

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

PRINTED: 09/13/2012  
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  C 08/03/2012
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  TWIN RIVERS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
--------------------------------------------------------------------------	---------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 000	INITIAL COMMENTS  AMENDED 09/13/12 F157 - deleted all references related to the diagnosis of Pneumonia  An abbreviated survey (KY #18806) was conducted on 08/02/12 through 08/03/12 to determine the facility's compliance with Federal requirements. KY #18806 was substantiated with deficiencies cited.	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  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).  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	F 157	F157  1. The physician of resident identified as resident #2's was notified by the LPN Charge Nurse on 7/27/2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chris Malvern</i>	TITLE NHA	(X8) DATE 9-13-12
-----------------------------------------------------------------------------------------------	--------------	----------------------

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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: 09/13/2012  
 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  C 08/03/2012
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER

TWIN RIVERS NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

2420 W. 3RD ST.

OWENSBORO, KY 42301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 157	<p>Continued From page 1 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> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to immediately consult with the resident's physician regarding a significant change in the resident's physical status for one resident (#2), in the selected sample of three residents. The facility assessed Resident #2 as having chest pain, on 07/26/12 at 9:00 PM; however, the physician was not notified until 11:00 PM, at which time the resident was sent to the hospital.</p> <p>Findings include:</p> <p>A review of the facility's "Notification of Resident Change in Condition" policy/procedure, undated, revealed to notify the physician immediately if there was a significant change in condition, regardless of the time.</p> <p>A record review revealed Resident #2 was admitted to the facility on 07/25/12 with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and Parkinson's Disease. A review of the Admission Assessment, dated 07/25/12, revealed the facility assessed the resident as alert, oriented to person, and confused. It was documented that the resident was not in pain upon admission.</p>	F 157	<ol style="list-style-type: none"> <li>2. An audit of all current resident records will be completed by the Director of Nursing, the Assistant Director of Nursing, the Unit Manager or the District Education and Training Director to assure that any significant change in condition that has occurred in the past thirty (30) days had physician notification. Any identified concerns will have immediate physician notification. This audit will be completed by 9/7/2012.</li> <li>3. All licensed staff will be re-educated by the District Education and Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on the facility policy for Physician Notification. This re-education will be completed by 9/7/2012.</li> <li>4. The District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will review ten (10) resident records per week for twelve (12) weeks to assure that physician notification is occurring with a significant change in condition. If at any time concerns are identified, the Quality Assurance committee will meet to review for further recommendations. The results of these audits will be reviewed with the Quality Assurance Committee at a minimum of monthly for three (3)</li> </ol>	

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

 PRINTED: 09/13/2012  
 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  C 08/03/2012
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 2  A review of the Skilled Nursing Notes, dated 07/26/12 at 9:00 PM, revealed Resident #2 complained of chest pain at this time. Two hours later (11:00 PM), the resident was sent to the emergency room with chest pain. A review of the Adult Acute Care Initial Assessment, dated 07/27/12, revealed the resident was admitted to the hospital.  An interview with Licensed Practical Nurse (LPN) #3, on 08/03/12 at 10:45 AM, revealed he was the nurse taking care of Resident #2, on 07/26/12 at 9:00 PM. He indicated the resident had been in the facility less than twenty-four hours. He revealed the resident complained of chest pain, but appeared in no distress. He stated that he did not feel it necessary to notify the physician of the chest pain.  An interview with the Director of Nursing (DON), on 08/03/12 at 12:55 PM, revealed she expected the staff to follow the policy related to a resident's change in condition. She revealed the nurse should notify the physician after assessing the resident; however, it would be up to the nurse whether or not the resident had a change in condition.  An interview with the Advanced Registered Nurse Practitioner (ARNP), on 08/03/12 at 1:25 PM, revealed Resident #2 was sent to the hospital on 07/26/12 at 11:00 PM, with a complaint of chest pain. If the resident was having chest pain two hours prior, the staff should have notified the physician.	F 157	months and until the Quality Assurance ascertains compliance. 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: 09/08/2012	09/08/2012	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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

PRINTED: 09/13/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2012
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

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 3  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 policy/procedure, it was determined the facility failed to ensure services were provided that met professional standards of quality for one resident (#3), in the selected sample of three residents. Resident #3 had a physician's order for oxygen at 2 Liters Per Minute (LPM) per nasal cannula (NC); however, observations during the abbreviated survey revealed it was administered at 4 L per N/C.  Findings include:  A review of the facility's policy/procedure for Oxygen Administration, undated, revealed the purpose was to provide guidelines for safe oxygen administration. A step in the procedure included to adjust the oxygen delivery device so that it was comfortable for the resident and the proper flow of oxygen was being administered.  A record review revealed Resident #3 was originally admitted to the facility on 12/01/09, and re-admitted on 06/28/11. Diagnoses included Respiratory Distress, Hypoxia, Lethargy, and Chronic Obstructive Pulmonary Disease (COPD). A review of the significant change Minimum Data Set (MDS), dated 08/12/11, revealed the facility assessed Resident #3 as cognitively intact.	F 281	F281  1. Resident # 3's oxygen was adjusted to two (2) LPM on 8/3/12 by the RN Unit Manager. 2. An audit of all residents who receive oxygen therapy was conducted by the Director of Nursing and Unit Managers on 8/3/12 to assure that all oxygen was set on the correct LPM as prescribed by the physician. No concerns were identified. 3. All licensed staff will be re-educated by the District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on the facility policy for Physician Notification and following physician orders. This re-education will be completed by 9/7/2012. 4. The District Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe all oxygen settings five (5) times per week for one (1) week, then three (3) times per week for three (3) weeks and weekly for eight (8) weeks to assure settings are per physician's order. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of three (3) months and 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	
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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

 PRINTED: 09/13/2012  
 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  C 08/03/2012
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>A review of the physician's orders, dated August 2012, revealed an order for oxygen at 2 LPM per NC while awake to maintain oxygen saturation greater than 90 percent.</p> <p>Observations, on 08/02/12 at 3:45 PM, and on 08/03/12 at 9:05 AM, 11:00 AM, and 12:00 PM, revealed oxygen was administered to Resident #3 at 4 L per NC.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 08/03/12 at 12:15 PM, revealed she worked on 08/02/12, but could not remember how much oxygen the resident was getting. She revealed it was on 3 LPM per NC "most times." She stated that the resident liked the oxygen between 3-4 LPM, and "will usually tell staff if [he/she] needs it higher."</p> <p>A review of the Medication Administration Record (MAR), dated August 2012, revealed the resident's oxygen order was initialed by LPN #5, on 08/03/12.</p> <p>An interview with LPN #5, on 08/03/12 at 11:40 AM, revealed she did initial the resident's oxygen order for 7-3 shift, on 08/03/12; however, she did not verify the resident's oxygen was set on the correct LPM. LPN #5 observed the resident's oxygen with the surveyor, on 08/03/12 at 12:00 PM, and verified it was at 4 LPM instead of 2 LPM.</p> <p>An interview with Resident #3, on 08/03/12 at 12:05 PM, revealed his/her oxygen was "always" on 4 LPM.</p> <p>An interview with the Advanced Registered Nurse</p>	F 281	<p>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: 09/08/2012</p>	09/08/2012

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

 PRINTED: 09/13/2012  
 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  C 08/03/2012
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>Practitioner (ARNP), on 08/03/12 at 12:40 PM, revealed she wanted to maintain residents on oxygen at the lowest level possible as she did not want residents to be dependent on higher doses. She expected the staff to follow the physician's order (2 LPM), unless oxygen saturations were less than 90 percent.</p> <p>An interview with the Director of Nursing (DON), on 08/03/12 at 12:55 PM, revealed she expected the staff to follow the physician's orders and the policy related to oxygen administration.</p>	F 281			