

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  06/26/2025
NAME OF PROVIDER OR SUPPLIER  River Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  305 Taylor Street Butler, KY 41006	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview, record review, and review of the facility's policies, the facility failed to develop and 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, and mental and and psychosocial needs for 1 of 17 sampled residents, Resident (R) 34.</p> <p>R34 was identified as exhibiting exit-seeking behaviors on 05/25/2025, and a Wander Guard device was placed on 05/26/2025. However, R34 was not care planned for wandering.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plans, 2025, revealed the facility would develop and implement comprehensive person-centered care plans for each resident to meet the resident's medical, nursing, and mental and psychosocial needs, and all services would meet professional standards of quality.</p> <p>Review of the facility's policy titled, Elopement and Wandering Residents, 2024, revealed residents identified with wandering behaviors or risk for elopement would receive adequate supervision in accordance with their person-centered plan of care.</p> <p>Review of R34's admission Record revealed the facility admitted the resident on 09/09/2024 with diagnoses to include schizophrenia unspecified; unspecified psychosis not due to a substance or known physiological condition; and insomnia, unspecified.</p> <p>Review of R34's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/19/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of five of 15, indicating severe cognitive impairment. No behaviors were noted on the MDS at that time.</p> <p>Review of R34's Nurse Progress Note, dated 05/25/2025 at 11:18 AM, revealed R34 attempted to exit a door by the nurses' station, and she indicated, when approached by staff, she wanted to go outside.</p> <p>Review of R34's Elopement Evaluation, dated 05/25/2025 at 11:20 AM, revealed the resident wanders aimlessly or non-goal-directed.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R34's Physician's Orders, dated 05/26/2025, revealed an order for the placement of a Wander Guard (a wireless system that protected memory care residents from elopement with bracelets and door controllers).</p> <p>Review of R34's Nurse Progress Note, dated 05/26/2025 at 11:31 AM, revealed a Wander Guard was applied to R34's left ankle.</p> <p>Review of R34's Nurse Progress Note, dated 05/30/2025 at 12:57 PM, revealed R34 ambulated in the hallway by herself and sat in the lobby at times. Per the note, R34 continued to wander at times, and a code alert (Wander Guard) was in place.</p> <p>Review of R34's Comprehensive Care Plan, last revised 06/24/2025, revealed no care plan for wandering behaviors or indicating placement of a Wander Guard.</p> <p>In an interview on 06/26/2025 at 9:22 AM with the Minimum Data Set (MDS) Coordinator and Director of Nursing (DON), the DON stated before she became DON, she was the MDS Coordinator. She stated when the replacement MDS Coordinator left in late 2023, she worked in that position in addition to being DON. She stated the facility was actively looking for a new MDS Coordinator. The DON stated whoever entered the order for the Wander Guard, was supposed to do an elopement assessment and develop the care plan around those issues. She stated she was not sure how R34's care plan was missed, describing it as an oversight that had since been corrected once brought to her attention. She stated not just one person, but several people reviewed the care planning process, but R34's just got overlooked somehow. The DON also stated it was important for resident information to be on the care plan so every staff member knew what they were supposed to do, a guide to follow in providing care.</p> <p>In an interview on 06/26/2025 at 9:48 AM with the Administrator, she stated she did not have involvement in the care planning process. She stated her expectation was for care plans to be comprehensive and resident centered. She stated accurate care plans were important so staff knew how to provide appropriate care for each resident.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, interview, record review, review of the manufacturer's medication prescribing information, and review of the facility's policy, the facility failed to ensure residents were free of any significant medication errors for 1 of 4 sampled residents, Resident (R) 17.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Medication Administration, undated, revealed medications were administered by licensed nurses or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Further review revealed medications should be administered as ordered in accordance with manufacturer's specifications.</p> <p>Review of R17's admission Record revealed the facility admitted the resident on 09/11/2024 with diagnoses including chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD), and type 2 diabetes.</p> <p>Review of R17's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/04/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of R17's Physician's Orders revealed an active order, dated 06/11/2025, for Trelegy Ellipta inhaler one puff once daily for COPD. Further review revealed instructions for mouth to be rinsed after use to avoid oral thrush.</p> <p>Review of R17's electronic medication administration record (eMAR) revealed documented daily administration of Trelegy Ellipta inhaler that began on 06/11/2025 per physician order.</p> <p>Review of the manufacturer's prescribing information for Trelegy Ellipta, revised 12/2022, revealed instructions located under warnings/precautions that stated mouth should be rinsed with water without swallowing after inhalation, so the risk of oral thrush was reduced. Further review revealed Trelegy Ellipta contained the active ingredient, fluticasone furoate (corticosteroid).</p> <p>Observation on 06/25/2025 at 9:34 AM revealed R17 was administered Trelegy Ellipta inhaler; however, staff did not ensure the resident rinsed her mouth after administration per the manufacturer's specifications.</p> <p>In an interview with Kentucky Medication Aide (KMA) 1 on 06/25/2025 at 3:21 PM, she stated prior to administration of inhalers, she performed hand hygiene and donned clean gloves. KMA1 stated following administration of an inhaler, the resident rinsed with water if indicated so oral infections such as thrush were prevented. KMA1 stated she failed to ensure R17 rinsed her mouth after her inhaler was used this morning.</p> <p>In an interview with KMA2 on 06/26/2025 at 9:17 AM, she stated R17 received a daily inhaler, Trelegy Ellipta, and the resident administered it herself. KMA2 stated inhalers often led to thrush, and it was important R17 rinsed with water after use so oral infections were prevented.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the contracted Pharmacist on 06/26/2025 at 10:18 AM, he stated rinsing the mouth with water after use was generally recommended for inhalers that contained steroids. He further stated if a resident failed to rinse after use, left over residue from the inhaler potentially led to thrush or other oral infections.</p> <p>In an interview on 06/26/2025 at 10:52 AM with Licensed Practical Nurse (LPN) 4, she stated when residents received inhalers, it was important staff ensured they rinsed with water after use because inhalers left a powder residue that could cause oral infections.</p> <p>In an interview with the Director of Nursing (DON) on 06/26/2025 at 12:25 PM, she stated she expected staff practiced what they had learned when they administered medications and that included staff stayed at the bedside, knew why medication was given, ensured resident swallowed medication, and medication was given at the right time. She further stated the facility's policy for medication administration was used as a guideline for administering medications. The DON stated it was her expectation staff educated residents regarding proper use of inhalers, so they knew to rinse their mouth with water after use. The DON stated it was important residents rinsed after an inhaler was used so oral infections such as thrush were prevented.</p> <p>In an interview with the Administrator on 06/26/2025 at 12:31 PM, she stated she expected medications prescribed to residents were administered as ordered and directed. She further stated if staff had questions, they referenced the medication administration policy or called the physician for clarification. The Administrator stated the facility's policy related to medication administration stated manufacturer's specifications were followed. She further stated she knew it was important staff ensured residents rinsed their mouth following inhaler use but was unsure why it should be done.</p>		