STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185272	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Haven Nursing and Rehabilitation Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for one out of five sampled residents (Resident (R)2). Review of the Diabetes Mellitus Care Plan for R2, revealed the care plan included interventions to provide regular podiatry care as ordered by the medical doctor (MD), which was not implemented.The findings include:Review of the facility's policy titled Comprehensive Care Plans Standard of Practice, reviewed 04/2025, revealed the facility's care planning / Interdisciplinary Team, in coordination with the resident, family, and/or representative were to develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain.Review of the Facesheet revealed the facility admitted R2 on 12/16/2025. Resident 2's diagnoses included diabetes mellitus, acquired absence of right leg above knee, and end stage renal disease (ESRD). Further review revealed R2 was discharged home from the facility on 04/02/2026 and was readmitted on [DATE].Review of the admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/20/2026 revealed the facility assessed R2 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R2 was cognitively intact.Review of the Diabetes Mellitus Care Plan for R2 revealed the care plan was established on 12/22/2025 and included the intervention to provide regular podiatry care as ordered by the medical doctor (MD). Further review of the care plan revealed it was reviewed by the MDS Coordinator on 03/20/2026 and 04/20/2026.Review of the Physician Orders dated 12/16/2025, revealed a general order for R2 to have consults with dental, vision, podiatry, psychiatric, pulmonology, audiology, and tele-medicine MD PRN of resident's choice.Review of the Physician Orders dated 12/16/2025, revealed a treatment order for R2's finger and toenails to be assessed once weekly by a nurse. Review of the Treatment Administration Record (TAR) dated December of 2025 through April of 2026, revealed documentation that an assessment was completed on R2's finger and toenails every seven days within the specified timeframe.Review of a Progress Note, dated 03/26/2026, revealed R2 was complaining that her great toenail had been rubbing against her second toe after sustaining a fall the day before. Further review of the progress note revealed the resident was quoted saying she missed the last time to see the foot doctor because she was at dialysis. Continued review of the progress note revealed the nurse practitioner was made aware and requested a podiatrist for R2.Review of a Progress Note, dated 04/24/2026, revealed Social Worker 1 documented that the dialysis center contacted the facility and asked the facility to make R2 an appointment with podiatry and it is noted that the nurse was made aware and replied she would make the appointment next week.Review of a Progress Note, dated 05/04/2026, revealed the facility sent a referral and request for an appointment with a podiatrist and the podiatry office was to contact the facility to schedule an appointment once approved. Observations in room [ROOM NUMBER] on 05/11/2026 at 4:08 PM, revealed R2 sitting up in her wheelchair. Further observation revealed the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's right leg had been amputated above the knee and the incision appeared healed. Continued observation revealed the resident removing her sock on her left foot to reveal extremely dry, flaky skin, her big toenail was thick and brown, growing sideways, and touching her second toe.During an interview with R2 on 05/11/2026 at 4:05 PM, she stated that no one at the facility tried to cut her toenail. She stated that the podiatrist had come here, but she was at dialysis when they came. She stated that the staff at the facility knew her toenail was long and touched her second toe. She stated the nurse practitioner did not look at her toes recently.During an interview with Licensed Practical Nurse (LPN)1 on 05/11/2026 at 11:40 AM, she stated that the resident wanted to do 360-care for podiatry and ophthalmology and they figured out that podiatry was coming on the resident's dialysis days and the resident was not able to see them. She stated that the resident wanted to go to Illinois to see a provider that she was already established with, but could not, due to her having insurance with Kentucky Medicaid. She stated that the resident had an ophthalmology appointment this month and the podiatrist's office was supposed to call with an appointment.During an interview with the podiatry company's MD on 05/11/2026 at 12:45 PM, he stated that the company sent consultants to the facility to see the residents for their podiatry needs. He stated that they were usually there monthly and saw patients on a rotating basis between every two to three months. He stated that they would come sooner if there was an urgent issue or medical necessity, upon request. He stated that it was 100% possible to rearrange or schedule to come on a different date than what was scheduled to accommodate the needs of the residents. He stated that they just received an email on 04/29/2026 from the facility's social services staff about coming on a different day for R2. He stated that they were scheduled to be at the facility on Tuesday, 05/26/2026. He stated that R2 was on their list to see on January 13th, and she refused to be seen. He stated that the next time they came was on 02/23/2026 and she was at dialysis and she was put back on the list to be seen on 04/10/2026, but she was discharged . He stated that after that they got the email on 04/29/2026 to tell them to come on a Tuesday or a Thursday. He stated that when they were there, they did a foot exam, checked for skin issues, looked for areas that may be breaking down, cut toenails, checked for interdigital infections, and would let the attending know if something needed to be looked at or followed.During an interview with R2's nurse at the dialysis center on 05/11/2026 at 4:49 PM, she stated that every time a foot check had been completed on R2, from initial admission at the clinic (December 2025) to date, she called the facility to ask about a podiatry referral. She stated on the initial foot check of 12/17/2025 and definitively on 02/11/2026, 03/13/2026, and 04/22/2026, she called to ask about the status of obtaining podiatry services for R2.During an interview with RN1 on 05/12/2026 at 9:00 AM, she stated that they had a treatment for R2's toe where we had to put iodine on her feet/nails. She stated that she missed her podiatry appointment, after that she discharged home and when she came back, she stated that she did not want to use the podiatrist that comes to the facility. She stated that she had not seen her toes recently and last time she saw it, it was curved over. She stated that she was not comfortable with cutting the resident's toenails herself. She stated that the resident had a podiatrist appointment that she missed. She stated that she was never notified by the dialysis center about their concerns. She stated that her DON handles rescheduling the providers that come to the facility. She stated that to her knowledge, she would be seen by an outside podiatrist.During an interview with LPN2 on 05/12/2026 at 11:00 AM, she stated that she normally worked on the 100-hall. She stated that social services was responsible for making sure the residents were seen by specialists in-house. She stated that they could give the podiatrists a call back to come see the residents if there was a need. She stated that foot wounds would not heal and it was imperative that someone looked at it because it could cause all kinds of complications like infections and amputations. She stated that the nurse should notify social services to call podiatry back to let them know the resident needed to be seen. She stated that she would follow up with them to make sure the resident was on the schedule to be seen. She stated that the nurses could cut toenails if they were not too thick and if they did not need a specialized tool to cut them. She stated that she was aware (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a call could be made for urgency or a missed appointment. She stated that she would let them know this resident needed to be seen as soon as possible.During an interview with the MDS Nurse on 05/12/2026 at 2:52 PM, she stated that a care plan was what they set up at the beginning of the residents' stay and it is updated throughout their stay. She stated that when residents come in, they start discharge planning and tailoring their care plans to the individual, so they are able to meet their highest functional ability. She stated that they have an interdisciplinary team and as of right now but, overall, it would be the MDS nurse to ensure the residents' care plans were updated properly. She stated that as of right now, the MDS nurse was implementing the care plans. She stated that the admitting nurse would initiate the care plan if the MDS nurse or interdisciplinary team was not available. She stated that she expected the care plans to be followed. She stated that she would see it as a concern if interventions were not followed on the care plan and she would investigate further if that occurred. She stated that R2 not being seen by podiatry thus far, is a problem because she had a care plan intervention for regular podiatry care. She stated that R2 came to this facility very sick and did not need to be discharged from the hospital based on her condition. She stated that the standard of practice for foot care in a long-term care facility is to assess the foot as part of their skin assessments. She stated that she did her own assessments rather than rely on the information that is charted in the system. During an interview with the Director of Nursing (DON) on 05/12/2026 at 4:07 PM, she stated that on admission, they did a baseline care plan and from the baseline, the MDS nurse came in and did a comprehensive care plan, and she and the IDT team would personalize it as needed. She stated that she expected the care plans to be followed and implemented. She stated that not following the care plan was a concern due to the negative outcomes of the resident not receiving the care they needed that was tailored to them individually. During an interview with the Administrator on 05/12/2026 at 4:42 PM, he stated that he expected his staff to reach out to the podiatrist to schedule the evaluation and treatment and for any reason if it needed to be rescheduled. He stated that he expected staff to follow the resident's care plan. Negative outcomes of the residents not following the care plans, in the situation of R2, she could cut her foot and have complications from that.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents received proper treatment and care to maintain good foot health. Additionally, the facility failed to provide foot care and treatment for Resident (R) R2 in accordance with professional standards of practice that included preventing complications from the resident's medical condition(s), assisting the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments, if needed for one of five sampled Residents (R2). An observation on 05/11/2026 at 4:08 PM revealed R2's left great toenail was thick, long, and curved to the left halfway over and was touching the 2nd digit.The findings include:During an interview with the Director of Nursing (DON) on 05/12/2026 at 2:02 PM, she stated the facility did not have a policy related to foot or nail care.Review of the Facesheet revealed the facility admitted R2 on 12/16/2025. Resident 2's diagnoses included diabetes mellitus, acquired absence of right leg above knee, and end stage renal disease (ESRD). Further review revealed R2 was discharged home from the facility on 04/02/2026 and was readmitted on [DATE].Review of the admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/20/2026 revealed the facility assessed R2 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R2 was cognitively intact.Review of the Diabetes Mellitus Care Plan for R2 revealed the care plan was established on 12/22/2025 and included the intervention to provide regular podiatry care as ordered by the medical doctor (MD). Further review of the care plan revealed it was reviewed by the MDS Coordinator on 03/20/2026 and 04/20/2026.Review of the Physician Orders dated 12/16/2025, revealed a general order for R2 to have consults with dental, vision, podiatry, psychiatry, pulmonology, audiology, and tele-medicine MD PRN of resident's choice.Review of the Physician Orders dated 12/16/2025, revealed a treatment order for R2's finger and toenails to be assessed once weekly by a nurse. Review of the Treatment Administration Record (TAR) dated December of 2025 through April of 2026, revealed documentation that an assessment was completed on R2's finger and toenails every seven days within the specified timeframe.Review of a Progress Note, dated 03/26/2026, revealed R2 was complaining that her great toenail had been rubbing against her second toe after sustaining a fall the day before. Further review of the progress note revealed the resident was quoted saying she missed the last time to see the foot doctor because she was at dialysis. Continued review of the progress note revealed the nurse practitioner was made aware and requested a podiatrist for R2.Review of a Progress Note, dated 04/24/2026, revealed Social Worker 1 documented that the dialysis center contacted the facility and asked the facility to make R2 an appointment with podiatry and it was noted that the nurse was made aware and replied she would make the appointment next week.Review of a Progress Note, dated 05/04/2026, revealed the facility sent a referral and request for an appointment with a podiatrist and the podiatry office was to contact the facility to schedule an appointment once approved. Observations in room [ROOM NUMBER] on 05/11/2026 at 4:08 PM, revealed R2 sitting up in her wheelchair. Further observation revealed the resident's right leg had been amputated above the knee and the incision appeared healed. Continued observation revealed the resident removing her sock on her left foot to reveal extremely dry, flaky skin, her big toenail was thick and brown, growing sideways, and touching her second toe.During an interview with R2 on 05/11/2026 at 4:05 PM, she stated that no one at the facility tried to cut her toenail. She stated that the podiatrist came, but she was at dialysis when they came. She stated that the staff at the facility knew her toenail was long and touched her second toe. She stated the nurse practitioner did not look at her toes recently.During an interview with Licensed Practical Nurse (LPN)1 on 05/11/2026 at 11:40 AM, she stated that the resident wanted to do 360-care for podiatry and ophthalmology and they figured out that podiatry was coming on the resident's dialysis days and the resident was not able to see them. She stated that the resident wanted to go to Illinois to see a provider that she was already established with, but could (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not, because she had insurance with Kentucky Medicaid. She stated that the resident had an ophthalmology appointment this month and the podiatrist's office is supposed to call with an appointment.During an interview with the podiatry company's MD on 05/11/2026 at 12:45 PM, he stated that the company sent consultants to the facility to see the residents for their podiatry needs. He stated that they were usually there monthly and saw patients on a rotating basis between every two to three months. He stated that they could come sooner if there was an urgent issue or medical necessity, upon request. He stated that it was 100% possible to rearrange or schedule to come on a different date than what was scheduled to accommodate the needs of the residents. He stated that they just received an email on 04/29/2026 from the facility's social services staff about coming on a different day for R2. He stated that they were scheduled to be at the facility on Tuesday, 05/26/2026. He stated that R2 had been on their list to see on January 13th, and she refused to be seen. He stated that the next time they came was on 02/23/2026 and she was at dialysis and she was put back on the list to be seen on 04/10/2026, but she had been discharged . He stated that after that they got the email on 04/29/2026 to tell them to come on a Tuesday or a Thursday. He stated that when they were there, they did a foot exam, checked for skin issues, and looked for areas that may be breaking down, cut toenails, and checked for interdigital infections and would let the attending know if something needed to be looked at or followed.During an interview with R2's nurse at the dialysis center on 05/11/2026 at 4:49 PM, she stated that every time a foot check had been completed on R2, from initial admission at the clinic (December 2025) to date, she called the facility to ask about a podiatry referral. She stated on the initial foot check of 12/17/2025 and definitively on 02/11/2026, 03/13/2026, and 04/22/2026, she called to ask about the status of obtaining podiatry services for R2.During an interview with RN1 on 05/12/2026 at 9:00 AM, she stated that they had a treatment for R2's toe where we had to put iodine on her feet/nails. She stated that she missed her podiatry appointment, after that she discharged home and when she came back, she stated that she did not want to use the podiatrist that came to the facility. She stated that she had not seen her toes recently and last time she saw it, it was curved over. She stated that she was not comfortable with cutting the resident's toenails herself. She stated that the resident had a podiatrist appointment that she missed. She stated that she was never notified by the dialysis center about their concerns. She stated that her DON handled rescheduling the providers that come to the facility. She stated that to her knowledge, she would be seen by an outside podiatrist.During an interview with the Social Services Director on 05/12/2026 at 10:05 AM, she stated that the nurse was responsible for making appointments and making sure residents were seen by an outside provider. She stated that she was responsible for making sure the resident was on the list to be seen by an in-house provider. She stated they had R2 on the list to be seen by their in-house podiatry and she refused to be seen. She stated that the resident was non-compliant and if the resident continued to refuse, they would not see her. She stated that she treated everything with urgency and she sent emails to the Podiatry Company to see if they could see her sooner because the resident asked her. She stated that when the resident told her at first that she wanted to see an outside provider, they worked on a referral for an outside provider. She stated that when there was a referral for an outside provider, the in-house providers did not see them. She stated that nursing sent a referral out for R2 for podiatry and ophthalmology. She stated that she had never spoken with anyone from dialysis about R2.During an interview with LPN2 on 05/12/2026 at 11:00 AM, she stated that she normally worked on the 100-hall. She stated that social services was responsible for making sure the residents were seen by specialists in-house. She stated that they gave the podiatrists a call back to come see the resident if there was a need. She stated that foot wounds would not heal and it was imperative that someone looked at it because it could cause all kinds of complications like infections and amputations. She stated that the nurse should notify social services to call podiatry back to let them know the resident needed to be seen. She stated that she would follow up with them to make sure the resident was on the schedule to be seen. She stated that the nurses could cut toenails if they were not too thick and if (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they did not need a specialized tool to cut them. She stated that she was aware that a call could be made for urgency or a missed appointment. She stated that she would let them know this resident needed to be seen as soon as possible.During an interview with the Nurse Practitioner for the facility on 05/12/2026 at 12:10 PM, she stated that she was familiar with R2. She stated that she remembered putting in a note on her chart requesting podiatry services for the resident. She stated that she did not remember when she last looked at the resident's foot, but she stated that she did not have any open areas and she had elongated toenails. She stated that the resident told her that she was not able to see podiatry when they were at the facility because they came on her dialysis days. She stated that she spoke to the ADON about it. She stated that it was important that she got her toenails cut because she lost her other foot to diabetic ulcers. She stated that R2 was a difficult resident and non-compliant. She stated that she often left dialysis early due to various excuses. She stated that when she was discharged from the facility last time, she did not follow through with her orders, her diet, her medicine, and continued to smoke and complain of shortness of breath. She stated that now she was making all kinds of complaints because the doctor would not restart her pain medicines because she did not need narcotic pain medicine for the kind of pain she was complaining of, like glaucoma pain. During an interview with the Director of Nursing (DON) on 05/12/2026 at 4:07 PM, she stated that R2 was admitted in December and they put her on the list for podiatry to see her and when they came, she refused. She stated that her feet were being assessed frequently. She stated that they reached out to in-house podiatry in April to ask them to come see her when she was not at dialysis. She stated that they also tried to send a referral to an outside provider, and the provider did not receive the fax they sent for the referral. She stated that if they could not get her a referral for an outside podiatry, in-house podiatry would see her. She stated that she expected the nurses to assess open areas, thick, long toenails, and report it to her and the doctor to get further orders. She stated that the patient was a diabetic and if she was to get an open area to the foot, they were harder to heal and the resident had a history of amputation of her other leg.During an interview with the Administrator on 05/12/2026 at 4:42 PM, he stated that he expected his staff to reach out to the podiatrist to schedule the evaluation and treatment and for any reason if it needed to be rescheduled. He stated that he expected staff to follow the resident's care plan. Negative outcomes of the residents not following the care plans, in the situation of R2, she could cut her foot and have complications from that.