose.

K 025

K 029 SS=D 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 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

K 029

The doors are self closing doors and non-rated or field applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. These doors are required to have a self-closure and the penetrations need to be sealed.

1. There were four areas noted that require self closures are the boiler room, maintenance, clean linen room therapy storage area doors. This did not affect any resident specifically but has the potential to affect all residents since it involves Life Safety and or fire safety issues.
2. This also has the potential to affect anyone in the building including the residents, visitors, staff and volunteers.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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K 029	<p>Continued From page 5</p> <p>determined the facility failed to ensure hazardous areas were protected, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, five (residents), staff and visitors.</p> <p>The findings include:</p> <p>Observation with the Maintenance Director, on 09/02/2014 at 12:43 PM, revealed the Clean Linen room was being used for storage of clean linen and medical supplies in boxes. Further observation revealed the room was not equipped with a self-closer, and contained multiple penetrations of the smoke partition walls. Interview with the Maintenance Director revealed he was not aware the door needed a self-closer and the penetrations needed to be sealed.</p> <p>Observation on 09/02/2014 at 12:51 PM, with the Maintenance Director, revealed the Maintenance Office/Area door was not equipped with a self-closer. Interview with the Maintenance Director, revealed he was not aware the Maintenance Office/Area needed a self-closer.</p> <p>Observation on 09/02/2014 at 12:53 PM, with the Maintenance Director, revealed the Boiler Room door was not equipped with a self-closer. The Boiler Room contained gas-fired equipment. Further observation revealed unsealed penetrations around five (5) pipes that penetrated the block wall of the Boiler Room. Interview with the Maintenance Director at the time of the observation revealed he was not aware the Boiler Room door needed a self-closer and the penetrations needed to be sealed.</p>	K 029	<p>3. The clean linen room, boiler room door, therapy storage and maintenance office area doors have had self closures installed by the Maintenance Director to insure compliance with this requirement. The penetration have been sealed in areas cited, which included the Clean linen, Boiler room, and above the ceiling in room 1-A with materials capable of maintaining the fire resistance of the fire barrier.</p> <p>4. The safety committee will be required to check these doors monthly and any other doors that currently have self closures.</p> <p>(See attached list of Safety Committee.)</p> <p>09/22/2014</p>

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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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K 029 Continued From page 6

Observation with the Maintenance Director, on 09/02/2014 at 1:02 PM, revealed the Therapy storage area door was not equipped with a self-closer. Further observation revealed the area was used for the storage of various items. Interview with the Maintenance Director revealed he was not aware the Therapy storage area door needed a self-closer.

The findings were confirmed with the Administrator during the exit conference.

Reference: NFPA 101 (2000 edition)  
8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke.

8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces.

Exception:\* Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met:

(a) The ceiling system forms a continuous membrane.

(b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling.

(c) The space above the ceiling is not used as a plenum.

19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a

K 029

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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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K 029 Continued From page 7  
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. Hazardous areas shall include, but shall not be restricted to, the following:  
(1) Boiler and fuel-fired heater rooms  
(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)  
(3) Paint shops  
(4) Repair shops  
(5) Soiled linen rooms  
(6) Trash collection rooms  
(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the 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 050 SS=F NFPA 101 LIFE SAFETY CODE STANDARD  
Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.

K 050 Fire drills are held at unexpected times under varying conditions at least quarterly on each shift. The are familiar with procedures and is aware that drills are are a part of our established routine. Responsibility for planning and conducting drills is designed only to competent persons who are qualified to exercise leadership.

10/01/2014

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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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K 050 Continued From page 8  
Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:  
Based on record review and interview it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect sixty (60) residents, staff and visitors.

The findings included:

Record review of the facility fire drills documentation, on 09/02/14 at 2:00 PM, revealed the facility had conducted all fire drills for each shift at the same time every quarter. Interview with the Maintenance Director confirmed the findings. Further interview revealed the Maintenance Director was not aware of the requirement to conduct fire drills at various times and under various conditions.

The findings were confirmed with the Administrator during the exit conference.

Reference: NFPA 101 (2000 edition)  
19.7.1.2\* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses,

K 050 continued from page 8  
Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms. 10/01/2014  
1. No specific resident was affected but all residents have the potential to be affected. Fire drills were held and will be conducted on all shifts as required and will be documented.  
2. All residents, families, visitors and staff would be affected by this deficient practice if a fire were to occur and the staff not be properly trained.  
3. In this case, the drills were held but not varying by time. The Maintenance Director will conduct shifts at unexpected times under varying conditions on each shift quarterly as required, the drill will be documented and a copy will be placed in the Maintenance Department and the Business Office to insure copies are available when requested.  
4. This will be monitored by the Administrator monthly to insure continued compliance.

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

PRINTED: 09/18/2014  
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  B. WING _____	(X3) DATE SURVEY COMPLETED  09/02/2014
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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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K 050 Continued From page 9  
interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

4.7.1 Where Required. Emergency egress and relocation drills conforming to the provisions of this Code shall be conducted as specified by the provisions of Chapters 11 through 42, or by appropriate action of the authority having jurisdiction. Drills shall be designed in cooperation with the local authorities.

4.7.2\* Drill Frequency. Emergency egress and relocation drills, where required by Chapters 11 through 42 or the authority having jurisdiction, shall be held with sufficient frequency to familiarize occupants with the drill procedure and to establish conduct of the drill as a matter of routine. Drills shall include suitable procedures to ensure that all persons subject to the drill participate

4.7.3 Competency. Responsibility for the planning and conduct of drills shall be assigned only to competent persons qualified to exercise leadership.

4.7.4 Orderly Evacuation. In the conduct of drills, emphasis shall be placed on orderly evacuation

K 050

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

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FORM APPROVED  
OMB NO. 0938-0391

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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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K 050	Continued From page 10 rather than on speed.  4.7.5* Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency.  4.7.6 Relocation Area. Drill participants shall relocate to a predetermined location and remain at such location until a recall or dismissal signal is given.	K 050			