

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

PRINTED: 10/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 10/22/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TWIN RIVERS NURSING AND REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2420 W. 3RD ST. OWENSBORO, KY 42301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>An onsite Revisit Survey to the 04/30/15 Recertification Survey, 06/12/15 Abbreviated Survey and 08/06/15 Abbreviated Survey, was conducted on 10/22/15 and determined the facility was in compliance on 08/27/15.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185087	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/22/2015
Name of Facility TWIN RIVERS NURSING AND REHAB CENTER		Street Address, City, State, Zip Code 2420 W. 3RD ST. OWENSBORO, KY 42301

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(I)</u> LSC _____	Correction Completed <u>08/27/2015</u>	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(II)</u> LSC _____	Correction Completed <u>08/27/2015</u>	ID Prefix <u>F0325</u> Reg. # <u>483.25(I)</u> LSC _____	Correction Completed <u>08/27/2015</u>
ID Prefix <u>F0333</u> Reg. # <u>483.25(m)(2)</u> LSC _____	Correction Completed <u>08/27/2015</u>	ID Prefix <u>F0425</u> Reg. # <u>483.60(a),(b)</u> LSC _____	Correction Completed <u>08/27/2015</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>ODH</u>	Date: <u>10/23/15</u>	Signature of Surveyor: <u>Richard C. Henderson NCE, DE</u>	Date: <u>10/23/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>6/12/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 185087	<b>(Y2) Multiple Construction</b> A. Building _____ B. Wing _____	<b>(Y3) Date of Revisit</b> 8/6/2015
<b>Name of Facility</b> TWIN RIVERS NURSING AND REHAB CENTER		<b>Street Address, City, State, Zip Code</b> 2420 W. 3RD ST. OWENSBORO, KY 42301

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed 07/22/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 07/22/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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Reviewed By _____	Reviewed By <u>DH</u>	Date: <u>08/21/15</u>	Signature of Surveyor: <u>Deborah C. Henderson, DC</u>	Date: <u>08/21/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 6/12/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 50px;">YES</td> <td style="width: 50px;">NO</td> </tr> </table>	YES	NO
YES	NO		

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(F 000)	<p><b>INITIAL COMMENTS</b></p> <p><b>AMENDED</b></p> <p>An Abbreviated Survey investigating Complaints #KY23528 and #KY23610 was conducted in conjunction with a Revisit Survey to the 08/12/15 Abbreviated Survey and a Second Revisit Survey to the 04/30/15 Recertification Survey on 07/28/15 through 08/06/15. Complaints #KY23528 &amp; #KY23610 were unsubstantiated with unrelated deficiencies cited.</p> <p>The Revisit Survey to the 08/12/15 Abbreviated Survey and a Second Revisit to the 04/30/15 Recertification Survey determined F280 and F323 were corrected on 07/22/15, as alleged. However, F281 and F282 were recited and additional deficiencies were cited at F325, F333 and F425 at the highest Scope and Severity of a "D" as unrelated deficiencies to Complaint #KY23528.</p>	(F 000)	<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>	
(F 281) SS=D	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14 Patient Care Orders and review of the Hospital Physician's Discharge Orders, it was determined the facility failed to ensure professional standards of practice were met related to following the Physician's Orders for one (1) of three (3)</p>	(F 281)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Yancey TITLE: Administrative (X6) DATE: 10/23/2015

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{F 281}	<p>Continued From page 1</p> <p>sampled residents (Resident #9); and, one (1) unsampled resident (Resident C). The facility failed to ensure Resident #9's Levothyroxine was reactivated after a three (3) day hospital stay which resulted in the resident not receiving his/her medication for sixty (60) days. In addition, the facility failed to administer Levothyroxine to Unsampled Resident D according to his/her Physician's Order for two (2) days.</p> <p>The findings include:</p> <p>Review of the KBN AOS #14 Patient Care Orders, last revised 10/2010, revealed licensed staff should administer medications and treatments as prescribed by a physician and advanced practice registered nurse by preparing and giving medication in the prescribed dosage, route and frequency.</p> <p>Review of the facility's policy titled, "Medication Administration", dated 12/2012, revealed medications should be administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices. Personnel authorized to administer medications should do so only after they have familiarized themselves with the medication.</p> <p>1. Review of the facility's re-admission checklist revealed two (2) nurses should check hospital orders with the Medication Administration Record (MAR) to ensure they are transcribed correctly and to make sure the physician and advanced registered nurse practitioner are aware of all re-admits.</p> <p>Record review revealed the facility admitted Resident #9 on 09/08/14 with diagnoses which</p>	{F 281}	<ol style="list-style-type: none"> <li>1. APRN did not reorder the Levothyroxine for Resident #9 because TSH level was within normal limits. Resident D's Levothyroxine was delivered from pharmacy on 7/31/15 per Pharmacia shipping manifest and given to Resident D by floor nurse on 8/1/15 as evidenced by the signed Electronic Medication Administration Record.</li> <li>2. Audit of all readmissions for the past thirty days by Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers was completed by 8/26/15 to ensure orders were transcribed and or reactivated correctly. Any issues were immediately corrected. Medication cart to medication administration record audit on all medication carts completed by pharmacy on 8/20/15 and any meds not available were ordered and delivered on 8/20/15.</li> <li>3. All licensed nurses were reeducated by the Director of Nursing, Education Training Director, Assistant Director of Nursing and/or Unit Managers by 8/26/15 on medication availability and reactivation of physician orders upon readmission (including a second nurse to verify accuracy of orders) Medication</li> </ol>		

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{F 281}	<p>Continued From page 2</p> <p>included Hypothyroidism. Further review revealed the resident was admitted to the hospital on 05/27/15 and returned to the facility on 05/29/15.</p> <p>Review of the Hospital Physician's Discharge Orders, dated 05/29/15, revealed an order for Levothyroxine (thyroid medication) 50 micrograms (mcg) every morning (AM). However, review of the Physician's Order Sheet from the facility, dated 05/29/15, revealed the order for the Levothyroxine had not been transcribed by the re-admitting nurse.</p> <p>Review of the June and July 2015 Physician's Orders and the May, June and July 2015 Medication Administration Records, (MAR) revealed Levothyroxine 50 mcg was not on the Physician's Orders or MARs which resulted in the facility failing to administer the Levothyroxine for sixty (60) days from 05/30/15 through 07/28/15.</p> <p>Interview with the nurse, who readmitted the resident, Registered Nurse (RN) #1, on 07/28/15 at 5:05 PM, revealed she entered the resident's orders into the computer system upon the resident's return to the facility on 05/29/15, but she was not certain if another nurse had assisted her. She stated their procedure required two (2) nurses to check the order, so the orders were looked at by "a second pair of eyes". RN #1 stated she could not remember if it was done or not.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/28/15 at 11:30 AM, revealed the MARs indicated Resident #9 was not administered Levothyroxine in June and July 2015 and there was no order from the physician</p>	{F 281}	<p>Availability training included use of Emergency Drug Kit, after hours pharmacy, physician notification, on-call nurse notification, medication refusals and if resident needs cannot be met the resident is to be sent to hospital.</p> <p>4. Medication administration record to medication cart audit will be performed by the Director of Nursing, Assistant Director of Nursing or Unit Managers two (2) times per month for three (3) months. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit five (5) readmits per month for three months to ensure orders were reactivated appropriately. 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: 8/27/15</p>		

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NAME OF PROVIDER OR SUPPLIER  TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301		
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{F 281}	Continued From page 3 to discontinue the medication. She stated Resident #9 should still be taking Levothyroxine for his/her thyroid. The ADON stated she could not provide information as to what happened and why Resident #9 was not receiving the medication anymore. She stated Resident #9 went to the hospital for oral surgery on 05/27/15 and returned to the facility on 05/29/15, and his/her medication should have been reactivated by the nurse who readmitted him/her.  Interview with the Director of Nursing (DON), on 07/28/15 at 2:41 PM, revealed she expected staff to double check the information entered into the computer to ensure it was correct so there were no transcription errors. She stated she was not the DON at the time, but she thought the medication was probably missed because Resident #9 was out of the facility for less than three (3) days. The DON stated if the resident had been treated as a readmission and there was a two (2) nurse check on the medications, as per policy, then there would not have been the transcription error of not reactivating the resident's Levothyroxine. She stated when a resident leaves the facility and goes to the hospital their computer system cannot hold medication so it has to be deactivated until the resident returns to the facility then the admission nurse will reactivate the medication. She revealed in this case, Resident #9 missed his/her medication for almost two (2) months and it would not have happened had the medication been reactivated and a second nurse checked to make sure the medication had been reactivated. In addition, she stated the nurses from that hall should have known the resident well enough to realize he/she was not receiving his/her Levothyroxine as normally prescribed and, then	{F 281}	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: 8/27/15		

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{F 281}	<p>Continued From page 4 they should have contacted the physician.</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP), on 07/28/15 at 2:15 PM revealed she was unaware Resident #9 was not receiving his/her Levothyroxine as prescribed by the physician. She stated not having that medication for that amount of time could be "tricky" and effect the resident in a multitude of ways to include weight and mental concerns. She said she expected the facility to provide medications as they were prescribed.</p> <p>Review of a Medical Laboratory Report, dated 07/09/15, revealed Resident #9's Thyroid Stimulating Hormone (TSH) level was 2.5 MIU/DL (normal 0.3-5.8 MIU/dl). The physician was notified and orders were received to discontinue the order for Levothyroxine and retest in one (1) month.</p> <p>2. Record review revealed the facility admitted Unsampled Resident D on 05/16/15 with diagnoses which included Hypothyroidism.</p> <p>Review of the July 2015 Physician's Orders revealed an order to administer Levothyroxine 0.088 milligrams (mg) by mouth every morning.</p> <p>Review of the July 2015 Medication Administration Record (MAR) revealed the Levothyroxine was marked as not being available for administration on 07/30/15 and 07/31/15 at 8:00 AM which resulted in two (2) missed doses.</p> <p>Review of Unsampled Resident D's Electronic-MAR revealed on 07/30/15 at 5:15 AM Licensed Practical Nurse (LPN) #4 documented the medication was not available for</p>	{F 281}			

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{F 281}	Continued From page 5 administration and the pharmacy was notified.  Interview (Post Survey) with the Licensed Practical Nurse (LPN) #4, on 08/11/15 at 7:40 PM, revealed she did not recall reordering Unsampler Resident D's Levothyroxine or writing on the E-MAR "it was not available and the pharmacy notified". She stated if she identified a medication was not available for administration she would check the Emergency Drug Kit (EDK) and call the pharmacy so the medication could be sent in the next hour or two (2).  Interview (Post Survey) with the Director of Nursing (DON), on 08/06/15 at 10:15 AM, revealed she called the pharmacy and looked in the record and could not find any documentation the medication was ordered prior to 07/31/15.  Review of a Pharmacy Shipping Manifest, dated 07/31/15 at 10:15 PM, revealed the Levothyroxine was delivered to the facility on 07/31/14 after 10:15 PM.  Interview with the Regional Quality Manager (RQM), on 08/05/15 at 1:00 PM, revealed the staff should administer medications according to the Physician's Orders.	{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	{F 282}	1. Resident #9 was weighed on - 7/28/15 by Administrator In Training, LPN. A review of the weight record by the Director of Nursing on 7/28/15 noted that Resident #9 weights have been obtained as care planned. The Director of Nursing audited Resident #9's Care plan on 7/28/15. Any issues noted were corrected immediately.		

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{F 282}	<p>Continued From page 6</p> <p>by:</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the staff implemented the care plan to monitor weights monthly and to follow facility protocol for reweighs for one (1) of three (3) sampled residents (Resident #9). Staff failed to obtain a weight for Resident #9 in June 2015 and failed to reweigh the resident when the resident's July 2015 weight show a weight loss of thirty-four (34) pounds in two (2) months.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 07/28/15 at 2:22 PM, revealed she had no policy related to weights but staff were trained on the facility protocol which was for the Certified Nurse Aides (CNAs) or nurses to obtain the weekly or monthly weights. She stated the DON was responsible for entering the weights into the computer. She stated the computer would indicate if a reweigh was needed and would prompt the nurse to take action or do a reweigh which would indicate the need for an assessment.</p> <p>Record review revealed the facility admitted Resident #9 on 09/08/14 and re-admitted him/her on 05/29/15, with diagnoses which included Hypothyroidism, Diaphragmatic Hernia, Cataract, Glaucoma, Hyperlipidemia, and Tricuspid Valve Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/08/15, revealed the facility assessed Resident #9's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was interviewable.</p> <p>Review of Resident #9's Comprehensive Care</p>	{F 282}	<ol style="list-style-type: none"> <li>On 7/31/15, the Registered Dietician and Director of Nursing reviewed all residents to determine the frequency of obtaining weights. An audit of all current resident's care was completed by 8/26/15 by the Director of Nursing, Assistant Director of Nursing, Education Training Director, Unit Managers, MDS Coordinator and Clinical Reimbursement Specialist to verify accurate frequency of weights updated on care plan and to ensure all interventions were in place.</li> <li>Licensed staff were re-educated on obtaining weights per care plan by the Director of Nursing, Education Training Director, Assistant Director of Nursing and/or Unit Managers by 8/26/15. Dietary Service Manager and Registered Dietician were re-educated by Healthcare Services Regional Dietician on 7/29/15 on obtaining the weight change report weekly to identify any needed re-weights or missing weights. The results of the reports will be reported to the Director of Nursing who will ensure the weights are obtained per care plan.</li> <li>The Director of Nursing will audit five (5) care plans per week for 12 weeks for all interventions in</li> </ol>		

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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  R-C 08/06/2015
NAME OF PROVIDER OR SUPPLIER  TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301		
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{F 282}	<p>Continued From page 7</p> <p>Plan, dated 03/14/15, revealed the resident was at risk for altered nutrition related to cardiac disease, thyroid disease, and vitamin deficiency. Further review revealed an intervention for staff to obtain and monitor weights per facility protocol, weekly weights for four (4) weeks then monthly, if stable</p> <p>Review of Resident #9's Weight Change History Record revealed staff failed to obtain monthly weights, as care planned, as there was no weight obtained in June 2015. Further review revealed the resident weighed 160 pounds on 05/07/15 and weighed 125.6 pounds on 07/17/15, which was a weight loss of approximately thirty-four (34) pounds. However, there was no documented evidence staff followed the care plan to monitor the resident's weights, per facility protocol by conducting a re-weight to determine if the weight obtained on 07/17/15 was accurate.</p> <p>Observation of Resident #9 being weighed, on 07/28/15 at 8:27 AM, revealed the resident weighed 142.4 pounds which still indicated a seventeen (17) pound weight loss.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/30/15 at 2:45 PM revealed the CNA was given a sheet of residents to weigh, and if there was a weight that did not look right the nurses will get a re-weigh of the resident.</p> <p>Interview with CNA #2, on 07/30/15 at 3:05 PM, revealed the CNAs received a list of residents to weigh from the nurse. She stated if there was a weight that looked like it was wrong they would re-weigh the resident and make sure that the scale had been zeroed out before weighing again. CNA #2 stated the CNAs were inserviced during</p>	{F 282}	<p>place. 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: 8/27/15</p>		

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{F 282}	Continued From page 8 their orientation with the Education Training Director on how to properly weigh residents and to go to their nurse if there were any issues with the weights.  Further interview with the Director of Nursing (DON), on 07/28/15 at 2:22 PM, revealed staff was expected to follow the care plan and facility protocol for weights. She stated Resident #9's weights should have been obtained monthly per the care plan. She stated when the resident was weighed on 07/08/15, a reweigh should have been completed, per the facility's protocol to ensure the weight was accurate. The DON stated it appeared there had been no action taken by the previous DON when the reweigh was needed. She stated she reviewed the documentation and stated no action had been taken because a reweigh had not been obtained. She stated the resident was weighed on 07/28/15 and weighed 142.4 pounds. She stated this was a seventeen (17) pound weight loss for this resident and was being addressed by the dietician and revision of the care plan.	{F 282}			
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	1. Resident #9 was weighed on - 7/28/15 by Administrator in Training, LPN. A review by the Director of Nursing on 7/28/15 noted that Resident #9 weights have been obtained as care planned. The Director of Nursing audited Resident #9's Care plan on 7/28/15. Any issues noted were corrected immediately.		

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F 325	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure their system to identify weight loss was effective for one (1) of three (3) sampled residents (Resident #9). Staff had documented Resident #9 had a weight loss of thirty-four (34) pounds from May through July 2015. The staff failed to obtain a monthly weight in June 2015 and failed to reweigh and assess the resident when the significant weight loss was identified to determine if the weight was accurate and/or if the resident needed a change in condition plan to address the resident's weight loss management.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Guidelines for Obtaining Accurate Resident Weights", dated 08/12/14, revealed the Interdisciplinary Team would develop a change of condition plan for any resident with weight variances greater than five (5) percent in thirty (30) days; 7.5 percent in ninety (90) days; and, ten (10) percent in one-hundred eighty (180) days.</p> <p>Interview with the Director of Nursing (DON), on 07/28/15 at 2:22 PM, revealed the facility's protocol was for the Certified Nurse Aides (CNAs) or nurses to obtain the weights and the DON would enter in the information, if a re-weight was needed the computer would prompt the nurse to take action or do a re-weigh which would indicate the need for an assessment.</p> <p>Record review revealed the facility admitted</p>	F 325	<ol style="list-style-type: none"> <li>2. On 7/31/15, the Registered Dietician and Director of Nursing reviewed all residents to determine the frequency of obtaining weights. Audit by Director of Nursing on 8/10/15 noted weights had been obtained per care plan and facility protocol. Audit of all care plans to ensure all interventions were in place was completed by 8/26/15 by the Director of Nursing, Assistant Director of Nursing, Education Training Director, Unit Managers, MDS Coordinator and Clinical Reimbursement Specialist. Any issues noted were corrected immediately.</li> <li>3. Licensed staff were re-educated on obtaining weights per care plan by the Director of Nursing, Education Training Director, Assistant Director of Nursing and/or Unit Managers by 8/26/15. Dietary Service Manager and Registered Dietician were re-educated by Healthcare Services Regional Dietician on 7/29/15 on obtaining the weight change report weekly to identify any needed re-weights or missing weights. The results of these reports will be reported to the Director of Nursing who will ensure the weights are obtained.</li> <li>4. The Director of Nursing will audit five (5) care plans per week for 12 weeks to validate weights/re-</li> </ol>		

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F 325	<p>Continued From page 10</p> <p>Resident #9 on 09/08/14 and he/she was readmitted to the facility on 05/29/15 with diagnoses which included Hypothyroidism, Diaphragmatic Hernia, Cataract, Glaucoma, Hyperlipidemia, and Tricuspid Valve Disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/08/15, revealed the facility assessed Resident #9's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicates the resident was interviewable. In addition, the MDS revealed the resident was assessed as having problems with swallowing and had a mechanically altered diet.</p> <p>Review of the Comprehensive Care Plan, dated 03/14/15, revealed the resident was at risk for altered nutrition related to cardiac disease, thyroid disease, and vitamin deficiency with interventions for staff to obtain and monitor the resident's weights weekly times four (4) weeks and monthly thereafter if stable.</p> <p>Review of Resident #9's Weight Change History Record revealed the resident weighed 160 pounds on 05/07/15 and weighed 125.6 pounds on 07/17/15. There was no monthly weight obtained in June 2015, (per the care plan, a weight should have been obtained); and, there was no documented evidence staff reweighed the resident per facility protocol, to determine if the weight was accurate, when it was identified that the resident had a weight loss of approximately thirty-four (34) pounds. In addition, review of the Nurse's Notes and Dietary Notes for July 2015 revealed there was no documented evidence the Physician or Dietician was made aware of the thirty-four (34) pound weight loss (over a 20%</p>	F 325	<p>weights have been obtained timely and interventions in place. Weekly weights will be obtained by the Restorative C.N.A.'s on a designated day of the week and the weights will be reviewed in the weekly Weight Meeting ongoing. 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</p> <p>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: 8/27/15</p>		

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F 325	<p>Continued From page 11</p> <p>weight loss in two (2) months) and no evidence the Interdisciplinary Team did a change of condition plan related to the weight change.</p> <p>Observation of Resident #9's being weighed, on 07/28/15 at 8:27 AM, revealed the resident weighed 142.4 pounds which still indicated a seventeen (17) pound weight loss (over ten percent(10%) in two (2) months).</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/30/15 at 2:45 PM revealed the CNA was given a list of residents to weight and if there was a weight that looks to be an error the nurses would get a re-weigh of the resident.</p> <p>Interview with CNA #2, on 07/30/15 at 3:05 PM, revealed the CNAs received a paper, from nursing, listing the residents that needed weights. She further stated if there was a weight that looked to be an error they would re-weigh the resident and make sure that the scale has been zeroed out before weighing the resident again. CNA #2 stated the CNAs were inserviced during their orientation with the Education Training Director on how to properly weigh residents and to go to their nurse if there were any issues with the weights.</p> <p>Interview with the Registered Dietician (RD), on 07/28/15 at 12:34 PM, revealed she had not been an RD at the facility for very long and she had only been to the facility twice. She stated Resident #9 was flagged for her to review quarterly and was not on the monthly reviews. She reviewed the weights and stated if Resident #9 weighed 160 pounds in May 2015 and then weighed 125.6 in July, then staff should have reweighed the resident to validate if there was a</p>	F 325			

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F 325	Continued From page 12 weight loss, and then implement interventions for weight loss if needed.  Interview with the Director of Nursing (DON), on 07/28/15 at 2:22 PM, revealed she had been at the facility since 07/06/15 but the previous DON was in the facility until 07/18/15 and was inputting the weights into the computer at that time. The DON stated she could not explain why there were not any reweighs for Resident #9, after the resident's weight was down to 125.6 pounds in July. The DON said it appeared there was no action taken by the previous DON when the reweigh was needed. The DON reviewed the documentation and stated no action had been taken because a reweigh had not been done and no weights were documented for June. She further stated it was a breakdown in the system and she was concerned for the residents. In addition, she stated she questioned all the weights done in June and entered in by the previous DON.	F 325			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure residents were free of any significant medication errors for one (1) of three (3) sampled resident (Resident #9). The	F 333	1. APRN did not reorder the Levothyroxine for Resident #9 because TSH level was within normal limits. 2. Audit of all readmissions for the past thirty days by Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers was completed by 8/26/15 to ensure orders were transcribed and/or reactivated correctly. Any issues noted were corrected immediately. Medication cart to medication administration record audit by pharmacy on 8/20/15		

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F 333	<p>Continued From page 13</p> <p>facility failed to administer Resident #9's Levothyroxine (thyroid medication) for sixty (60) days.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Medication Administration", dated 12/12, revealed medications should be administered as prescribed in accordance with the manufacturer's specifications and good nursing principles and practices.</p> <p>Record review revealed the facility admitted Resident #9 on 09/08/14 with diagnoses which included Hypothyroidism. Further review revealed Resident #9 was admitted to the hospital on 05/27/15 and returned to the facility on 05/29/15</p> <p>Review of the Hospital Physician's Discharge Orders, dated 05/29/15, revealed an order for Levothyroxine (thyroid medication) 50 micrograms (mcg) every morning (AM). Review of the Physician's Order Sheet from the facility, dated 05/29/15, revealed the order for the Levothyroxine had not been transcribed by the Admissions Nurse; therefore, the medication was not on the Physician's Order for June and July 2015.</p> <p>Review of the May, June, and July 2015 Medication Administration Record (MAR) revealed the facility had not administered Levothyroxine (thyroid medication) 50 micrograms every AM to Resident #9 for sixty (60) days from 05/30/15 through 07/28/15.</p> <p>Interview with Registered Nurse (RN) #1, who readmitted the resident, on 07/28/15 at 5:05 PM,</p>	F 333	<p>and any meds not available were ordered and delivered on 8/20/15.</p> <p>3. All licensed nurses were reeducated by the Director of Nursing, Assistant Director of Nursing and Education Training Director, and/or Unit Managers by 8/26/15 on medication availability and reactivation of physician orders upon readmission (including a second nurse to verify accuracy of orders). Medication Availability training included use of Emergency Drug Kit, after hours pharmacy, physician notification, on-call nurse notification, medication refusals and if resident needs cannot be met the resident is to be sent to hospital.</p> <p>4. Medication administration record to medication cart audit will be performed by the Director of Nursing, Assistant Director of Nursing or Unit Managers two (2) times per month for three (3) months. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit five (5) readmits per month for three months to ensure orders were reactivated appropriately. 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</p>	
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F 333	<p>Continued From page 14</p> <p>revealed she entered the resident's orders into the computer system upon his/her return to the facility on 05/29/15, but she was not certain if another nurse assisted her or not. She stated she may have missed reactivating the Levothyroxine, but she was not sure if she was the one who missed it. RN #1 stated there was a two (2) nurse check in place so orders were looked at by a second pair of eyes, but she could not remember if this was done or not.</p> <p>Interview with the Educational Training Director (ETD), on 07/29/15 at 8:10 AM, revealed she occasionally assisted the nurses. She stated there was a two (2) nurse check to make sure they did not miss any information from the checklist during the readmission process; however, she did not assist with Resident #9's readmission.</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP), on 07/28/15 at 2:15 PM revealed she was unaware Resident #9 was not receiving his/her Levothyroxine as prescribed by the physician. She stated not having that medication for that amount of time could be "tricky", and could effect the resident in a multitude of ways, including weight and mental concerns. She said she expected the facility to provide medications as they were prescribed.</p> <p>Review of a Medical Laboratory Report, dated 07/09/15, revealed Resident #9's Thyroid Stimulating Hormone (TSH) level was 2.5 MIU/DL (normal 0.3-5.6 MIU/dl). The physician was notified and orders were received to discontinue the order for Levothyroxine and retest in one (1) month.</p>	F 333	<p>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: 8/27/15</p>		

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F 333	Continued From page 15 Interview with the Director of Nursing (DON), on 07/28/15 at 2:41 PM, revealed she expected staff to double check the information entered into the computer to ensure it was correct so there were no transcription errors. She stated she was not the DON at the time, but the medication was probably missed because Resident #9 was out of the facility for less than three (3) days. She stated if the resident had been treated as a readmit there would have been a two (2) nurse check on the medications then there would not have been the transcription error of not reactivating the Levothyroxine. She stated when a resident leaves the facility and goes to the hospital their system cannot hold medication so the medication(s) were deactivated until the resident returned to the facility, then the admission's nurse would reactivate the medication. She stated Resident #9 missed his/her medications for almost two (2) months because the medication was not reactivated. The DON stated a second nurse check was not conducted to ensure all medications were reactivated. In addition, she stated the nurse from that hall should have known the resident well enough to realize the resident was not receiving his/her Levothyroxine as normally prescribed and they should have contacted the physician.	F 333			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	1. Resident D's Levothyroxine was delivered from pharmacy on 7/31/15 per Phamerica shipping manifest and given to Resident D by floor nurse on 8/1/15 as evidenced by the signed Electronic Medication Administration Record by floor nurse on 8/1/15 as observed by the Director of Nursing.		

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NAME OF PROVIDER OR SUPPLIER  TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301		
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F 425	<p>Continued From page 16</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility education review, it was determined the facility failed to ensure their system to obtain needed medication was effective for one (1) unsampled resident (Resident D). The facility failed to ensure Unsampled Resident D's Levothyroxine (thyroid medication) was available for administration for two (2) days.</p> <p>The findings include:</p> <p>Interview with the Regional Quality Manager (RQM), on 08/05/15 at 1:00 PM, revealed process for ordering medication was provided in training on 06/30/15 and provided this training documentation to the surveyor.</p> <p>Review of training provided by the facility pharmacy, on 06/30/15, revealed to reorder medication staff should submit the reorder request electronically through the electronic Medication Administration Record (MAR) system</p>	F 425	<p>2. Medication cart to medication administration record audit by pharmacy on 8/20/15 and any meds not available were ordered and delivered on 8/20/15.</p> <p>3. All licensed nurses will be reeducated on medication availability, reactivation of physician orders upon readmission (including a second nurse to verify accuracy of orders) by the Director of Nursing, Education Training Director, Assistant Director of Nursing and/or Unit Managers by 8/26/15. Medication Availability training included use of Emergency Drug Kit, after hours pharmacy, physician notification, on-call nurse notification, medication refusals and if resident needs cannot be met the resident is to be sent to hospital. Director of Nursing, Assistant Director of Nursing or Unit Managers are responsible for reviewing readmission orders for accuracy ongoing.</p> <p>4. Medication administration record to medication cart audit will be performed by the Director of Nursing, Assistant Director of Nursing or Unit Managers two (2) times per month for three (3) months. The results of these observations will be reviewed</p>		

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F 425	<p>Continued From page 17</p> <p>three (3) days before the quantity is exhausted. In addition, staff can pull the reorder sticker and fax it to the pharmacy, three (3) days before the quantity is exhausted. Staff should allow up to twenty-four (24) hours for delivery</p> <p>Record review revealed the facility admitted Unsampled Resident D on 05/16/15 with diagnoses which included Hypothyroidism.</p> <p>Review of the July 2015 Physician's Orders revealed an order to administer Levothyroxine 0.088 milligrams (mg) by mouth every morning; however, review of the July 2015 Medication Administration Record (MAR) revealed the Levothyroxine was marked as not being available for administration on 07/30/15 and 07/31/15 at 6:00 AM which resulted in two (2) missed doses.</p> <p>Observation of the North Hall Medication Cart, on 07/31/15 at 1:25 PM, revealed Unsampled Resident D had no Levothyroxine 0.088 milligrams (mg) in the medication cart drawer.</p> <p>Review of Unsampled Resident D's Electronic-MAR revealed on 07/30/15 at 5:15 AM Licensed Practical Nurse (LPN) #4 documented the medication was not available for administration and the pharmacy was notified.</p> <p>Interview (Post Survey) with the Licensed Practical Nurse (LPN) #4, on 08/11/15 at 7:40 PM, revealed she did not recall reordering Unsampled Resident D's Levothyroxine or writing on the E-MAR "it was not available and the pharmacy notified". She stated staff was supposed to reorder medication through the computer by clicking the box and/or faxing the sticker from the medication package. She stated</p>	F 425	<p>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 recommendation 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: 8/27/15</p>		

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F 425	<p>Continued From page 18</p> <p>this was supposed to be done five (5) to seven (7) days prior to the running out of the medication. LPN #4 stated she normally ordered medication through the computer and faxed the sticker to ensure the medication would be delivered. She stated if she identified a medication was not available for administration she would check the Emergency Drug Kit (EDK) and call the pharmacy so the medication could be sent in the next hour or two (2). She did not recall if she checked the EDK for Unsampled Resident D's Levothyroxine. She stated she received training from a Pharmacist when the new pharmacy went into effect on 07/01/15.</p> <p>Interview with LPN #2, on 08/05/15 at 3:20 PM, revealed if a medication was not available for administration staff should check the EDK and call pharmacy so the medication could be sent. She stated if the medication was not available to be administered during the allowable timeframe according to the Physician's Order she would notify the physician. She said staff was supposed to reorder the medication approximately three (3) days before the medication supply ran out through the EMAR system by clicking a button, or by faxing the sticker from the medication package to the pharmacy. She stated she received training from a Pharmacist when the new pharmacy went into effect on 07/01/15.</p> <p>Review of a Pharmacy Shipping Manifest, dated 07/31/15 at 10:15 PM, revealed the Levothyroxine was delivered to the facility on 07/31/15 after 10:15 PM.</p> <p>Interview with the Regional Quality Manager (RQM), on 08/05/15 at 1:00 PM, revealed the facility had changed over to a new pharmacy on</p>	F 425			

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F 425	Continued From page 19 07/01/15 and training had been conducted with staff on 08/30/15. She stated staff should have ensured medications were available for administration by either ordering the medication three (3) days prior to the last dose through the E-Mar system or faxing the sticker per the training provided by the new pharmacy. She was unable to provide documentation the Levothyroxine had been ordered prior to 07/31/15. She stated the medication listed on the 07/31/15 after 10:15 PM manifest was ordered after an audit was conducted on the medication cart that afternoon due to the State Survey Surveyor identified that the medication was not available in the medication cart.	F 425			