

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER River Haven Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 867 McGuire Avenue Paducah, KY 42001	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents had a right to a safe, clean, comfortable, and homelike environment which had the potential to affect all of the facility's 81 residents. The findings include: Review of the facility policy titled, Homelike Environment Standard of Practice, reviewed 04/2025, revealed the facility was to provide residents with a safe, clean, comfortable, and homelike environment. In addition, policy review revealed the facility was to encourage residents to use their personal belongings to the extent possible. Further review revealed the facility's protocol included cleanliness and order. Review of the facility policy titled, Resident Rights Standard of Practice, reviewed 04/2025, revealed the facility was to ensure each resident was treated with respect and dignity, and cared for in a manner that promoted maintenance or enhancement of his/her quality of life. Further review revealed the facility's residents had the right to a safe, clean, comfortable, and homelike environment. Observation on 08/19/2025 at 9:30 AM, of the 100 Hall shower room, revealed a dirty adult brief lying in a shower chair and a pile of dirty linens lying on the floor. Continued observation of the shower room revealed the toilet was full of feces, and a mold-like substance on the ceiling and wall tiles in the shower. During interview with Housekeeper (HK) 1 on 08/19/2025 at 9:55 AM, she stated she had worked at the facility for three months, and mold was all over the facility. She said the mold was there when she started working at the facility; however, she had not reported it to anyone. HK 1 said the residents deserved a clean and safe place to live. She further stated she was responsible for cleaning the shower rooms daily, but they were short staffed and only had six hours a day to get their jobs done. During interview with the HK Supervisor on 08/19/2025 at 3:10 PM, she stated the facility was aware of the mold issue, but had failed to do anything about it. She said she and her staff worked for a contract company. The HK Supervisor reported she expected the showers to be cleaned daily and deep cleaned once a week. She further stated they were short staffed and were only allotted six hours to clean the whole facility. During interview with Resident (R)2 on 08/20/2025 at 1:15 PM, she stated she had seen mold in the shower room. She reported the mold was all over. R2 further stated she had not said anything to anyone about it because she thought they already knew. During interview with R26 on 08/20/2025 at 2:20 PM, he stated mold was all over the showers, including the walls, ceiling and floors. He further stated he did not said anything about it though because the facility would not have done anything about it. During interview with the Maintenance Director on 08/20/2025 at 4:00 PM, he stated the black substance on the shower floors was most likely the grout he just replaced. He reported however, the ceiling and wall tiles were probably molded. The Maintenance Director said he had noticed the mold on 08/18/2025, and had one of the assistants put some sealer on the ceiling earlier today. He stated nobody had reported the mold to him though. The Maintenance Director further explained the facility did have a system in place to report things that needed to be repaired or replaced and he was trying to educate staff to use it. He said there had been a lot of staff turnover in the last few months since he started working at the facility. The Maintenance Director further stated he was unsure of the cause of the mold because he had not had time to crawl into the attic to investigate it. During interview with the Director of Nursing (DON) on 08/26/2025 at 11:30 AM, she stated she was unaware of mold being in the shower rooms. She further stated mold could cause respiratory problems and skin rashes for residents or staff. During interview with the Administrator on 08/26/2025 at 11:45 AM, she stated maintenance was responsible for checking for (water) leaks. She stated she expected mold issues in shower rooms to be identified and treated. The Administrator reported she expected staff to follow facility policy as well as state and federal guidelines. She further stated going forward, shower rooms would be inspected periodically to identify issues before they became problems.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to report an alleged violation of abuse related to an allegation that occurred on or around 03/10/2025 for 1 of 5 residents sampled for abuse out of the total 26 sampled residents, (Resident (R)8). The findings include: Review of the facility's policy titled, Abuse Prohibition Standard of Practice reviewed 04/2025, revealed sexual abuse was defined as nonconsensual sexual contact of any type with a resident/patient. Continued review revealed it was the policy of the facility to report allegations of sexual abuse to the State Survey Agency (SSA), Adult Protective Services (APS), and all other required agencies within the specified time frames. Further policy review revealed the results of all investigations were to be reported to the appropriate state agency within 5 working days of the alleged violation's initial report. Review of the admission Facesheet for R8 revealed the facility admitted the resident on 01/17/2025, with diagnoses that included acute upper respiratory infection, alcohol abuse, bipolar disorder, and cellulitis of unspecified part of limb. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/22/2025, revealed the facility assessed R8 as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident had intact cognitive function. Review of a facility document titled, Assessment, dated 04/22/2025, provided by APS, revealed R8 called APS on 04/22/2025 to report on an unspecified date in March of 2025, he woke up to Certified Nurse Aide (CNA) 6 touching him inappropriately in a sexual nature, in his private region. Continued review of the document revealed R8 told APS he reported that information to the facility and was told not to go around CNA 6 anymore. Further review revealed in was noted the facility told CNA 6 he could not work with R8 anymore and to not go into the area where R8's room was. Review of Rehab (self care) care plans, dated 01/17/2025 through 04/16/2025, for R8 revealed a care plan started on 03/10/2025, with a description/intervention of Resident prefers no male caregivers. During interview with Department for Community Based Services (DCBS) 2 on 08/19/2025 at 2:49 PM, he stated he could not figure out why R8 had been in the nursing home to begin with because he was so independent. He stated R8 told him that he overheard a staff member talking to his boyfriend on the phone which triggered a discussion about homosexuality. DCBS 2 reported R8 told him he did not have anything against gay people, but he did not swing that way. He said R8 reported he had been lying on his stomach in his bed and felt the staff member touch the back of his right leg and thigh. DCBS 2 explained R8 told him the staff member also knelt down beside him like he was going to give him oral sex. He stated R8 told him that had made him really uncomfortable, and he talked about it all the time like he was going to pursue legal action. DCBS 2 reported he had spoken to the Administrator about the incident involving R8, and the Administrator was very dismissive of the allegation and at first denied knowing about the incident. He said he (DCBS 2) had to drag it out of him (the Administrator). DCBS 2 stated R8 told him he told the Social Worker (SW) about what happened, and SW denied being told about the incident by R8. He further stated he unsubstantiated his investigation against CNA 6 because it had basically been one person's word against the other. During interview with the facility's Administrator on 08/20/2025 at 11:00 AM, she stated the facility had no investigation file related to the alleged sexual abuse incident that occurred on or around 03/10/2025, involving R8 and CNA 6. During interview with CNA 5 on 08/20/2025 at 4:00 PM, she stated she remembered R8 used to talk her head off about somebody trying to hit on him. She said R8 had already told everyone, including the Administrator about the incident. CNA 5 explained she told the nurse about what R8 was saying, but did not remember who the nurse was. She further stated R8 told her that it was a male staff member that was gay, but they had like four gay male staff members, so she never knew who it was. During interview with the facility's former Administrator on 08/20/2025 at 4:46 PM, he stated he remembered R8, and said the incident in question had been reported to APS by the resident. He reported he had been aware R8 made allegations of a staff member touching him inappropriately, but come to find out he just was not used to people waking him up in the middle of the night because he had been in prison. The Administrator explained he did not report the allegations/incident to OIG (Office of Inspector General) or perform an investigation, because nothing happened. He further stated the facility had a soft file on the incident, and he did not know where the file was located as he was not the Administrator anymore. Review of a soft file (requested after the interview with the former Administrator) provided by the facility's current Administrator, for the incident involving R8, revealed it contained no documentation related to the incident involving R8 and CNA 6. Continued review of the soft file revealed it contained only a grievance form dated 01/29/2025 and		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to thoroughly investigate an alleged abuse violation related to an allegation that occurred on or around 03/10/2025 for 1 of 5 residents sampled for abuse out of the total sample of 26, (Resident (R)8). The findings include: Review of the facility's policy titled, Abuse Prohibition Standard of Practice reviewed 04/2025, revealed sexual abuse was defined as nonconsensual sexual contact of any type with a resident/patient. Per review, the facility's Administrator or designee was to oversee the center in conducting an internal investigation of any violation/alleged violation of abuse. Continued review revealed a report of the results of the investigation to the enforcement agency was to occur in accordance with state law, including the State Survey Agency (SSA) within five working days of the incident. Policy review revealed the (facility's) investigations were to be prompt, comprehensive, and responsive to the situation. Review of the policy revealed the facility's investigation was to include: notification of physician and resident/resident representative; identification and removal of the alleged person or persons; type of alleged abuse and where and when the incident occurred. Further review revealed the investigation was to also include: interviews of all involved persons including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations to obtain factual information; and follow-up resolution and measures to prevent repeat incidents. In addition, review revealed all material and documentation of the pertinent data to the investigation was to be collected, maintained, and safeguarded by the center (facility). Review of R8's Facesheet revealed the facility admitted him on 01/17/2025, with diagnoses that included bipolar disorder, cellulitis of unspecified part of limb, acute upper respiratory infection, and alcohol abuse. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/22/2025, revealed the facility assessed R8 to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating he was cognitively intact. Review of a document, provided by the State Adult Protective Services (APS) agency, titled, Assessment, dated 04/22/2025, revealed R8 called APS on 04/22/2025, to report on an unspecified date in March of 2025, he woke up to Certified Nurse Aide (CNA) 6 touching him inappropriately in a sexual nature, in his private area. Per review, R8 reported that information to the facility and he was told not to go around CNA 6 anymore. Review further revealed R8 also reported the facility told CNA 6 he could not work with the resident anymore and was not to go into the area where R8's room was located. Review of the facility's Rehab (self care) care plans, dated 01/17/2025 through 04/16/2025, revealed a care plan for R8 initiated on 03/10/2025, with an intervention noting, Resident prefers no male caregivers. In interview on 08/19/2025 at 2:49 PM, Department for Community Based Services (DCBS) 2 (an APS worker) stated R8 was independent and he could not figure out why the resident was in the nursing home. DCBS 2 said R8 told him he (R8) overheard a male staff member talking to his boyfriend on the phone that triggered a discussion with the resident about homosexuality. He explained R8 said he did not have anything against gay people; however, he did not swing that way. DCBS 2 informed him he (R8) had been lying on his stomach on his bed when he felt the (male) staff member touch the back of his right leg and thigh. He reported R8 told him the staff member also had knelt down beside him like he was going to give him oral sex, which made him really uncomfortable. DCBS 2 said he spoke to the Administrator about it and the Administrator had been very dismissive of the allegation and at first denied knowing about the incident involving R8. He stated he had to drag it out of him (the Administrator). DCBS 2 said R8 told him he told the Social Worker (SW) about it and the SW had denied being told about the incident by the resident. DCBS 2 further stated that he unsubstantiated his investigation against CNA 6 because it had basically been one person's word against the other. In interview on 08/20/2025 at 11:00 AM, the (current) Administrator stated there was no investigation file regarding the alleged sexual abuse incident that occurred on or around 03/10/2025 involving R8 and CNA 6. In interview on 08/20/2025 at 4:00 PM, CNA 5 stated she recalled R8 used to talk her (the aide's) head off about somebody trying to hit on him. She said R8 had already told everyone including the Administrator about the incident. The CNA further stated R8 told her it was a male staff member that was gay, but they had like 4 gay male staff members, so she never knew who it was. In interview on 08/20/2025 at 4:46 PM, the facility's former Administrator stated he was familiar with R8, and said the incident in question had been reported to APS by the resident. He reported he had been aware R8 made allegations about a staff member touching him inappropriately; however, had not performed an investigation. The former Administrator said the facility had a soft file (unofficial file) on the incident, but he did not know where the soft file was because he was no		