

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

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2013
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NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
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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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS A recertification survey and an abbreviated survey (KY #19976) were conducted on 04/02/13 through 04/05/13 to determine the facility compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "F". KY #19976 was unsubstantiated with no deficiencies.	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, it was determined the facility failed to ensure care was provided in a manner that maintains resident dignity for one resident (#11), in the selected sample of 24 residents. The Certified Nurse Aide (CNA) failed to close the privacy curtain all the way during catheter care, leaving him/her exposed to anyone on the hall when the resident's room door was opened. Findings include: A review of the facility's "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving, under the heading Privacy Curtains and Room Dividers, revealed the privacy curtain	F 241	F241 1. Resident #11's privacy curtain was noted to be completely closed while care was being provided as observed by the Director of Nursing on 4/3/13.	

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

Chris Malvers

TITLE

Administrator 4-29-13

(X6) DATE

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 241	Continued From page 1 should be closed, or a room divider used, when you are providing care for your patients or residents. The door to the room should also be closed, as the privacy curtains do little to keep voices and other sounds private. Observation on 04/03/13 at 10:20 AM, revealed CNA #8 was providing catheter care and failed to pull the privacy curtain all the way closed. While care was being provided, the Housekeeping Supervisor and CNA #11 separately opened the resident's bedroom door and exposed the resident to anyone on the hallway. Interviews on 04/03/13 at 10:40 AM, 10:45 AM and 10:50 AM respectively, with CNA #8, CNA #11 and the Housekeeping Supervisor revealed the privacy curtain should be pulled all the way when providing care to the resident so if anyone opened the bedroom door the resident would not be visible to anyone on the hall. Interview with Licensed Practical Nurse (LPN) #3, on 04/03/13 at 11:03 AM, revealed staff should make sure the resident is covered and the curtain is pulled all the way past the door. Interview on 04/04/13 at 4:00 PM, with the Director of Nursing (DON), revealed the privacy curtain should be closed or the door shut or both, if feasible. She stated the privacy curtain should be pulled all the way around.	F 241	2. The Director of Nursing observed care provisions on 4/5/2013 and noted that the privacy curtains were completely closed with no concerns identified. 3. All Direct care staff will be re-educated by the Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on the facility policy for Resident Rights to include pulling completely privacy curtains during care. This re-education will be completed by 5/16/2013. 4. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe patient care to ensure that privacy curtains are pulled during catheter care five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. Compliance Date: 05/17/2013	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		05/17/2013

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F 281	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure services provided meet professional standards related to the failure to follow physician orders for oxygen (O2) therapy for one resident (#5), in the selected sample of 24 residents. Resident #5 was observed being administered O2 at two (2) liters per minute (L/m) instead of the prescribed three (3) L/m.</p> <p>Findings include:</p> <p>A review of the undated facility policy, titled Oxygen Administration Policy, revealed 1. Obtain order from Physician for oxygen therapy. 2. Assemble necessary equipment according to Physician order. 3. Set flow rate on concentrator or E tank according to Physician order. 4. Verify oxygen settings every shift. 5. Check oxygen sats per Physician order. 6. Follow Interact process for Change of Condition.</p> <p>A record review revealed Resident #5 was admitted to the facility on 07/01/12 with diagnoses to include Oropharyngeal Dysphagia, Chronic Pain Syndrome, Hypoxemia, Sleep Apnea, Seizure Disorder and Congestive Obstructive Pulmonary Disease.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/28/13, revealed the facility had assessed Resident #5 with no cognitive impairment and requiring extensive</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> 1. Resident # 5's oxygen was adjusted to three (3) LPM on 4/4/13 by the RN Unit Manager. Resident #5's oxygen tubing was replaced with new tubing and connected to the concentrator by the RN Unit Manager on 4/4/13. 2. An audit of all residents who receive oxygen therapy was conducted by the Director of Nursing and Unit Managers on 4/4/13 to assure that all oxygen was set on the correct LPM as prescribed by the physician and that all oxygen tubing was connected. No concerns were identified. 3. All Licensed staff will be re-educated by the Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding proper placement of oxygen tubing including assuring connection to the concentrator and facility policy for Physician Notification and following Physician orders. This re-education will be completed by 5/16/2013. 4. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe all oxygen settings and oxygen tubing five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks to assure settings are per physician's order. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and 		

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F 281	Continued From page 3 assistance with activities of daily living. A review of Resident #5's Physician's Orders, dated 04/2013, revealed O2 should be administered at 3 L/m. Observations, on 04/02/13 at 7:00 PM and 04/03/13 at 8:45 AM, 9:00 AM, 3:45 PM and 4:00 PM, revealed Resident #5's O2 infusing at 2L/m. Further observation, on 04/04/13 at 8:30 AM, revealed the O2 tubing not connected and pulled away from the concentrator and the resident was not receiving any oxygen. Resident #5 stated at this time that he/she did not know what setting the O2 was supposed to be set on. Observation at 10:00 AM revealed the resident asleep with O2 per nasal cannula at 2 L/minute. An interview with the Licensed Practical Nurse (LPN) #2, on 04/05/13 at 11:40 AM, revealed Resident #5's O2 should be administered at 3L/m, as prescribed. LPN #2 verified the O2 was infusing at 2 L/m and adjusted it to 3L/m. An interview with the Director of Nursing (DON), on 04/05/13 at 11:45 AM, revealed Resident #5's O2 should be administered at 3L/m as per the Physician's Order.	F 281	until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. Compliance Date: 05/17/2013	05/17/2013	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F312 1. Observation on 4/2/13 by the RN Unit Manager noted that incontinent care for resident # 15 was provided timely. 2. An observation by the Director of Nursing on 4/5/2013 of incontinent care including observation during meal times showed care was provided		

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F 312	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure one resident (#15), in the selected sample of twenty six residents, who was unable to carry out his/her own activities of daily living, received incontinent care in a timely manner. Resident #15 was observed to wait approximately forty-five minutes after putting on the call light and requesting incontinent care before incontinent was provided.</p> <p>Findings include:</p> <p>An interview with the Director of Nursing (DON), on 04/05/13 at 9:30 AM, revealed there was no policy related to answering call lights at meal time or picking up trays but it was no different than any other time. She revealed the facility follows the Lippincott's manual regarding answering call lights.</p> <p>A review of Lippincott's Textbook for Nursing Assistants, revealed "when a person pushes the button on the call light, it alerts the staff that the person needs help. Answer all requests for assistance promptly. Part of helping meet a person's safety and security needs is your quick response to a request for help."</p> <p>A record review revealed the facility admitted Resident #15 on 03/22/13 with diagnosis to include Other Pulmonary Insufficiency, Chronic Airway Obstruct, Congestive Heart Failure, Acute Kidney Failure, Acute Chronic Kidney Disease Stage Three, Obesity, Hypertension, Gout,</p>	F 312	<p>in a timely manner and no concerns were identified.</p> <ol style="list-style-type: none"> Licensed staff and C.N.A.'s will be re-educated by the Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding timely incontinent care including during meal service. This re-education will be completed by 5/16/2013. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe patient care to ensure incontinent care is provided timely five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. <p>Compliance Date: 05/17/2013</p>	05/17/2013

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F 312	<p>Continued From page 5 Pacemaker and Hospice.</p> <p>A record review revealed the facility had not completed the Minimum Data Assessment; however, interviews with staff and Resident #15 revealed Resident #15 was cognitively intact,</p> <p>A review of the Physician Orders, dated April 2013, revealed Resident #15 was taking a Diuretic daily.</p> <p>A review of the Resident #15's Plan of Care, dated 03/22/13, revealed Resident #15 was incontinent with a goal to be clean and dry with the use of incontinent products. Interventions included incontinent care, change incontinent product as needed (PRN), change soiled clothing PRN and provide and assist with peri-care after each incontinent episode. A review of the Activities of Daily Living (ADL) Plan of Care, dated 04/04/13, revealed the resident used briefs with one person physical assist.</p> <p>Observation during the initial tour, on 04/02/13 at 6:33 PM, revealed Resident #15 was awake and stated "I need to be changed, I put my light on and they came in and turned it off. I just put it on again." CNA #3 came into the resident's room and told the resident "as soon as we finish picking up trays, she would get another aide to help her change the resident." Resident #15 stated, "when you turn on your light they come in here and say they will be back and never come back". An interview with CNA #3, at the time revealed "we pick up trays first and then go in and change residents as soon as the trays are picked up. We are just about done. Resident #15 is alert and oriented and can make her needs known. It takes</p>	F 312			

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F 312	<p>Continued From page 6</p> <p>two people to help the resident roll over and assist with her care." At 7:05 PM, CNA #3 and another staff member reentered Resident #15's room and was assisting the resident's roommate to bed and closed the door and then exited. Interview with Resident #15 at the time revealed "they said they would be right back to change me". At 7:15 PM, two staff members went into Resident #15's room and closed the door. Interview with Resident #15, on 04/02/13 at 7:25 PM, revealed the resident had received incontinent care and was changed.</p> <p>An interview with CNA #3, on 04/02/13 at 8:00 PM, revealed she was assigned to Resident #15 and stated usually when a resident has to go to the bathroom we take them then. Resident #15 is a check and change and requires two assist. She stated when a resident puts their call light on, we try to answer them and if they need to go to the rest room, we assist them. She revealed she had told Resident #15 they would be back and was told later that someone else had helped the resident. She stated "we try to get them to the bathroom or change them and return as soon as possible to pick up trays".</p> <p>An interview with Licensed Practical Nurse (LPN) #1 Charge Nurse, on 04/02/13 at 8:15 PM, revealed if resident's have to go to the bathroom during meals and trays were being passed, staff would ask them if they can wait, if not, we take them. She stated if a resident needs to go to the bathroom, the aides should stop what they were doing, and take the resident to the bathroom. She revealed she expected the residents to be changed if they needed to be changed when trays were picked up.</p>	F 312		

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F 312	Continued From page 7 An interview with Resident #15 on 04/02/13 at 8:20 PM and 04/05/13 at 10:40 AM revealed "I have a problem with staff answering my light, they just don't show up and I have to tell you that sometimes I lay wet. I just want to be changed when I need it. The staff say we will be back and don't come back. I have to put my light on again and again and yell out too sometimes to get help. I know when I have to go, I call and nothing happens. Sometimes they come and sometimes they don't. I have been wet for long periods of time, laid wet about two hours last week and called my family member to come in." The family member at bedside stated they were here everyday and usually every time the staff was picking up trays or helping someone else when Resident #15 needed help. The family member stated it takes a long time for the staff to answer the call light and help the resident. The family member revealed the resident called the family member in around 11:00 PM, one night last week. The family member came in, went to the nurses desk and told the staff the resident needed to be changed. The family member stated the staff said, as soon as we can get to the resident, we will. An interview with the Director of Nursing (DON), on 04/05/13 at 9:30 AM and 12:10 PM, revealed the staff know they should stop what they were doing and take care of the resident unless they are taking care of another resident. She was not aware of any resident's complaints of being wet or having to wait for anything. She stated when a resident puts on their call light, she expected the CNA to answer it, and if the resident needed to be changed, the CNA would get help, if needed, and	F 312			

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F 312	Continued From page 8 change the resident. She expected the staff to take care of the residents' needs.	F 312			
F 315 SS=D	An interview with the Administrator, on 04/05/13 at 10:11 AM, revealed it was her expectation that the CNA's would change the resident and they could ask for help either to change the resident or pick up the trays and not to wait. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy it was determined the facility failed to ensure appropriate care and treatment to prevent infections to the extent possible for one resident (#2), in the selected sample of 24 residents, related to an indwelling urinary catheter. Observation revealed Resident #2's urinary drainage bag was lying on the floor. Findings include: A review of the Lippincott's Textbook for Nursing Assistants, Chapter 22, Urinary Elimination,	F 315	F315 1. Resident #2's urinary drainage bag was removed from the floor and placed in a dignity bag by the RN Nurse Manager on 4/5/2013. 2. The residents with urinary drainage bags were observed by the Director of Nursing on 4/5/2013 and none of the bags were noted to be on the floor. No concerns were identified. 3. All Licensed staff and C.N.A.'s will be re-educated by the Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding proper placement of urinary drainage bags. This education will be completed by 5/16/2013. 4. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe placement of urinary drainage bags to assure none are on the floor five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3)		

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F 315	<p>Continued From page 9</p> <p>Drainage Systems, revealed the catheter drainage bag hangs from the bed frame, chair, or wheelchair and "it must not touch the floor."</p> <p>A record review revealed Resident #2 was admitted to the facility on 07/15/11 with diagnoses to include Systemic Lupus Erythematosus, Decubitus Ulcer; Benign Hypertension; Polymyositis, Depression; Protein-Caloric Malnutrition, Generalized Anxiety, Generalized pain, and Anemia.</p> <p>A review of a the Comprehensive Care Plan, dated 10/25/12, and a Care Area Assessment (CAA) summary, dated 06/26/12, revealed Resident #2 required the use of a urinary catheter related to a Stage 4 wound to his/her sacral area. The facility assessed the resident as incontinent of bowels.</p> <p>An observation, on 04/02/13 at 6:45 PM, revealed Resident #2 lying in bed asleep. The dignity bag was hanging on the bed frame and the urinary catheter drainage bag was lying on the floor.</p> <p>An interview with Licensed Practical Nurse (LPN) #6, on 04/02/13 at 6:47 PM, revealed the urinary catheter drainage bag was not in a dignity bag and was lying on the floor. When asked if the urinary catheter drainage bag should be on the floor she replied "no it should not."</p> <p>An interview with the Director of Nursing (DON), on 04/03/13 at 9:00 AM, revealed the Certified Nursing Assistants (CNAs) were trained and expected to provide appropriate catheter care which included placing the catheter drainage in a dignity bag and to keep the bag off of the floor.</p>	F 315	<p>months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 05/17/2013</p>	05/17/2013	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure proper treatment and care for one resident (#5), in the selected sample of twenty four residents, related to oxygen (O2) therapy. Resident #5 was observed with his/her O2 tubing disconnected from the concentrator and laying on the floor. Additional observations revealed Resident #5 was administered O2 at two (2) liters per per minute (L/m) instead of the prescribed 3L/m.</p> <p>Findings include: A review of the undated facility policy, titled Oxygen Administration Policy, revealed 1. Obtain order from Physician for oxygen therapy. 2. Assemble necessary equipment according to Physician order. 3. Set flow rate on concentrator or E tank according to Physician Order. 4. Verify oxygen settings every shift. 5. Check oxygen</p>	F 328	<p>F328</p> <ol style="list-style-type: none"> 1. Resident # 5's oxygen was adjusted to three (3) LPM on 4/5/13 by the RN Unit Manager. Resident #5's oxygen tubing was replaced with new tubing and connected to the concentrator by the RN Unit Manager on 4/4/13. 2. An observation by the Director of Nursing on 4/5/2013 for oxygen tubing properly connected and not on the floor showed no concerns identified. An audit of all residents who receive oxygen therapy was conducted by the Director of Nursing and Unit Managers on 4/5/13 to assure that all oxygen was set on the correct LPM as prescribed by the physician. No concerns were identified. 3. All Licensed staff and C.N.A.'s will be re-educated by the Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding proper placement of oxygen tubing including assuring connection to the concentrator and facility policy for Physician Notification and following Physician orders. This re-education will be completed by 5/16/2013. 4. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe placement of oxygen tubing to assure none are on the floor or disconnected and on the facility policy for Physician Notification and following Physician 		

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F 328	<p>Continued From page 11</p> <p>sats per Physician Order. 6. Follow Interact process for Change of Condition.</p> <p>A record review revealed Resident #5 was admitted to the facility on 07/01/12 with diagnoses to include Oropharyngeal Dysphagia, Chronic Pain Syndrome, Hypoxemia, Sleep Apnea, Seizure Disorder and Congestive Obstructive Pulmonary Disease.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/28/13, revealed the facility had assessed Resident #5 with no cognitive impairment and requiring extensive assistance with activities of daily living.</p> <p>A review of Resident #5's Physician's Orders, dated 04/2013, revealed to administer O2 at 3L/m.</p> <p>Observations on 04/02/13 at 7:00 PM and 04/03/13 at 8:45 AM, 9:00 AM, 3:45 PM and 4:00 PM revealed Resident #5 was being administered O2 per nasal cannula at 2L/m.</p> <p>Further observation, on 04/04/13 at 8:30 AM, revealed the O2 tubing not connected and pulled away from the concentrator and the resident was not receiving any O2. Resident #5 stated at this time that he/she did not know what setting the O2 was supposed to be set on.</p> <p>Interview with Registered Nurse (RN) #6, on 04/04/13 at 8:32 AM, revealed she was not sure why the O2 tubing was separated from the concentrator and thought that when the Certified Nurse Aide (CNA) had assisted Resident #5 up in the bed for breakfast it might have caused the</p>	F 328	<p>orders five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 05/17/2013</p>	05/17/2013	

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F 328	Continued From page 12 tubing to separate. RN #6 stated the resident was not getting any O2 with the tubing separated. Further observation at 10:00 AM revealed the resident asleep with oxygen per nasal cannula at 2L/per minute. Observation, on 04/05/13 at 11:40 AM, revealed Resident #5 with O2 per nasal cannula at 2L/m. Licensed Practical Nurse (LPN) #2 verified the O2 was being administered at 2L/m at the time. LPN #2 stated Resident #5's oxygen should be administered at 3L/m as per the Physician order and adjusted the O2 to 3L/m. An interview with the Director of Nursing (DON), on 04/05/13 at 11:45 AM, revealed Resident #5's O2 should be administered at 3L/m as per the Physician's Order. The DON stated nursing was responsible for appropriate administration of O2 therapy every shift.	F 328		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure one resident (#5), in the selected sample of twenty four residents, was served food in the form to meet the resident's needs. Resident #5 was served a solid piece of meat instead of the prescribed mechanically altered diet.	F 365	F365 1. Resident # 5's solid piece of meat was replaced with mechanically soft meat immediately on 4/4/13 by the Dietary Manager. 2. Observation of meal trays was conducted by the Dietary Manager on 4/5/13 to assure that all prescribed diets were served to the residents. No concerns were identified. 3. Dietary staff will be reeducated by the Education and Training Director or the Dietary Manager on the guidelines for a Mechanical soft diet and serving the	

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F 365	Continued From page 13 Findings include: A review of the guidelines (undated) utilized by the facility for Mechanical Soft Diet revealed "The Mechanical Soft Diet is designed to permit easy chewing. The General Diet is modified in consistency and texture by cooking, grinding, chopping, mincing or mashing". The guidelines indicated "Very tender, shredded or ground meats and poultry, moistened with gravy or sauce. Also, it stated "Avoid whole meats and poultry, hot dogs, bacon, meats with thick hard breading and dry or tough meats. The guidelines indicated the use of this diet is for individuals who have difficulty chewing but are able to tolerate a wide variety of foods. Modifications in the diet need to be individualized according to the patient's needs. A record review revealed Resident #5 was admitted to the facility on 07/01/12 with diagnoses to include Oropharyngeal Dysphagia, Chronic Pain Syndrome, Hypoxemia, Sleep Apnea, Seizure Disorder and Congestive Obstructive Pulmonary Disease. A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/28/13, revealed the facility had assessed Resident #5 with no cognitive impairment, requiring extensive assistance with activities of daily living, and required supervision and assistance of one for eating. A review of Resident #5's physician's orders, dated 04/2013, revealed an order for Mechanical Soft Diet with thin liquids.	F 365	prescribed diet. This re-education will be completed by 5/16/2013. 4. The Dietary Manager, Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe meal service to assure prescribed diet is served five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. Compliance Date: 05/17/2013	05/17/2013	

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F 365	<p>Continued From page 14</p> <p>An observation during the lunch meal, on 04/04/13 at 12:50 PM, revealed Resident #5 in bed with the lunch tray sitting on the over the bed table. The diet card on the tray read Mechanical Soft Diet. The tray included a solid piece of pork loin steak. A Certified Nurse Aide (CNA) #16 began to cut the solid piece of meat into bite size pieces for the resident. Interview at the time with CNA #16 revealed the solid piece of meat on the resident's tray was not mechanically soft as per the resident's diet card and she took the resident's tray and exchanged it for the appropriate form of mechanically soft.</p> <p>An interview with Dietary Staff #1, on 04/04/13 at 1:50 PM, revealed the cook was to check the diet card when plating the food on the residents' trays. The dietary staff at the end of the line was to check the tray for accuracy and the person that delivers the tray to the resident was to also check the tray for accuracy.</p> <p>An interview with the Dietary Manage, on 04/04/13 at 1:00 PM, revealed mechanically altered diet means mechanically altered and that a solid piece of meat was not considered mechanically altered. She stated the cook plates the food by the diet card and it should be double checked by the aide and a third check when the aide removes the dome lid from the plate when serving.</p> <p>An interview with the Speech Language Pathologist (SLP), on 04/04/13 at 2:10 PM, revealed Resident #5 had been prescribed a Mechanical Soft Diet on 03/12/13. The SLP stated a Mechanical Soft Diet was all ground meat and chewable sandwiches usually with</p>	F 365		

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F 365	Continued From page 15 gravy and soft vegetables. She stated Resident #5 was on a Mechanical Soft Diet so the resident wouldn't have to work so hard to chew and that complications of attempting to consume food that was not Mechanically Altered would be aspiration pneumonia and or choking.	F 365		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, it was determined the facility failed to ensure special eating equipment was provided for one (1) resident (#26), not in the selected sample. Observation on 04/03/13 and 04/04/13 revealed Resident #26 had not been provided with a gray handled spoon or his/her dessert in a bowl according to the resident's assessed needs. Findings Include: A record review revealed Resident #26 was admitted to the facility on 04/04/12 with diagnoses to include Cerebral Vascular Accident, Aphasia, Seizures, Colon Cancer, and Hypertension. A review of the Activities of Daily Living Plan of Care Plan, dated 02/22/13, revealed an intervention for special silverware and dessert bowls. Observation during the lunch meal, on 04/03/13	F 369 F369	1. Resident # 26's regular spoon and dessert plate were replaced with a gray handled spoon and dessert bowl that were per resident's assessed adaptive equipment needs by the Dietary Manager on 4/3/13. 2. Observation of meal trays was conducted by the Dietary Manager on 4/5/13 to assure that all assessed adaptive equipment was present on the resident's trays. No concerns were identified. 3. Dietary staff will be re-educated by the Education and Training Director or the Dietary Manager regarding placement of the assessed adaptive equipment on resident trays. This re-education will be completed by 5/16/2013. 4. The Dietary Manager, Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe meal service to assure placement of the assessed adaptive equipment on	

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F 369	Continued From page 16 at 11:30 AM, revealed the meal card stated Resident #26 should have a gray handled spoon. Further observation revealed the resident was eating his/her meal with a regular spoon. Interview, on 04/03/13 at 12:20 PM, with Certified Nursing Assistant (CNA) #6 and CNA #7 revealed the meal card indicated Resident #26 should have a gray handled spoon but the resident had a regular spoon. Observation during the lunch meal, on 04/04/13 at 11:40 AM, revealed the meal card stated Resident #26 should have a gray handled spoon and the dessert should be served in a bowl. Further observation revealed the resident was eating with a regular spoon and the dessert (slice of pie) was served on a plate. Interview, on 04/05/13 at 11:45 AM, with CNA #5 revealed the resident was eating with a regular spoon and should have been provided a gray handled spoon. She also revealed the resident's pie should have been served in a bowl. Interview with the Dietician, on 04/04/13 at 12:20 PM, revealed Resident #26 should have been provided with a gray handled spoon and his/her dessert should have been served in a bowl. She stated the gray handled spoon had been misplaced with breakfast that morning.	F 369	resident trays five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. Compliance Date: 05/17/2013	05/17/2013
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	F 441	F441 1. Resident # 8's incentive spirometer was replaced, labeled and stored in a bag by the RN Unit Manager on 4/3/13. Resident #25's oxygen tubing	

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F 441	Continued From page 17 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 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, staff interview, record review, and facility policy review, it was determined the facility failed to ensure a sanitary	F 441	and nasal cannula were replaced by the RN Unit Manager and stored appropriately on 4/2/13. Resident #7's cup was replaced and ice chest was sanitized on 4/4/13 by RN Unit Manager. All sinks on Resident #7's hall were sanitized by housekeeping on 4/4/13. Observation by the RN Unit Manager on 4/5/13 of staff entering resident # 7's room on were noted to be wearing gown and gloves with no concerns related to infection control noted. 2. Observation of incentive spirometers and other patient care equipment in the facility to assure all were labeled and stored appropriately was made by the RN Unit Manager on 4/5/13. Observation of all residents with oxygen tubing was connected and appropriately stored if not in use was made by the RN Unit Manager on 4/5/13. Observation of ice pass and handwashing to assure that infection control policies are followed was conducted by the RN Nurse Manager on 4/5/13. No concerns were identified. 3. Licensed staff and C.N.A.'s will be re-educated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Managers regarding Infection Control policy. This reeducation will be completed by 5/16/2013.	

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F 441	<p>Continued From page 18</p> <p>environment and/or help prevent the development and transmission of infection for three (two) residents (#7 and #8), in the selected sample of 24 residents and one resident (#25), not in the selected sample. Resident #8's incentive spirometer was observed lying on a shared countertop unlabeled, Resident #25 was observed with oxygen tubing and nasal cannula laying on the floor. Additionally, a staff member entered Resident #7's room (on contact isolation) without applying gloves and picked up a cup and brought the cup out into the hall for a refill, then returned to the room. Another staff entered Resident #7's room and was observed to leave the room and enter another resident's room for hand-washing.</p> <p>Findings include:</p> <p>1. Interview with the Director of Nursing (DON), on 04/04/13 at 4:00 PM, revealed there was no policy on spirometer storage and labeling.</p> <p>A record review revealed Resident #8 was admitted to the facility on 07/01/12 with diagnoses to include Chronic Airway Obstruction, Tobacco Use Disorder, Folate Deficiency Anemia, Respiratory Distress Syndrome, and Depressive Disorder.</p> <p>Observation, on 04/03/13 at 9:45 AM, revealed an Incentive Spirometer was sitting on the shared sink counter with the mouth piece lying across the counter in Resident #8's room.</p> <p>Interview, on 04/03/13 at 9:57 AM with Certified Nursing Assistant (CNA) #10 and CNA #14, revealed the mouthpiece of the Incentive</p>	F 441	<p>4. The Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe storage and labeling of incentive spirometers, hand washing, ice pass, placement and storage of oxygen tubing to assure infection control policy is being followed five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 05/17/2013</p>	05/17/2013

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2013
NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301		
(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)	(X6) COMPLETION DATE	
F 441	<p>Continued From page 19</p> <p>Spirometer was on the sink and there was no resident's name on it. The CNAs stated with no name on the spirometer you could not tell who it belonged too. The CNAs revealed the spirometer should be in a bag and have a name on it; however, the CNAs left the room without bagging or labeling the spirometer with the resident's name.</p> <p>Interview, on 04/03/13 at 10:05 AM with Registered Nurse (RN) #4, revealed the spirometer should have a name on it, and the mouthpiece should be in the holder and the spirometer should be bagged when not in use. RN #4 then placed the mouthpiece in the holder of the Incentive Spirometer but she left the room without labeling and bagging the Incentive Spirometer.</p> <p>Further interview, on 04/04/13 at 4:00 PM with the DON, revealed the Incentive Spirometer should be labeled and in a bag. She stated the mouthpiece should be attached to the incentive spirometer and in the holder.</p> <p>2. A review of the policy titled, Departmental (Respiratory Therapy) Prevention of Infection dated April 2007, revealed to keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. Further review revealed to change the oxygen cannula and tubing every seven (7) days, or as needed.</p> <p>Observation on 04/02/13 at 6:30 PM, revealed Resident #25 lying in bed asleep. An oxygen</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>concentrator was running and a nasal cannula was laying on the floor beside the resident's bed. CNA #12 entered the room to pick up the supper tray and when asked if the resident should have the oxygen on, she replied, "We have a hard time keeping the oxygen on the resident." CNA #12 proceeded to pick up the nasal cannula from the floor and placed it in the resident's nose. When asked if that is what she would normally do, she replied, "No, that is not typically what I would do. I just heard the other residents screaming for their supper and I am trying to get it out to them."</p> <p>An interview with the Director of Nursing (DON), on 04/05/13 at 10:45 AM, revealed the CNAs were trained to reapply the nasal cannula if dislodged, but not to adjust the oxygen level. She further revealed the CNA should have reported to the nurse the nasal cannula was laying on the floor and the nurse should replace the cannula.</p> <p>3. A review of the facility's policy "Contact Isolation", not dated, revealed the center will utilize contact precautions for specified resident's known or suspected to be infected with epidemiologically important microorganisms that can be transmitted by direct contact with the resident as recommended by the Center of Disease Control. Procedure #2 states Gloves and Handwashing - remove gloves before leaving the room and use appropriate hand hygiene. Procedure #3 states Gown - wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room. * wear a gown if the resident has</p>	F 441		

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F 441	<p>Continued From page 21 wound drainage not contained by a dressing.</p> <p>A record review revealed the facility had admitted Resident #7 on 07/01/12 with diagnosis to include Asthma NOS, General Osteoarthritis, Chronic Pain Syndrome, Insomnia NOS, Venous Insufficiency NOS, Barrett's Esophagus, Glaucoma NOS, Methicillin Resistant Staphylococcus Aureus.</p> <p>A review of the facility's Minimum Data Set (MDS) assessment, dated 03/27/13, revealed the facility assessed Resident #7 as cognitively intact.</p> <p>A review of the Physician's Orders, dated April 2013, revealed to keep Resident #7 in isolation, leave the wound on the left lower extremity exposed, open to air as much as possible and as much as the resident will tolerate. A review of a wound culture revealed the culture was positive for Methicillin Resistant Staphylococcus Aureus (MRSA), Streptococcus, and Pseudomonas.</p> <p>A review of the Comprehensive Care Plan for Impaired Skin Integrity, dated 07/01/12, revealed there was a stasis ulcer to the left lower extremity with a goal "will maintain contact isolation". The approach listed "Contact Isolation as ordered".</p> <p>Observation, on 04/03/13 at 9:22 AM, revealed Resident #7 was in bed with no dressing on the left lower leg. Certified Nurse Aide (CNA) #1 was in Resident #7's room with no protective wear on</p>	F 441		

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F 441	<p>Continued From page 22</p> <p>except gloves. CNA #1 moved the walker and straightened the catheter tubing and linens. CNA #1 was observed to remove gloves and to go across the hall into another resident's room and wash her hands.</p> <p>Interview with CNA #1, on 04/03/13 at 9:25 AM, revealed she was assigned to Resident #7 and the resident was in isolation. She stated the facility's policy was to wear gloves as long as you were not providing any care.</p> <p>Interview with Registered Nurse (RN) #1, on 04/03/13 at 9:30 AM, revealed Resident #7 has a stasis ulcer on the left lower leg. The last wound culture on 03/13/13 revealed MRSA, Streptococcus and Pseudomonas. She stated the resident was on contact precautions which included the use of a gown and gloves when you enter the resident's room. She revealed if you are going to touch anything in the room such as separate carts for linens and/or move the walker, you should have a gown and gloves on. She stated Resident #7's wound was open to air. She stated she expected the CNAs to have a gown and gloves on if touching anything in the room. She stated the CNA should have washed her hands before she left Resident #7's room.</p> <p>Observation, on 04/03/13 at 2:00 PM, revealed the Activity Assistant entered Resident #7's room without putting on a gown and gloves. The Activity Assistant picked up Resident #7's cup and brought it out to the hall to a cooler to fill the cup with ice. RN #1 told the staff member she needed</p>	F 441		

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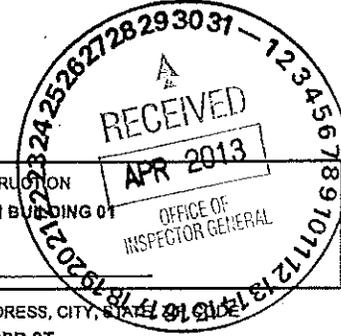
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F 441	<p>Continued From page 23</p> <p>to have on a gown and gloves to go into the room if she was going to touch anything. The RN told the Activity Assistant to throw away the cup, wash her hands and get another cup for the resident to use.</p> <p>Interview with RN #1, on 04/03/13 at 2:00 PM, revealed she would have expected the Activity Assistant to put on a gown and gloves because the Activity Assistant was touching the resident's cup. She stated the Contact Isolation policy was you only have to wear gloves if you are only going to touch items in the room. If you are going to touch the resident you must wear gown and gloves.</p> <p>Interview with Activity Assistant, on 04/03/13 at 2:05 PM, revealed she helps all over and normally doesn't go in the resident's room without a gown and gloves on. She stated she just wasn't paying any attention, and did not know why she did it. She stated the facility's policy was for staff to put on gown and gloves when entering a room of a resident who was in contact isolation.</p> <p>Interview with the DON, on 04/04/13 at 4:00 PM, revealed she expected the staff to wear gloves if the staff was only providing ice in the resident's cup.</p> <p>Interview with the Director of Nursing (DON), on 04/04/13 at 4:00 PM and on 04/05/13 at 9:30 AM and 10:05 AM, revealed she expected the staff to wear gloves if the staff was only providing ice in</p>	F 441			

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F 441	<p>Continued From page 24</p> <p>the resident's cup. She stated she expected the staff to wear gloves if in a room of a resident in contact isolation when moving a walker, straightening up linens and if not coming in contact with the resident's body and not doing care. She revealed the CNA should have washed her hands in the room she was in and not in another resident's room. She stated the CNA would not have to wear a gown if she didn't anticipate coming into contact with the resident's clothing.</p> <p>Interview with the Administrator on 04/05/13 at 10:11 AM revealed staff probably should have washed her hands in the resident's room she was in. If the staff was not going to have any contact with the resident or if the staff is not picking up anything or picking up something clean, wouldn't expect her to wear gloves. But if the staff was picking up a cup already in the room and bringing it out to fill with ice, she would have expected the staff to have gloves on.</p>	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: 1969, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system upgraded in 2008 with five (5) heat and (42) smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 04/03/13 to 04/04/13. Twin Rivers Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Chris Malvern* TITLE: *Adm. 4-29-13* (X6) DATE

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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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000			
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at " F " level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, all residents, staff and visitors. The facility is</p>	K 018	K018		
			<ol style="list-style-type: none"> 1. The corridor doors to rooms #218, #336 and #106 gap was sealed on 4/5/13 by the Maintenance Director to not exceed ½ inch around the jamb. The doors to resident rooms #450, #457, #464 were repaired on 4/5/13 by Maintenance Director and the doors now latch properly. 2. An audit of all facility doors was conducted by the Maintenance Director on 4/5/13 and no other issues were found. 3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 101, 19.3.6.3.1, 19.3.6.3.2 and 19.3.5.2 regarding requirements for closure and gaps on doors. This re-education will be completed by 5/16/13. 4. The Maintenance Director will audit all facility doors for gaps exceeding ½ inch and proper closures monthly for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. The results of these observations will be reviewed with the Quality Assurance 		

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K 018	<p>Continued From page 2</p> <p>certified for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The facility failed to ensure three (3) corridor doors to the resident rooms did not have a gap smaller than ½ inch around the jamb and three (3) doors latched when closed.</p> <p>The findings include:</p> <p>Observations, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed the corridor doors to rooms #218, #336, and #106 had a gap larger than ½ inch around the jamb.</p> <p>Interview, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware of the acceptable gap around the doors.</p> <p>Observations, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed the doors to resident rooms #450, #457, and #464 did not latch when closed.</p> <p>Interview, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware these three (3) doors were not latching.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of</p>	K 018	<p>Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 05/17/2013</p>	05/17/2013	

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K 018	Continued From page 3 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.	K 027		

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K 027	<p>Continued From page 4</p> <p>Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, eighty-eight (88) residents, staff and visitors. The facility is certified for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The facility failed to ensure four (4) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.</p> <p>The findings include:</p> <p>Observation, on 04/03/13 between 12:08 PM and 4:00 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at the Dining Room, next to rooms #216, #332 and #115 would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Further observation revealed coordinators had been installed on the doors but the coordinators were not functioning properly.</p>	K 027	<p>K027</p> <ol style="list-style-type: none"> 1. The coordinators on the cross-corridor doors located at the Dining Room and next to rooms #216, #332 and #115 were adjusted on 4/5/13 by the Maintenance Director so that the doors close completely. 2. An audit of all facility doors was conducted by the Maintenance Director on 4/5/13 and no other issues were found. 3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 80, Standard for Fire Doors 2-3.1.7 and NFPA 101, 8.3.4.1. related to doors closing correctly to prevent a smoke penetrating gap. This re-education will be completed by 5/16/13. 4. The Maintenance Director will audit all facility doors for proper closure and gaps monthly for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance 		

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301	
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K 027	Continued From page 5 Interview, on 04/03/13 between 12:08 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware of how the doors were to properly close. He stated that he only maintained the doors closing correctly on the first release from the fire alarm magnets. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027	Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. Compliance Date: 05/17/2013	05/17/2013
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K056 1. Lights will be moved in the Clean Linen room, room #342 bathroom, room #343 bathroom, Housekeeping supply on 400 hall, Ice Machine room on 400 hall, room #455 bathroom and the three lights in the lobby area to meet the standards of NFPA 13, 5-5.5.2.2 and not block the spray of the sprinkler by 5-16-2013. Ceiling fans will be removed from the Business Office, Administrator office, Employee Lounge, room #216, room #231, Housekeeping Supervisor office	

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K 056	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures in fourteen (14) areas, located at least 4 inches from a wall in three (3) areas, and one (1) room had sprinkler coverage. The findings include: Observations, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the Clean Linen room, room #342 bathroom, room #343 bathroom, Housekeeping supply on 400 hall, Ice Machine room on 400 hall, room #455 bathroom, and the lobby area had three (3) lights that were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by ceiling fans in the Business office, Administrator office, Employee Lounge, room #216, room #231, Housekeeping Supervisor office, and the supply room on 400 hall. Interview, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures	K 056	and the supply room on 400 hall by 5-16-2013. A sprinkler will be installed in the Receptionist Office closet by 5-16-2013. Sprinkler heads will be moved by 5-16-2013 in bathrooms of resident rooms #102, #104 and the west hall med room to meet the standards of NFPA 13, 5-6.3.3 of 4 inches from the wall. 2. An audit of all facility sprinkler heads was conducted by the Maintenance Director on 4/5/13 and no other issues were found. 3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 13, 5-5.5.2.2, NFPA 13, 5-6.3.3. to include distance of sprinkler heads from the wall and distance to prevent the blockage of sprinkler spray. This re-education will be completed by 5/16/13. 4. The Maintenance Director will audit all facility sprinklers to assure all are positioned to meet the standards of NFPA 13, 5-5.5.2.2 and NFPA 13, 5-6.3.3 monthly for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a	

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K 056	<p>Continued From page 7</p> <p>and ceiling fans could block the spray pattern of the sprinkler head.</p> <p>Observation, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed sprinkler heads in the resident bathrooms of rooms #102, #104, and the west hall med room that were located within 4 inches of the wall.</p> <p>Interview, on 04/03/13 between 12:21 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware of the requirement that a sprinkler head must be installed at a minimum of 4 inches from any wall.</p> <p>Observations, on 04/03/13 at 3:05 PM with the Maintenance Supervisor, revealed the Receptionist Office closet did not have sprinkler protection.</p> <p>Interview, on 04/03/13 at 3:05 PM with the Maintenance Supervisor, revealed he was unaware the closet did not have a sprinkler installed.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid</p>	K 056	<p>minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 05/17/2013</p>	05/17/2013

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K 056	Continued From page 8 Obstructions to Discharge (SSU/SSP) Maximum Allowable Distance Distance from Sprinklers to of Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 2 1/2 1 ft 6 in. to less than 2 ft 3 1/2 2 ft to less than 2 ft 6 in. 5 1/2 2 ft 6 in. to less than 3 ft 7 1/2 3 ft to less than 3 ft 6 in. 9 1/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 16 1/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056			
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and	K 143	K143 1. The doors of the oxygen trans-filling room at skilled B and on north hall will be replaced with fire rated door and frame by 5-16-2013. 2. An audit of all facility doors where transfer of liquid oxygen occurs was conducted by the Maintenance Director on 4/5/13 and no other issues were found.		

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K 143	<p>Continued From page 9</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, one-hundred (100) residents, staff and visitors. The facility is certified for one hundred thirty two (132) beds with a census of one hundred twenty two (122) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and frame that had an one (1) hour fire resistive rating.</p> <p>The findings include:</p> <p>Observation, on 04/03/13 at 3:00 PM with the Maintenance Supervisor, revealed the oxygen trans-filling room at skilled B and on north hall did not have a fire rated door and frame installed. The door frame was steel but there was no fire rated tag located on the door frame.</p> <p>Interview, on 04/03/13 at 3:00 PM with the Maintenance Supervisor, revealed he was unaware the oxygen trans-filling room was</p>	K 143	<p>3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 99, 8-6.2.5.2, to include the requirements for fire protection on liquid oxygen transfer areas. This re-education will be completed by 5/16/13.</p> <p>4. The Maintenance Director will audit all doors and frames where liquid oxygen is transferred to assure they are fire rated monthly for three (3) months and quarterly for three (3) quarters in order to validate continued compliance. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains continuous compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 05/17/2013</p>	05/17/2013	

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K 143	<p>Continued From page 10 required to have a rated door installed.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p> <p>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.</p>	K 143			