Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100061	A. BUILDING _____ B. WING _____	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HAVEN REST HOME	190 MCDANIEL STREET SANDERS, KY 41083

(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) COMPLETE DATE
{P 000}	Initial Comments A onsite Revisit Survey was initated on 05/28/2024 and concluded on 05/28/2024. It was determined the facility had achieved substanital complaince on 04/02/2024 as alleged. Survey Date: 03/05/2024-03/08/2024 Survey Census: 40 Sample Size: 12	{P 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE S SIGNATURE | TITLE | (X6) DATE

(2)

PRINTED: 03/22/2024
FORM APPROVED

Office of Inspector General

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P 000	Initial Comments A Complaint and Re-licensure survey was initiated on 03/05/2024 and concluded on 03/08/2024. Complaints KY00032605, KY00034630, KY00035481, KY00036146, KY00037360, KY00040023, KY00040258, and KY00041928 were investigated during the course of the survey. Complaints KY00032605, KY00036146, KY00037360, KY00040023, and KY00040258 were within regulatory requirements. Complaints KY00034630, KY00035481, and KY00041928 were not within regulatory compliance and deficient practice was cited. The facility's census was 40.	P 000	This plan of correction is being completed soley for the purpose of complying with the regulatory requirements by virtue of completing this pl n of correction.The facility d e not admit to or acquese in he claim of regulatory violation The statements made here hould not be consented as admiss on of regulatory violation or any li bility resulting from any regulator violation.	
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4 Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility.	P 185	P185 1. Uncertain at this time how diagnoses pertains to any incidents . Residents of Valley Haven Personal Care Home all have a SMI diagnosis that we care for daily. No other residents identified as harmed by or because of this incident. The following were interviewed: R1 stated he feels safe in smoke rooms , he loves living here. He also stated he is not scared because he doesn't feel like anyone is going to hurt him or make him unsafe.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Pifer | TITLE: Chief administrator | (X6) DATE: 3-27-24

STATE FORM 6899 JYPP11 If continuation sheet 1 of 7

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APR 01 2024
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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P 185	Continued From page 1 This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide supervision and monitoring of the residents to assure that the residents' health care needs were met for three (3) of twelve (12) sampled residents, Resident (R)1, R5, and R12. .The findings include: Review of the document, "Resident Rights," dated 1992, revealed the facility must care for (the resident) in a manner that enhances (the resident's) quality of life. 1. Review of the health record revealed the facility admitted R1 on 07/07/2016 with a diagnosis of schizophrenia. Review of the health record revealed the facility admitted R2 on 10/04/2023 with diagnoses that included paranoia, schizophrenia, and anxiety. Review of the "Discharge Summary Final Report," dated 02/28/2024, revealed R1 was admitted to the acute care hospital on 02/24/2024. The report read that R1 presented to the hospital from his/her assisted living facility status post (s/p) assault with an acute right Subdural Hematoma (abbreviated SDH and meaning a bruise inside the resident's skull). R1 also suffered a nasal fracture, and facial lacerations. The acute care hospital discharged R1 on 02/28/2024. According to the report,	P 185	R2 stated he has no issues with smoke rooms, he likes living here, he has never felt unsafe. R3 stated why are you asking me these questions? I like the smoke rooms when it rains we stay dry and warm in winter. I am safe here. Are you asking everyone else this? R4 states I have lived here for a long time and have no problems with smoke room or anyone living here. Living here is alright. 2. Metal trash cans were removed from premises. Items were removed on 3-27-2024 two metal cans and six metal ash trays. Metal cans were replaced with non flammable rubber trash cans as well as rubber ash trays on 3-27-24. They were filled with sand for smoking purposes also on 3-27-24. Staff was educated by administrator and state ombusdsman on abuse and neglect on 3/12/2024. Staff was also educated on supervision and safety of all residents on 3/28/24. Please see attached inservice sheets for signatures of	3-27-2024 3-12-24 3-28-24

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P 185	Continued From page 2 procedures during R1's hospital stay were debridement and closure of laceration on 02/24/2024. R1's primary discharge diagnosis was acute subdural hematoma, right side. Secondary discharge diagnoses were facial lacerations, nasal fracture, dislocated intraocular lens, left eye, anisocoria (meaning different size pupils), subconjunctival hemorrhage and chemosis, periorbital edema and ecchymosis, both eyes, (meaning both of R1's eyes were swollen and bruised), schizophrenia, hypertension, chronic obstructive pulmonary disease, and diabetes. During an interview, on 03/05/2024 at 3:00 PM, R1 stated he/she has lived at the facility for "a long time," and that last month R2 "busted me upside all over my whole body." R1 stated R2 hit him/her "hard" and the incident happened at nighttime after dinner. R1 stated he/she and R2 were the only residents on the "smoke porch." R1 stated he/she said the phrase "The price is right, man" to R2, and then R2 "grabbed a metal trash can and started hitting me." R1 stated R2 "hit me on my head so hard it bent the metal can." R1 stated he/she went to the hospital and had staples in his/her head that home health would take out in two (2) days. R1 stated his/her head "hurt a little," and had pain medicine if he/she needed it." Further interview revealed R1 stated he/she had not had any problems with R2 before R2 hit him/her. R1 stated the two residents were just sitting on the "smoke porch" when R2 attacked him/her. During an interview, on 03/07/2024 at 8:29 AM, the Guardian Alternate of R1 (G-Alt) stated he visited R1 in the acute-care hospital because the	P 185	all employess who attended educational meeting. 3. Incident between R6 and R5 happened when in med line in dayroom on 1-6-22 .Residents were visible to staff. Incident between R7 and R12 occurred on 9-24-21. These files are located in shed .Due to these incidents occurring two and three years ago , files are changed yearly and relocated to shed to be held for five years. Former administrator was terminated shortly "after" this incident occurred on 9-24-21, resulting in resident hitting their head on window. R2 and R1 occurred two years after .Immediately staff had state police remove R2 from facility , he is now in jail with charges pressed. R1 was transported to hospital. Frequent monitoring of areas/smoking porch will be implemented with hourly log and initialed by supervising staff that observed residents within hour. (Please see attached hourly log sheet)	

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P 185	Continued From page 3 Guardian of R1 was not available at the time. G-Alt stated R1 told him he/she was attacked, and said R1 said something to R2, and then R2 attacked R1. The G-Alt stated R1 complained of a headache and his/her eyes were feeling weird. G-Alt stated R1 had staples and was able to tell G-Alt what had happened to him. Observation, on 03/05/2024 at 11:00 AM, revealed the facility's "smoke porch" was a partially enclosed area on the front of the facility and was accessed by going out of the facility's front door. The "smoke porch" was not visible to staff who were inside the facility. Further observation revealed on the "smoke porch" there was a metal garbage can. Observation, on 03/05/2024 at 3:15 PM, revealed R1 had approximately eight (8) staples securing a wound on the top and center of his/her head. The wound was clean and dry, with no drainage, and the staples were intact. There were faint red circles around the pupils of R1's eyes. During an interview, on 03/07/2024 at 2:30 PM, R10 stated on the evening R1 was attacked by R2 he/she was sitting in the common area waiting to "round up the residents" for medications, meaning R10 would let some of the other residents know the Med Tech was ready to distribute medication. R10 stated he/she saw R2 kick R1 in the face and he/she told Med Tech 2 about it During an interview, on 03/07/2024 at 2:00 PM, Resident 11 stated R2 "was always mad." During an interview, on 03/06/2024 at 8:33 PM, Med Tech 2 stated she was the first staff member to the scene of the attack by R2 on R1 on the	P 185	4. Logs will be reviewed for compliance daily for fourteen days then weekly on going by administrator. 5. 4/02/2024 will be compliance date.	4-2-2024

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P 185	Continued From page 4 evening of 02/23/2024. Med Tech 2 stated Resident 10 came and got her because she was in the medication room giving evening meds. Med Tech 2 stated when she got to the "smoke porch" R1 was on the ground and "hollering." When R1 sat up, Med Tech 2 stated she saw blood on R1's scalp and called 911. Med Tech 2 stated she stayed with R1 while the Administrator prepared the paperwork for the Emergency Medical Services (EMS) team. Further interview revealed Med Tech 2 stated she saw R2 leaving the "smoke porch" where the incident occurred. She heard later that after the attack, R2 went back into the facility and started rolling cigarettes. Med Tech 2 stated she got off shift and went home while the Administrator and Med Tech 1 stayed at the facility until the State Trooper came and got R2. Med Tech 2 stated when she came to work the next morning, R2 was not at the facility. During an interview, on 03/05/2024 at 2:35 PM, the Administrator stated R1 came home from the hospital last Thursday evening. She stated the police arrested R2 in the acute care facility on the night after R1 was injured and R2 was now in jail. The Administrator stated although no one saw R2 hit R1, R2 told the police that he/she did hit R1 with a metal garbage can and kicked him/her in the head because the resident wanted to get out of the facility. The Administrator stated she had known R2 for about five (5) years from a previous facility, and that the resident "had issues but he/she had never violently attacked other residents." Further interview revealed the Administrator stated if residents were fighting, she and the facility staff were trained to separate the residents	P 185		

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P 185	Continued From page 5 and de-escalate the situation. She stated she did not know what triggered R2 to attack R1 with a metal garbage can, and "we could remove" the metal garbage cans. The Administrator stated residents of the facility had a right to be safe, and we "try to intervene" before the situation gets out of control. However, in the case of R2 hitting R1, the Administrator stated no staff were present to intervene. 2. During an interview, on 03/06/2024 at 2:15 PM, R6 stated he/she remembered that one, and "hated to think about him/her." R6 stated he/she recalled it was a couple of years ago when R5 kept calling him/her insulting names. R6 stated he/she was handling it at first but got to the point when he/she "could not handle it and he/she shoved R5." During an interview, on 03/07/2023 at 10:45 AM, the Administrator stated she did an investigation of the incident between R6 and R5 and called Adult Protective Services (APS), but the file of the investigation was in a storage shed. 3. During an interview, on 03/06/2024 at 11:43 AM, R13 stated he/she recalled that one day all of a sudden R7 started fighting with R12 and that was why one of the facility's windows on the "smoke porch" was covered with a board. R13 stated the former Administrator "called the cops and she took R7 to the psych unit and R12 to the hospital." Observation on 03/07/2024 at 3:10 PM revealed the glass was missing from one of the windows of the facility's "smoke porch." A board replaced the hole where the glass window had been. During an interview, on 03/06/2024 at 8:33 AM,	P 185		

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P 185	Continued From page 6 Med Tech 2 stated she recalled that about one month after she started working at the facility, she recalled that R7 put R12's head through a glass window, but it was so long ago she did not remember any more details. During an interview, on 03/06/2024 at 2:35 PM, the Administrator stated the incident when R7 started fighting with R12 happened "before her time," and she had no recall of the event.	P 185		