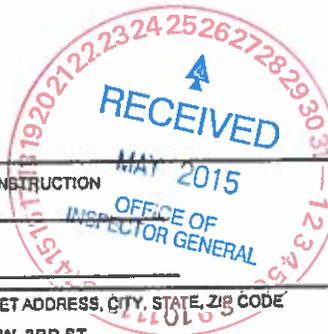


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2015
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 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of 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 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 time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or admission by the facility. The plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	06/05/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Malvern, Administrator TITLE: Administrator (X8) DATE: 05/22/2015

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.

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident's physician was notified when there was a possible need to alter treatment for one (1) of twenty-four (24) sampled residents (Resident #4). On 12/22/14, the physician ordered Clobetasol (topical corticosteroid) twice a day; however, the licensed staff failed to notify the physician when the resident continued to scratch and itch.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Notification of Resident Change in Condition", not dated, revealed the facility should notify the physician and family or legal representative at the earliest possible time, during waking hours, if there was a non-critical change in condition and document in the nurses notes the times notification was made and the names of the person or persons whom was notified.</p> <p>Record review revealed the facility admitted Resident #4 on 12/22/14 with diagnoses which included Diabetes Mellitus, Type Two (2), Disc Degeneration, Fractured Neck of Femur, Arthropathy, Fractured Rib, Colostomy Status, and Malignant Neoplasm Rectum and Anus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/19/15, revealed the facility was unable to assess the resident's cognition using a Brief Interview for Mental Status (BIMS) and determined the resident's cognition was severely impaired.</p>	F 157	<ol style="list-style-type: none"> 1. Resident #4's physician and Family/legal representative were notified by the Charge Nurse that the prescribed treatment was not effective on 04/30/2015. New treatment orders were obtained by Charge Nurse on 04/30/2015. 2. 100% chart audit of all current residents will be completed by the DON, ADON, and Unit Manager on By 06-04-2015 to identify any changes in condition that require physician notification that the physician has not been notified including skin treatments. Any identified will have immediate physician notification for further direction. 3. All licensed Nursing staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing, Unit Manager or QA Nurse regarding physician and family or legal representative notification when a treatment is ineffective or there is a significant change in condition. This re-education will be completed by 06/04/2015. 4. The Education Training Director, Director of Nursing, Assistant Director of Nursing, Unit Manager or QA Nurse will audit treatment records and medical records of five residents per week for twelve 		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 2</p> <p>Review of an Admission skin assessment, dated 12/19/14, revealed the nurse assessed Resident #4 to have multiple areas of abrasions and bruising. Review of a physician's order, dated 12/22/14, revealed to apply Clobetasol (topical corticosteroid) 0.05 percent cream two (2) times a day to affected areas.</p> <p>Review of a shower sheet, dated 01/18/15, revealed a Certified Nurse Aide (CNA) identified scratches to the back of Resident #4's neck and right shin; a scab to the right and left posterior ankle; and, a scab and skin tear to right forearm. In addition, monthly skin assessments, dated 02/04/15 and 04/02/15, revealed the resident continued to have scabs and scratches noted on his/her body. However, further review of Resident #4's medical record revealed there was no documented evidence the facility had notified the physician the medication had not resolved the resident's skin issue.</p> <p>Observation of a skin assessment for Resident #4, on 04/30/15 at 12:15 PM by Licensed Practical Nurse (LPN) #1 and CNA #4, revealed the resident was scratching his/her neck, bilateral arms and the sides of his/her trunk area. Resident #4 was verbally redirected to not scratch those areas by CNA #4 and he/she stated, "well, when you got an itch you itch it and I'm tired of itching." Further observation revealed the resident had multiple scabbed areas and scratches on his/her bilateral arms, bilateral sides of his/her trunk, left side of the back of the neck, and to bilateral hip areas.</p> <p>Interview with LPN #1, on 04/30/15 at 12:30 PM and 2:30 PM, revealed she would notify the physician if the resident's impaired skin integrity</p>	F 157	<p>(12) weeks to ensure that the physician and responsible party have been notified of any significant change in condition. The results of these audits 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: 06/05/2015</p>		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 157	Continued From page 3 was not healing. Interview with Director of Nursing, on 04/30/15 at 01:00 PM, revealed she expected the licensed staff to notify the physician, at least every fourteen (14) days, for a re-evaluation if a treatment was ineffective and the condition did not improve or had worsened. Interview with the Administrator, on 04/30/15 at 12:30 PM, revealed she would have expected the nurse performing treatments to have notified the physician if the present treatment was not effective and to request an evaluation for possibly changing the treatment. Interview with the Advanced Practice Registered Nurse (APRN), on 04/30/15 at 3:25 PM, revealed she could not recall anyone making her aware of the resident's constant itching and scratching or of the scabbed and scratched areas on the resident's body and she stated she would have expected the facility to have notified her.	F 157			
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Medication Drug Guide (Nursing 2015 by Lippincott) it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one (1) of twenty-four (24) sampled residents	F 281	1. Resident #4's physician and Family/legal representative were notified by the Charge Nurse that the prescribed treatment was not effective on 04/30/2015. A new treatment order was obtained by Charge Nurse on 04/30/2015. 2. A 100%t audit of all current resident's Medication administration records and Treatment Administration Records will be completed by the DON, ADON, and Unit Manager by 06/04/15 to	06/05/2015	

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 4</p> <p>(Resident #4) related to the failure to notify the physician of the continued use of a medicated cream that was for short term use only so another medication could be ordered, if needed.</p> <p>The findings include:</p> <p>Review of facility's drug handbook, Nursing 2015, pages 349-351, revealed Clobetasol 0.05 percent cream was a short term topical treatment to be used twice a day for up to fourteen (14) days for moderate to severe plaque-type psoriasis of non-scalp regions, excluding the face and intertriginous areas (where two skin areas may touch or rub together).</p> <p>Record review revealed the facility admitted Resident #4 on 12/22/14 with diagnoses which included Diabetes Mellitus, Type Two; Disc Degeneration, Fractured Neck of Femur, Arthropathy, Fractured Rib, Colostomy Status, and Malignant Neoplasm Rectum and Anus.</p> <p>Review of a Physician's Order, dated 12/22/14, revealed an order for Clobetasol (topical corticosteroid) 0.05 percent cream to be applied twice daily to affected areas however, the order did not specify where the affected areas were located.</p> <p>Observation of a skin assessment of Resident #4 by Licensed Practical Nurse (LPN) #1 and Certified Nurse Aide (CNA) #4, on 04/30/15 at 12:15 PM, revealed the resident was scratching his/her neck, bilateral arms and sides of his/her trunk area. Resident #4 was verbally redirected to not scratch those areas by CNA #4 and the resident stated "well, when you got an itch you itch it and I'm tired of itching." There were</p>	F 281	<p>identify any medication or treatment intended for short term use that is used long term and will notify the physician for further guidance of any identified.</p> <p>3. All Licensed Nurses will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing, Unit Manager or QA Nurse on use of short term medications long term. This re-education will be completed by 06/04/2015.</p> <p>4. The Pharmacy Consultant will audit all current residents physician orders monthly for three (3) months to identify any orders for medications or treatments intended for short term use that is used long term. The results of these audits 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</p>		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 5</p> <p>multiple scabbed areas and scratches on the resident's bilateral arms, bilateral sides of his/her trunk, left side of the back of the neck, and bilateral hip areas.</p> <p>Review of Resident #4's April 2015 Physicians Orders, revealed he/she continued to receive the same medicated cream treatment, (Clobetasol 0.05 percent cream bid to affected areas) since he/she was admitted on 12/22/14 (for approximately four (4) months) even though the facility drug book stated it was a short term treatment to be used for up to fourteen (14) days. Further review of the record revealed there was no documented evidence the facility had notified the physician the resident continued on the medication even though it was for short term use only and the resident was still itching and scratching.</p> <p>Interview with LPN #1, on 04/30/15 at 12:30 PM, revealed the facility uses the Nursing 2015 drug handbook by Lippincott at the facility. LPN #1 stated she would notify the physician promptly if a resident was being prescribed something that was for short term use and had received it long term. She revealed she was unaware that the medicated cream (Clobetasol 0.05 percent cream) treatment was to be used as a short term topical treatment, but she would withhold the medication until she spoke with the resident's physician if a medication or treatment was listed as a short term treatment in the Nursing 2015 drug hand book.</p> <p>Interview with Director of Nursing, on 04/30/15 at 01:00 PM, revealed she expected staff to use the facility's drug hand book, Nursing 2015, to be aware of a residents's medication. She stated</p>	F 281	<p>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: 06/05/2015</p>		

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

PRINTED: 05/14/2015
FORM APPROVED
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 281	Continued From page 6 the drug handbook indicated the treatment Resident #4 had been receiving was suggested for short term treatment up to fourteen (14) days and the nurse should have contacted the physician to determine if the order needed to be changed. The DON also stated the order for the treatment should of been specific to locations of where the medicated cream was to be applied and "to affected" areas, as the order listed, was to vague.	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedures, it was determined the facility failed to follow the Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents (Resident #5). Resident #5 was care planned to obtain consults and provide treatment as ordered; however, the facility failed to refer the resident to a oral surgeon per the dentist recommendation. The findings include: Review of the facility's policy and procedure titled, "Resident Comprehensive Care Plan", dated 09/08, revealed the Comprehensive care plan should be viewed as an Interdisciplinary approach to managing the acute and chronic needs of the	F 282	1. A pain assessment was completed on Resident #5 on 04/30/2015 by the Charge Nurse which revealed no concerns. Resident #5 has an appointment with an oral surgeon on 09/09/2015. The care plans for resident # 5 were reviewed on 05/05/2015 by the DON to determine if all care planed interventions are being followed. No concerns were identified. 2. 100% chart audit was completed on all current residents care plans by the Director of Nursing or Assistant Director of Nursing, or Unit Manager or MDS nurses to identify any intervention not in place. All identified as not in place will be immediately put in place. This will be completed by 06/04/20105.	06/05/2015	

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE
F 282	<p>Continued From page 7 resident living in the facility.</p> <p>Record review revealed the facility admitted Resident #5 on 09/19/13 with diagnoses which include Dysphagia, Dementia, Depression, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of a Nurse's Note, dated 01/08/15 at 6:20 AM, revealed Resident #5's right jaw and right side of his/her bottom lip was swollen. Further review revealed Resident #5 stated his/her jaw was sore.</p> <p>Review of a Progress Note, dated 01/09/15, revealed the Advanced Practice Registered Nurse (APRN) had assessed Resident #5 to have swelling to his/her right jaw which was tender to palpation (touch). Further review revealed Resident #5 had severe dental caries (cavities).</p> <p>Review of a Comprehensive Care Plan, dated 01/10/15, revealed the facility determined Resident #5 had a dental abscess and interventions were put in place to provide consults and treatment as ordered.</p> <p>Review of a Dental Consultation Report, dated 01/12/15, revealed Resident #5 had multiple decayed and fractured teeth. Further review revealed the dentist made recommendations to refer Resident #5 to an Oral Surgeon for extractions of ten (10) teeth (#9, 10, 11, 13, 14, 18, 27, 29, 30, and 31); however, further review of the record revealed there was no evidence the resident was referred to an Oral Surgeon.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 03/24/15, revealed the facility had assessed Resident #5's cognition as</p>	F 282	<p>3. All Licensed nurses will be re-educated by the Education Training Director, Director of Nursing or Assistant Director of Nursing regarding following. The plan of care and if unable to follow the plan of care and an alternative is not within their scope of practice they must notify the physician. All Current C.N.A.s will be re-educated by the Education Training Director, Director of Nursing Assistant Director of Nursing or Unit Managers on following the plan of care and if unable to follow the plan of care to report to the charge nurse. The above training will be completed by 06/04/2015 with no staff working after 06/04/15 without having had this re-education.</p> <p>4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or Unit Manager will audit (5) five resident care plans per week for twelve (12) weeks to validate that care plan interventions are in place. The results of these audits will be reviewed with the Quality</p>	

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 282	Continued From page 8 moderately impaired with a Brief Interview of Mental Status (BIMS) score of nine (9) indicating the resident was interviewable. Observation and interview on 04/30/15 at 1:08 PM, revealed Resident #5 had broken and missing teeth which were visible. Resident #5 stated his/her teeth did not hurt and did not interfere with activity at this time; however, had in the past. Further interview revealed she had not been to an oral surgeon and had not had any teeth pulled. Interview with the MDS Coordinator, on 04/30/15 at 4:40 PM, revealed the comprehensive plan of care was important for guiding the resident's care. Further interview revealed it was her expectation for staff to follow the care plan. Interview with the Director of Nursing, on 04/30/15 at 3:00 PM, revealed Resident #5 had other health issues going on during this time. She stated the dental abscess resolved and the referral for the oral surgery was overlooked. She further stated the resident's care plan should have been followed. Interview with the APRN, on 04/30/15 at 3:40 PM, revealed she expected the facility to follow all orders and to schedule any needed appointments.	F 282	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: 06/05/2015		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	1. Resident #4's physician and Family/legal representative were notified by the Charge Nurse that the prescribed treatment was not effective on 04/30/2015. New treatment	06/05/2015	

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 9 accordance with the comprehensive assessment and plan of care.</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 provide the necessary care and services to attain and maintain the highest level of practicable physical, mental and psychosocial well-being in accordance to the comprehensive assessment and plan of care for one (1) of twenty-four (24) sampled residents (Resident #4), in regards to a rash-like skin condition and unrelieved itching. Resident #4 was ordered Clobetasol (topical corticosteroid) cream to affected areas twice a day due to scratching and itching; however, Resident #4 continued to scratch and itch approximately four (4) months later and there was no documented evidence the physician was notified the medication was not effective.</p> <p>The findings include: Review of facility's policy, "Skin System Policy and Procedure, not dated, revealed the Skin Committee should meet at least weekly to review the care of residents with pressure ulcers, complex wounds and skin compromise; to include resident's nutritional status and response to healing. It further revealed the assigned nurse manager would provide oversight of the resident's skin/wound care in collaboration with the nurse, nurse assessment coordinator, physician and report changes to the Skin Committee on a</p>	F 309	<p>orders were obtained by Charge Nurse on 04/30/2015.</p> <ol style="list-style-type: none"> 100% chart audit of all current residents will be completed by the DON, ADON, and Unit Manager on By 06-04-2015 to identify any changes in condition that require physician notification that the physician has not been notified including skin treatments. Any identified will have immediate physician notification for further direction. All licensed Nursing staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing, Unit Manager or QA Nurse regarding physician and family or legal representative notification when a treatment is ineffective or there is a significant change in condition. This re-education will be completed by 06/04/2015. The Education Training Director, Director of Nursing, Assistant Director of Nursing, Unit Manager or QA Nurse will audit treatment records and medical records of five residents per week for twelve (12) weeks to ensure that the physician and responsible party have been notified of any significant change in condition. The results of 		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10 weekly basis.</p> <p>Record review revealed the facility admitted Resident #4's clinical record revealed the facility admitted Resident #4 on 12/22/14 with diagnoses which included Diabetes Mellitus, Type Two, Fractured Neck of Femur, Arthropathy, Fractured Rib, Colostomy Status, Malignant Neoplasm Rectum and Anus, and Hypertension. Further review revealed there was no documented evidence the resident had Psoriasis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/19/15, revealed the facility was unable to assess the resident using a Brief Interview for Mental Status (BIMS) exam and determined the resident's cognition was severely impaired which indicated the resident was not interviewable.</p> <p>Review of Impaired Skin Integrity Comprehensive Care Plan, dated 01/05/15, revealed the goal was for Resident #4 to be free from additional skin breakdown/irritation times ninety (90) days and the interventions were to apply treatment as ordered and conduct weekly skin checks.</p> <p>Review of the Physician's Order, dated 12/22/14, revealed to apply Clobetasol (topical corticosteroid) 0.05 percent cream twice daily to affected areas.</p> <p>Review of a shower sheet, dated 01/18/15, and monthly skin assessments, dated 02/04/15 and 04/02/15, revealed the resident continued to have scratches and scabs on him/her due to scratching. Observation of a skin assessment for Resident #4, on 04/30/15 at 12:15 PM by Licensed Practical Nurse (LPN) #1 and CNA #4, revealed the resident was scratching his/her</p>	F 309	<p>these audits 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: 06/05/2015</p>		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 11</p> <p>neck, bilateral arms and the sides of his/her trunk area. Further observation revealed the resident had multiple scabbed areas and scratches on his/her bilateral arms, bilateral sides of his/her trunk, left side of the back of the neck, and to bilateral hip areas.</p> <p>Review of Resident #4's April 2015 Physicians Orders, revealed he/she continued to receive the same medicated cream treatment, (Clobetasol 0.05 percent cream bid to affected areas) since he/she was admitted on 12/22/14. However, further record review revealed there was no documented evidence the physician had been notified the resident continued to scratch and complain of itching.</p> <p>Interview with CNA #3, on 04/30/15 at 2:10 PM, revealed she had seen Resident #4 with scratches and scabbed areas on his/her arms and belly. She stated she often seen him/her scratching worse in the early morning hours and after showers and that she reported this to whomever the nurse was on duty.</p> <p>Interview with CNA #4, on 04/30/15 at 2:20 PM, revealed she had seen Resident #4 itching and scratching often since she began employment with the facility in January 2015 and staff had frequently had to redirect him/her from scratching and itching. This interview further revealed that Resident #4 verbalized often that he/she itched.</p> <p>Interview with LPN #1, on 04/30/15 at 2:30 PM, revealed she would notify the physician if a resident had an ongoing skin condition that was not healing. LPN #1 stated Resident #4 had "Geri Sleeves" on bilateral arms due to frequent itching self and fragile skin.</p>	F 309			

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 309	Continued From page 12 Further record review revealed there was no documented evidence Resident #4's ongoing skin condition had been discussed in the Skin Committee Meeting as stated in the facility's policy. Interview with the Advanced Practice Registered Nurse (APRN), on 04/30/15 at 3:25 PM, revealed she could not recall anyone making her aware of Resident #4's constant itching and scratching or of the scabbed and scratched areas on the resident's body and she stated she would have expected the facility to have notified her. Interview with Director of Nursing (DON), on 04/30/15 at 01:00 PM, revealed she expected the licensed staff to re-evaluate treatments at least every fourteen (14) days to determine if a treatment was effective or ineffective and the need to notify physician for potential treatment change.	F 309			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a	F 411	1. Resident #5 has appointment scheduled with an oral surgeon on 09/09/2015. 2. 100% chart audit was completed by the Director of Nursing or Assistant Director of Nursing, or Unit Manager on 05/27/2015 to ensure residents with dental needs have routine dental services. There were no concerns identified. An audit of all current resident dental permission agreement was completed by the Social	06/05/2015	

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 411	<p>Continued From page 13 dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure each resident was afforded the opportunity to have routine dental services for one (1) of twenty-four (24) sampled residents (Resident #5). Refer to F282</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 04/30/15 at 1:47 PM, revealed the facility did not have a policy and procedure regarding dental services.</p> <p>Record review revealed the facility admitted Resident #5 on 09/19/13 with diagnoses which include Dysphagia, Dementia, Depression, and Chronic Obstructive Pulmonary Disease. Review of a Admission Data Set Nursing Assessment, dated 09/19/13, revealed Resident #5 had teeth in poor condition.</p> <p>Review of a Nurse's Note, dated 01/08/15 at 6:20 AM, and review of the Advanced Practice Registered Nurse (ARNP) Progress Note, dated 01/09/15, revealed Resident #5's right jaw and right side of his/her bottom lip was swollen, the jaw was tender with palpitation (touch) and the resident had severe dental cavities. Further review revealed Resident #5 stated his/her jaw was sore.</p> <p>Review of a Dental Consultation Report, dated 01/12/15, revealed the dentist identified Resident</p>	F 411	<p>Services Director or Assistant Social Services Director by 06/04/15 to identify any resident who wishes to be seen by dental services. Any resident who agrees to be seen will be added to the dental list for our contract dental service to see on next visit.</p> <p>3. The Social Services Director will maintain a list of residents who wish for dental services and schedule with our in facility dental services. Any emergent needs will be addressed through local dental services arranged by Social Services. The Administrator will re-educate the Social Services Director on the above by 06/04/2015.</p> <p>4. The Administrator will audit three (3) new admissions per month for three (3) months to ensure dental needs are addressed if urgent and residents who indicate they would like routine dental services are placed on the facility list for dental visits. The results of these audits will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and until the Quality Assurance Committee ascertains</p>		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE
F 411	<p>Continued From page 14</p> <p>#5 had multiple decayed and fractured teeth. Further review revealed the Dentist recommended Resident #5 be referred to an Oral Surgeon for extractions of ten (10) teeth, (#9, #10, #11, #13, #14, #18, #27, #29, #30, and #31). However, further review of Resident #5's record revealed there was no documented evidence Resident #5 was offered or provided the needed dental care.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 03/24/15, revealed the facility had assessed Resident #5's cognition as moderately impaired with a Brief Interview Mental Status (BIMS) score of nine (9) indicating the resident was interviewable.</p> <p>Observation and interview on 04/30/15 at 1:08 PM, revealed Resident #5 had broken and missing teeth which were visible. Resident #5 stated his/her teeth did not hurt and did not interfere with activity at this time; however, had in the past. Further interview revealed she had not been to an oral surgeon and had not had any teeth pulled.</p> <p>Interview with the Social Services Director, on 04/30/15 at 9:30 AM, revealed all residents received standing orders from the physician on admision for routine dental services. He stated the facility had a contract with a dental agency which comes to the facility every six (6) months.</p> <p>Interview with the DON, on 04/30/15 at 3:00 PM, revealed Resident #5 had other health issues going on during this time. She stated the dental abscess resolved and the referral for the oral surgery was overlooked.</p>	F 411	<p>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: 06/05/2015</p>	

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 411	Continued From page 15 Interview with the APRN, on 04/30/15 at 3:40 PM, revealed she expected the facility to follow all orders and to schedule any needed appointments.	F 411			
F 441 SS=E	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 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	F 441	1. The biohazard storage door located on the North hall was locked by the Maintenance Director on 04/30/2015. An automatic lock was installed by the Maintenance Director on 04/30/2015. 2. 100% Observation of all storage doors was completed by the Administrator on 04/30/2015. All doors were locked. All (13) thirteen storage room doors will be replaced with automatic locking door knobs by the Maintenance Director by 06/04/2015. 3. The Administrator will re-educate the Maintenance Director on obtaining automatic locks for any hazardous room by 06/04/2015. 4. The Administrator will observe biohazard storage/storage closets to ensure they are locked (2) two times per week for (12) twelve weeks. If a room is found to be unlocked it will be secured immediately. The results of these audits will be reviewed with the Quality Assurance Committee for a minimum of three (3) months	06/05/2015	

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

PRINTED: 05/14/2015
FORM APPROVED
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 16</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy/procedure review, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection related to one (1) Bio-Hazard Storage Room out of thirteen (13) storage rooms unlocked.</p> <p>Interview with the Director of Nursing (DON), on 04/29/15 at 9:05 AM, revealed there were fourteen (14) residents with wandering capabilities in which one could wander into this area and become entrapped in the room and be injured.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Regulated Medical Waste", dated 05/07, revealed the facility must designate a locked regulated waste storage area(s) and identify this area clearly.</p> <p>Observations on 04/28/15 at 2:06 PM, 2:23 PM, 2:40 PM, 3:57 PM and on 04/29/15 at 7:31 AM and 9:15 AM, revealed an unlocked door on the 100 hallway labeled "Bio- Hazard Storage".</p>	F 441	<p>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: 08/05/2015</p>		

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

PRINTED: 05/14/2015
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 04/30/2015
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)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 17</p> <p>There were six (6) full biohazard bags inside of the biohazard boxes and all were exposed because the box tops were not closed.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 04/29/15 at 8:40 AM, revealed the Bio-Hazard door should be locked to secure the waste at all times. She stated there were wanderers on the hallway and the Bio-Hazard waste should be secured to prevent residents or visitors from entering this area. She stated there were sharps and hazards stored in this area at all times.</p> <p>Further interview with the Director of Nursing (DON), on 04/29/15 at 9:05 AM, revealed she expected the Bio-Hazard Storage Room door to be locked at all times to secure the waste products (sharps and chemicals). She stated a resident/visitor could be injured in this area.</p> <p>Interview with Maintenance Director, on 04/29/15 at 9:25 AM, revealed the Bio-Hazard Storage Room contained waste that should be secured behind a locked door at all times. He revealed a resident could become trapped in the room or become injured on the hazardous waste.</p> <p>Interview with the Administrator, on 04/30/15 at 10:40 AM, revealed she expected the Bio-Hazardous Storage Room door to remain locked at all times. She stated a resident/visitor entering the room could become trapped or contamination by the hazardous waste. She revealed that this area does contain blood borne pathogens and a resident/visitor could become contaminated.</p>	F 441			

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING	RECEIVED MAY 2015 OFFICE OF INSPECTOR GENERAL	(X3) DATE SURVEY COMPLETED 04/30/2015
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 K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1989, 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (211) SMOKE COMPARTMENTS: Seven (7) smoke compartments FIRE ALARM: Complete fire alarm system upgraded in 2008 with five (5) heat and (42) smoke detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is propane. A Recertification Life Safety Code Survey was initiated on 04/29/15 and concluded on 04/30/15. The facility 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 nineteen (119) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of 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 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 time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or admission by the facility. The plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	(X5) COMPLETION DATE	

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

Chris Malvern

TITLE

NHA

(X6) DATE

05/22/15

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.

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at "E" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 Roller latches are prohibited by CMS regulations in all health care facilities. 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 would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5)	K 018	<ol style="list-style-type: none"> 1. The corridor doors to rooms #101 and #339 were adjusted to latch properly by the Maintenance Director on 04/30/2015. 2. An audit of all facility doors was conducted by the Maintenance Director on 05/20/2015 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 regarding requirements for doors fully closing. This re-education will be completed by 06/04/2015. 4. The Maintenance Director will observe all facility corridor doors for proper latching weekly times (12) twelve 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 	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 018	<p>Continued From page 2</p> <p>smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred thirty-two (132) beds and at the time of the survey, the census was one-hundred nineteen (119).</p> <p>The findings include:</p> <p>1.) Observation, on 04/29/15 at 2:05 PM, with the Maintenance Supervisor revealed the corridor door to room #101 would not latch when tested.</p> <p>Interview, on 04/29/15 at 2:08 PM, with the Maintenance Supervisor revealed he was unaware the door would not latch.</p> <p>2.) Observation, on 04/29/15 at 3:05 PM, with the Maintenance Supervisor revealed the corridor door to room #339 would not latch when tested.</p> <p>Interview, on 04/29/15 at 3:06 PM, with the Maintenance Supervisor revealed he was unaware the door would not latch.</p> <p>The census of one-hundred nineteen (119) was verified by the Administrator on 04/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical</p>	K 018	<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: 06/05/2015</p>	06/05/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015	
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)	(X5) COMPLETION DATE
K 018	<p>Continued From page 3</p> <p>openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>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.</p> <p>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.</p> <p>Reference: CMS: S&C-07-18</p>	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 025	<p>Continued From page 4</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred thirty-two (132) beds and at the time of the survey, the census was one-hundred nineteen (119).</p> <p>The findings include:</p> <p>1.) Observation, on 04/30/15 at 7:55 AM, with the Maintenance Supervisor revealed an unsealed pipe sleeve and a one (1) inch hole located in the smoke barrier extending above the ceiling by Room #216.</p> <p>Interview, on 04/30/15 at 7:56 AM, with the Maintenance Supervisor revealed he was not aware of the penetration.</p>	K 025	<ol style="list-style-type: none"> The unsealed pipe sleeve and one (1) inch hole located in the smoke barrier extending above the ceiling by Room #216 was sealed with fire caulk by the Maintenance Director on 05/21/2015. An access panel will be installed by 06/04/2015 to the Skilled A side of the barrier extending above the ceiling between Skilled A and B to ensure Skilled A can be inspected. The Maintenance Director observed smoke barriers to ensure they were sealed with approved materials. No issues noted on 05/21/2015. Observation of all facility smoke barrier access doors was conducted by the Maintenance Director on 05/20/2015 and no other issues were found. The Maintenance Director will be re-educated by the Administrator regarding NFPA 101, 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 and 8.2.3.2.2 regarding requirements for smoke barriers. This re-education will be completed by 06/04/2015. The Maintenance Director will observe all facility smoke barriers to ensure they are sealed properly and access is available for proper latching weekly times (12) twelve 	06/05/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 025	Continued From page 5 2.) Observation, on 04/30/15 at 8:05 AM, with the Maintenance Supervisor revealed the smoke barrier extending above the ceiling between Skilled A and Skilled B was not accessible from the Skilled A Side for inspection. Interview, on 04/30/15 at 8:06 AM, with the Maintenance Supervisor revealed he was not aware both sides would need to be inspected. The census of one-hundred nineteen (119) was verified by the Administrator on 04/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/30/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 19.3.7.5 Openings in smoke barriers shall be protected by	K 025	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: 06/05/2015	06/05/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 025	<p>Continued From page 6</p> <p>fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted.</p> <p>Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>Reference: NFPA 80 Standard for Fire Doors and Windows (1999 edition)</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.2.3.2.2</p> <p>Fire window assemblies shall be permitted in fire barriers having a required fire resistance rating of 1 hour or less and shall be of an approved type with the appropriate fire protection rating for the location in which they are installed. Fire windows shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows, and shall comply with the following:</p> <p>(1) * Fire windows used in fire barriers, other than existing fire window installations of wired glass and other fire-rated glazing material in approved metal frames, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 257, Standard on Fire Test for Window and Glass Block Assemblies.</p> <p>(2) Fire windows used in fire barriers, other than existing fire window installations of wired glass and other fire-rated glazing material in approved metal frames, shall not exceed 25 percent of the area of the fire barrier in which they are used.</p> <p>Exception: Fire-rated glazing material shall be permitted to be installed in approved existing frames.</p>	K 025		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 025	Continued From page 7 Reference: NFPA 80 Standard for Fire Doors and Windows (1999 edition) 13-1 Windows. 13-1.1 General. This chapter shall cover the installation of fire windows. 13-1.2 Testing. Fire windows shall be tested in accordance with NFPA 257, Standard Research Test Method for Determining Smoke Generation of Solid Materials, for the required fire protection rating of the window opening. Fire windows shall be labeled. 13-1.3 Labels. 13-1.3.1 Fire window frames shall be labeled for such use.	K 025		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure locks on doors in the path of egress were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, residents, staff and	K 038	<ol style="list-style-type: none"> 1. The second lock on the Receptionist office door and the Education and Training office door were removed by the Maintenance Director on 05/04/2015. The door to the resident smoking area was removed by the Maintenance Director on 05/21/2015. 2. The Maintenance Director observed all doors to ensure they did not have second locks within the building on 05/04/2015. The Maintenance Director observed all outside doors to ensure they did not swing in the direction of the path of egress on 05/21/2015. 3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 101, 7.1, 19.2.1 regarding Exit access is arranged so that exits are readily accessible at 	06/05/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 038	<p>Continued From page 8</p> <p>visitors. The facility has the capacity for one-hundred thirty-two (132) beds and at the time of the survey, the census was one-hundred nineteen (119).</p> <p>The findings include:</p> <p>1.) Observation, on 04/29/15 at 2:20 PM, with the Maintenance Supervisor revealed two (2) locks on the Receptionist Office door to the corridor.</p> <p>Interview, on 04/29/15 at 2:21 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for locks in the path of egress.</p> <p>2.) Observation, on 04/29/15 at 2:24 PM, with the Maintenance Supervisor revealed two (2) locks on the Education and Training Office door.</p> <p>Interview, on 04/29/15 at 2:25 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for locks in the path of egress.</p> <p>3.) Observation, on 04/29/15 at 3:15 PM, with the Maintenance Supervisor revealed the door to the resident smoking area did not swing in the direction of the path of egress.</p> <p>Interview, on 04/29/15 at 3:16 PM, with the Maintenance Supervisor revealed he was not aware of the requirement.</p> <p>The census of one-hundred nineteen (119) was verified by the Administrator on 04/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the</p>	K 038	<p>all times. This re-education will be completed by 06/04/2015.</p> <p>4. The Maintenance Director will observe interior doors to ensure they do not have double locks and that all outside doors do not swing in the direction of the path of egress weekly times (12) twelve 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: 06/05/2015</p>	

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE	
K 038	Continued From page 9 exit interview on 04/30/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors	K 038			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 038	Continued From page 10 serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the	K 038		

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 038	Continued From page 11 door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFFA 101 LIFE SAFETY CODE STANDARD	K 038		
K 056 SS=D	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 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the	K 056	<ol style="list-style-type: none"> The light fixture will be moved in the Employee Break room so the sprinkler head will not be obstructed from developing a full pattern on 05/26/2015 by the Maintenance Director. A sprinkler will be installed on the recessed area from the front door to the porch beam by Armor Fire Protection by 06/04/2015. The Maintenance Director observed sprinkler heads to ensure proper placement and complete coverage of the building on 05/21/2015 and no other issues were found. The Maintenance Director will be re-educated by the Administrator regarding NFPA 101, 19.3.5 sprinkler systems. 	

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 056	<p>Continued From page 12</p> <p>sprinklers were installed, in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred thirty-two (132) beds and at the time of the survey, the census was one-hundred nineteen (119). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p> <p>1) Observation, on 04/29/15 at 1:55 PM, with the Maintenance Supervisor revealed a sprinkler head located in the Employee Break Room was obstructed from developing a full pattern by a light fixture installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler deflector.</p> <p>Interview, on 04/29/15 at 1:56 PM, with the Maintenance Supervisor revealed he was aware of the requirement; however, he had not noticed the sprinkler head being obstructed in the Employee Break Room.</p> <p>2) Observation, on 04/29/15 at 2:22 PM, with the Maintenance Supervisor revealed incomplete sprinkler coverage of the Front Porch. The recessed area from the front door to the porch beam did not have sprinkler protection.</p> <p>Interview, on 04/29/15 at 2:23 PM, with the Maintenance Supervisor revealed he was not aware the porch roof did not have complete coverage.</p>	K 056	<p>This re-education will be completed by 06/04/2015.</p> <p>4. The Maintenance Director will observe all facility sprinklers to ensure proper placement weekly times (12) twelve 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: 06/05/2015</p>	06/05/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 056	<p>Continued From page 13</p> <p>The census of one-hundred nineteen (119) was verified by the Administrator on 04/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements.</p> <p>19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>19.3.5.2* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria:</p> <p>(1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as</p>	K 056		

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 056	Continued From page 14 nonsprinklered. Reference: NFPA 101 (2000 Edition) 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code. Exception No. 2: NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code. 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. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) Maximum Allowable Distance	K 056		

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 058	Continued From page 15 Distance from Sprinklers to above Bottom of Side of Obstruction (A) of Deflector 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. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 058		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070	1. The portable space heater in the North Shower room will be hard wired in so it cannot be moved by 06/04/2015 by the Maintenance Director.	06/05/2015

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
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)	(X5) COMPLETION DATE
K 070	<p>Continued From page 16</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility has the capacity for one-hundred thirty-two (132) beds and at the time of the survey, the census was one-hundred nineteen (119).</p> <p>The findings include:</p> <p>Observation, on 04/29/15 at 2:00 PM, with the Maintenance Supervisor revealed a portable space heater attached to the wall located in the North Hall Shower Room. The portable heater had a heating element that exceeds 212 degrees.</p> <p>Interviews, on 04/29/15 at 2:01 PM, with the Maintenance Supervisor revealed he was not aware of the portable space heater being in use in the Shower Room.</p> <p>The census of one-hundred nineteen (119) was verified by the Administrator on 04/30/15. The findings were acknowledged by the Administrator and verified by Maintenance Supervisor at the exit interview on 04/30/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.8 Portable Space-Heating Devices. Portable space-heating</p>	K 070	<ol style="list-style-type: none"> 2. The Maintenance Director observed all health care occupied areas in building to ensure there were no portable space heaters on 04/30/2015 and no other issues were found. 3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 101, 19.7.8 portable space heaters. This re-education will be completed by 06/04/2015. 4. The Maintenance Director will observe all health care occupied areas in building to ensure there were no portable space heaters weekly times (12) twelve 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 	

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
K 070 K 147 SS=D	<p>Continued From page 17 devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred thirty-two (132) beds and at the time of the survey, the census was one-hundred nineteen (119).</p> <p>The findings include:</p> <p>Observation, on 04/29/15 at 1:45 PM, with the Maintenance Supervisor revealed the Hydrocollator located in the Modality Room of the Therapy Gym was not plugged into a ground fault circuit interrupter (GFCI) receptacle.</p> <p>Interview, on 04/29/15 at 1:45 PM, with the Maintenance Supervisor revealed he was not</p>	K 070 K 147	<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: 06/05/2015</p> <ol style="list-style-type: none"> 1. The Maintenance Director I installed a G.F.C.I. receptacle in the Modality Room of the Therapy gym. The Hydrocollator was plugged into the G.F.C.I. on 05/21/2015 by the Maintenance Director. 2. The Maintenance Director observed electrical devices to ensure they were plugged into the correct electrical outlet on 04/30/2015 and no other issues were found. 3. The Maintenance Director will be re-educated by the Administrator regarding NFPA 101, 9.1.2 regarding electrical wiring and equipment. This re-education will be completed by 06/04/2015. 	06/05/2015

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 18 aware of the requirement.</p> <p>The census of one-hundred nineteen (119) was verified by the Administrator on 04/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference NFPA 70 (1999) edition National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles Installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.</p> <p>Reference NFPA 70 (1999 edition) 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel.</p>	K 147	<p>4. The Maintenance Director will observe all electrical devices to ensure they are plugged into the correct electrical outlet weekly times (12) twelve 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: 06/05/2015</p>	06/05/2015
-------	--	-------	---	------------

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 19</p> <p>FPN: See 215.9 for ground-fault circuit-interrupter protection for personnel on feeders.</p> <p>(A) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1) through (8) shall have ground-fault circuit-interrupter protection for personnel.</p> <p>(1) Bathrooms</p> <p>(2) Garages, and also accessory buildings that have a floor located at or below grade level not intended as habitable rooms and limited to storage areas, work areas, and areas of similar use</p> <p>Exception No. 1: Receptacles that are not readily accessible.</p> <p>Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Receptacles installed under the exceptions to 210.8(A)(2) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(3) Outdoors</p> <p>Exception: Receptacles that are not readily accessible and are supplied by a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426.</p> <p>(4) Crawl spaces - at or below grade level</p> <p>(5) Unfinished basements - for purposes of this section, unfinished basements are defined as portions or areas of the basement not intended as habitable rooms and limited to storage areas, work areas, and the like</p> <p>Exception No. 1: Receptacles that are not readily accessible.</p>	K 147		
-------	--	-------	--	--

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 20</p> <p>Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8).</p> <p>Exception No. 3: A receptacle supplying only a permanently installed fire alarm or burglar alarm system shall not be required to have ground-fault circuit-interrupter protection.</p> <p>Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(6) Kitchens - where the receptacles are installed to serve the countertop surfaces</p> <p>(7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.</p> <p>(8) Boathouses</p> <p>(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1), (2), and (3) shall have ground-fault circuit-interrupter protection for personnel:</p> <p>(1) Bathrooms</p> <p>(2) Rooftops</p> <p>Exception: Receptacles that are not readily accessible and are supplied from a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426.</p> <p>(406.8 Receptacles in Damp or Wet Locations.</p> <p>(A) Damp Locations. A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug</p>	K 147		
-------	--	-------	--	--

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

PRINTED: 05/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
K 147	<p>Continued From page 21</p> <p>cap not inserted and receptacle covers closed). An installation suitable for wet locations shall also be considered suitable for damp locations. A receptacle shall be considered to be in a location protected from the weather where located under roofed open porches, canopies, marquees, and the like, and will not be subjected to a beating rain or water runoff.</p> <p>(B) Wet Locations.</p> <p>(1) 15- and 20-Ampere Outdoor Receptacles. 15- and 20-ampere, 125- and 250-volt receptacles installed outdoors in a wet location shall have an enclosure that is weatherproof whether or not the attachment plug cap is inserted.</p> <p>(2) Other Receptacles. All other receptacles installed in a wet location shall comply with (a) or (b):</p> <p>(a) A receptacle installed in a wet location where the product intended to be plugged into it is not attended while in use (e.g., sprinkler system controller, landscape lighting, holiday lights, and so forth) shall have an enclosure that is weatherproof with the attachment plug cap inserted or removed.</p> <p>(b) A receptacle installed in a wet location where the product intended to be plugged into it will be attended while in use (e.g., portable tools, and so forth) shall have an enclosure that is weatherproof when the attachment plug is removed.</p> <p>(C) Bathtub and Shower Space. A receptacle shall not be installed within a bathtub or shower space.</p> <p>3) Kitchens</p> <p>Reference NFPA 70 (1999) edition 370-28(c) Covers. All pull boxes, junction boxes, and</p>	K 147		

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2015
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	Continued From page 22 conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147		
-------	---	-------	--	--