

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: 185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/22/2015
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NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</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.



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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 000)	INITIAL COMMENTS AMENDED 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 04/30/16 Recertification Survey on 07/28/15 through 08/06/15. Complaints #KY23528 & #KY23610 were unsubstantiated with unrelated deficiencies cited. 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.	(F 000)	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.	
{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 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)	{F 281}		

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

Carolyn Louence

TITLE

Administrator

(X6) DATE

10/23/2015

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{F 281}	<p>Continued From page 1</p> <p>sampled residents (Resident #8); 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"> 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. 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. 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 Availability training included use of Emergency Drug Kit, 		

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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>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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{F 281}	<p>Continued From page 3</p> <p>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.</p> <p>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</p>	{F 281}			

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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 0.3-5.6 MU/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 Unsamped Resident D on 05/18/15 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 6:00 AM which resulted in two (2) missed doses.</p> <p>Review of Unsamped 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 Unsampld 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"> 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. 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. The Director of Nursing will audit five (5) care plans per week for 12 weeks for all interventions in place. The results of these observations will be reviewed with the Quality Assurance Committee for a minimum of 		

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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-weigh 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>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(i) 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. 2. On 7/31/15, the Registered Dietician and Director of Nursing reviewed all residents to determine the frequency of		

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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-weight which would indicate the need for an assessment.</p> <p>Record review revealed the facility admitted</p>	F 325	<p>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.</p> <p>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.</p> <p>4. The Director of Nursing will audit five (5) care plans per week for 12 weeks to validate weights/re-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</p>		

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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 08/08/15, 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>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 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 07/08/15 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		

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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>Immediately. 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 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</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 0.3-5.8 MUI/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>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 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 Pharmacia 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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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 8/28/15. 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</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 Unsampld Resident D on 05/18/15 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 8:00 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 Unsampld Resident D had no Levothyroxine 0.088 milligrams (mg) in the medication cart drawer.</p> <p>Review of Unsampld 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 Unsampld 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>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 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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(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 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			

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

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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	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			

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 6/12/2015
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>F0157</u> Reg. # <u>483.10(b)(11)</u> LSC _____	Correction Completed <u>06/05/2015</u>	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed <u>06/05/2015</u>	ID Prefix <u>F0411</u> Reg. # <u>483.55(a)</u> LSC _____	Correction Completed <u>06/05/2015</u>
ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>06/05/2015</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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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>DA</u>	Date: <u>07/01/15</u>	Signature of Surveyor: <u>Deborah R. Hudson NCH, OR</u>	Date: <u>07/01/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>4/30/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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#730 P.002/043

07/29/2015 12:36

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE BUILDING INSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2015
NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. STATE ST. OWENSBORO, KY 40301		
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{F 000}	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Onsite Revisit to the 04/30/15 Recertification Survey was conducted in conjunction with Abbreviated Survey (KY#23320 and KY#23321) on 06/10/15 through 06/12/15 and determined F157, F309, F411 and F441 were corrected on 06/05/15; however, the facility remained out of compliance at F281 and F282. KY#23320 was substantiated with deficiencies cited at the highest Scope and Severity of a "G". KY#23321 was unsubstantiated with no deficiencies cited.</p> <p>On 06/03/15, Certified Nurse Aide (CNA) #20 and CNA #21 transferred Resident #4 with a Sit to Stand Lift in the shower room. The facility failed to ensure Resident #4 was assessed for the use of the lift; and, failed to ensure the CNAs were trained to use the Sit to Stand Lift safety. Resident #4 slipped from the sling onto his/her knees with his/her leg bent at an approximate forty five (45) degree angle and his/her right foot beneath the wheelchair. CNA #20 had failed to apply the safety belt appropriately. Three (3) Certified Nurse Aides (CNAs) then lifted Resident #4 and placed the resident in his/her wheelchair without having licensed staff assess the resident prior to the transfer. The CNAs then wheeled the resident to his/her room and transferred the resident with the Sit to Stand Lift again. Resident #4 was transferred to the hospital ER and admitted with a diagnosis of right distal femoral meta diaphyseal fracture (right Femur Fracture). Resident #4 returned to the facility on 04/05/15 on comfort measures.</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>		

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

TITLE

(X6) DATE

Chris Valvern

NHA

7-24-15

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.

From:

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{F 000}	Continued From page 1 The facility failed to have an effective system in place to ensure Resident #1 received adequate supervision while ambulating and toileting. Resident #1 was admitted on 04/14/15 and Licensed Practical Nurse (LPN) #8 failed to conduct the fall assessment per facility instructions. Resident #1 was care planned for one (1) person physical assist while ambulating and toileting. Interviews with staff revealed Resident #1 had difficulty ambulating, continuously got out of bed without asking for assistance, and would exit the bathroom into the wrong room and at times was found in the bed in that room; however, the CNAs failed to use the facility's stop and watch program to make the licensed staff aware that new interventions might be needed to ensure Resident #1 was adequately supervised when ambulating. The facility failed to revise the care plan to address the resident's continued ambulation without assistance and confusion when exiting the bathroom. On 04/26/15 at approximately 11:55 PM, Resident #1 was found in the adjacent room (Room #106) on the floor. Resident #1 was transferred to the hospital emergency room (ER) where he/she was admitted to the hospital with a diagnosis of acute, displaced left subcapital femoral neck fracture (left hip fracture). Resident #1 died in the hospital on 04/29/15.	{F 000}			
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	1. Resident #1 was discharged from the center on April 27, 2015 to the hospital for hip fracture. 2. The center interdisciplinary team consisting of the Director of Nursing, Assistant Director of Nursing, Unit Managers, Activities Director, Social		

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F 280	<p>Continued From page 2</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Emergency Room (ER) record and hospital Discharge Summary, and facility policy review it was determined the facility failed to revise the care plan for one (1) of five (5) sampled residents (Resident #1).</p> <p>The facility admitted Resident #1 on 04/14/15 and care planned the resident for the assistance of one staff for ambulation and toileting on 04/15/15. Interviews with staff revealed Resident #1 continuously got out of bed without asking for assistance, and would exit the bathroom into the wrong room and at times was found in the bed in that room. However, the facility failed to revise the care plan to address the resident's safety due to getting up without assistance and failed to address the resident's confusion when leaving the bathroom. On 04/26/15 at approximately 11:55</p>	F 280	<p>Services Director and Facility Rehab Coordinator completed a 100% plan of care chart audit of current resident by June 5, 2015 to ensure that current plans of care were appropriate for each resident. A 100% chart audit of Accunurse care plans (CNA plans of care) for all current residents was completed on June 28, 2015 by the Director of Nursing, a nursing assistant who was familiar with the resident, and Quality Assurance RN, to ensure that the Accunurse plan of care was accurate to meet the needs of the resident. Any issues identified were corrected at this time.</p> <p>3. All Certified Nursing Assistants will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding following the Accunurse plan of care and reporting changes in residents care to the assigned nurse by July 8, 2015. All licensed nurses will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding following plan of care and updating plan of care with changes by July 8, 2015. No staff will work after July 8, 2015 without being re-educated. The Administrator will oversee and validate education.</p>		

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F 280	<p>Continued From page 3</p> <p>PM (per Nurse's Notes), Resident #1 was found in the adjacent room (Room #106) on the floor. Resident #1 was transferred to the hospital ER where he/she was admitted to the hospital with a diagnosis of acute, displaced left subcapital femoral neck fracture (left hip fracture). Resident #1 died in the hospital on 04/29/15.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Clinical Quality Assurance and Performance Improvement (QAPI) Daily Review Process", dated 08/01/14, revealed the Nurse Assessment Coordinator and Assistant Director of Nursing (ADON)/ Director of Nursing (DON)/designee will ensure appropriate updates to the Comprehensive Care Plan and Accunurse Activities of Daily Living (ADL) care plan are carried out and communicated to the direct care staff and Interdisciplinary Team (IDT)</p> <p>Interview with the Director of Nursing (DON), on 06/11/15 at 10:10 AM, revealed there was no specific policy on Stop and Watch. However, interview with the Education and Training Director (ETD), on 06/08/15 at 2:05 PM, revealed the facility used Interact, (Interventions to Reduce Acute Care Transfers), a quality improvement program that focused on the management of acute change in resident condition. It included clinical and educational tools and strategies for use in every day practice in long-term care facilities. The ETD said one of the educational tools within the Interact system was "Stop and Watch" notepads used by direct care staff to report changes in residents' condition to licensed nurses. The ETD said she expected care plan Interventions to be added for changes in</p>	F 280	<p>4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will audit (5) accunurse plans of care and comprehensive plans of care weekly x 12 weeks to ensure that the care plan is updated to meet the needs of the resident.</p> <p>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: 7/22/15</p>		

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F 280	<p>Continued From page 4</p> <p>condition, behavior changes, and if residents were not following directions. The ETD said the Stop and Watch process was covered during orientation.</p> <p>Record review revealed the facility admitted Resident #1 on 04/14/15, with diagnoses which included Osteoporosis and Compression Fracture of the Back with uncontrolled pain and anxiety. Review of an Admission Minimum Data Set (MDS), dated 04/15/15, revealed the facility assessed Resident #1 as alert and oriented to person, place, time, and purpose with no memory problem.</p> <p>Review of Resident #1's Comprehensive Plan of Care, dated 04/14/15, revealed the resident was at risk for fall/injury related to generalized weakness and compression fracture, with an intervention to refer to a plan of care in the voice-assisted, hands free documentation and communication system (AccuNurse Activities of Daily Living Care Plan) Review of the Activities of Daily Living (ADL) Plan of Care, dated 04/15/15, revealed the resident required one (1) person physical assistance for ambulation, bathing and dressing. Toileting cautions listed on the plan of care included assistance needed for toileting transfer, do not leave unattended in bathroom and high risk for falls.</p> <p>Review of a Nursing Note, dated 04/27/15 at 1:44 AM, revealed Resident #1 was found on the floor in the adjoining room (Room 106). The resident told staff he/she went to the bathroom and exited the wrong door into the wrong room. The resident stated he/she fell onto his/her back and when trying to get up rolled onto his/her right side. The resident was assessed with no apparent external</p>	F 280			

#730 P.007/043

07/29/2015 12:37

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 280	<p>Continued From page 5</p> <p>Injuries noted, but he/she was complaining of tenderness to his/her left leg and was unable to move it related to the tenderness. The Primary Care Physician was notified and the resident was sent to the ER for evaluation.</p> <p>Review of Resident #1's ER record, dated 04/27/15, revealed, "Clinical Impression 1. Fall from slipping, tripping or stumbling. 2. Closed left hip fracture." Review of the resident's Hospital Discharge Summary, dated 04/29/15, revealed the resident was admitted and surgery was planned; however, the resident's condition declined and it was determined the resident would not survive surgery. Palliative care was provided and the resident expired on 04/29/15.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 06/05/15 at 8:10 AM, revealed she worked the North Unit and had witnessed Resident #1 out of bed unassisted and reminded the resident to use the call light. The CNA worked on 04/26/15 from 11:00 PM to 7:00 AM and was told in report that Resident #1 was weak and that he/she could go to the bathroom on his/her own. The CNA said she was passing ice and when she entered Resident #1's room (108) she realized Resident #1 was not in the bed or in the bathroom. The CNA stated she told Licensed Practical Nurse (LPN) #2 and the two (2) of them split-up to do room checks. CNA #5 stated she opened the door to room 106, flipped on the light switch and saw Resident #1 lying on his/her side on the floor near the sink. CNA #5 stated the resident said he/she was in the bathroom, went out of the wrong bathroom door, was weak and fell. The resident said he/she did not know the time of the fall; the resident was complaining of left hip and lower back pain. CNA #5 stated LPN #2 came in</p>	F 280			

From:

#730 P.008/043

07/29/2015 12:38

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 280	<p>Continued From page 6</p> <p>and said not to move the resident. LPN #2 called the ambulance and the ambulance arrived between 11:45 PM and 12:00 AM. The resident was transferred to the hospital.</p> <p>Interview with LPN #2, on 06/05/15 at 8:55 AM, revealed she worked at the facility for five (5) years and floated to all units and shifts as needed. LPN #2 stated she worked on 04/26/15 from 11:00 PM to 7:00 AM on the North Unit. She stated she completed a bed check at 10:50 PM and Resident #1 was in the bed. The LPN said she was at the nurse's station completing paper work when CNA #5 asked her to come to room 108 because Resident #1 was not in his/her bed or bathroom. LPN #2 stated she and the CNA divided all the rooms and began searching for Resident #1 and after approximately ten (10) minutes CNA #5 yelled she found Resident #1 in room 106, on the floor. The LPN stated Resident #1 was on the floor on his/her right side, holding his/her left leg. LPN #2 said the resident told her that he/she went to the bathroom alone, went out the wrong bathroom door, turned back toward the bathroom, realized he/she was going to fall and grabbed toward the sink and fell. The LPN said she did not move the resident due to the resident's history of fractures. CNA #5 remained with the resident while she (LPN #2) went to the nurse's station to call the doctor, family, on-call administration, and Emergency Medical Services (EMS).</p> <p>Interview with CNA #9, on 06/07/15 at 3:20 PM, revealed she previously worked full time on night shift until three (3) months ago and now worked an as needed schedule. The CNA said Resident #1 was care planned for assistance of one (1) and had a bad habit of getting out of bed at night</p>	F 280			

From:

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F 280	<p>Continued From page 7</p> <p>and getting into an unoccupied bed in the adjacent room. CNA #9 said there was a resident in the bed near the door but the window bed was unoccupied and she had witnessed Resident #1 in the unoccupied bed. The CNA said she heard other staff say, "keep an eye on the resident because he/she got turned around, and went into room 106". CNA #9 said she told LPN #5 the night she found Resident #1 in the unoccupied bed in the adjacent room and LPN #5 said the resident "just got turned around." In addition, CNA #9 said a couple nights prior to finding Resident #1 in the adjacent room in an unoccupied bed she saw Resident #1 walking down the hallway and she told LPN #5. CNA #9 said they usually began using bed alarms when a resident was getting out of bed without using the call light.</p> <p>Interview with LPN #5, on 06/08/15 at 9:20 AM, revealed she remembered someone telling her Resident #1 was in an unoccupied bed in an adjacent room but she did not remember if she was working and she was unsure if she would have documented the incident. LPN #5 said Resident #1 was confused at times and might have gone out the wrong bathroom door because he/she was in a new environment. LPN #5 stated she did not remember anyone telling her the resident was walking down the hallway unassisted.</p> <p>Interview with CNA #7, on 06/07/15 at 2:25 PM, revealed Resident #1 would not call for assistance prior to getting out of bed. CNA #7 said he told a nurse about Resident #1 getting out of bed alone but did not remember which nurse he told. The CNA said he did not remember who he told and he did not complete a Stop and Watch form.</p>	F 280			

#730 P.010/043

07/29/2015 12:38

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F 280	Continued From page 10 using the system.	F 280			
{F 281} SS=G	<p>Interview with the Administrator, on 06/12/15 at 12:50 PM, revealed she expected the CNAs to complete a Stop and Watch form if they witnessed a change in the resident. In addition, the Administrator said she had total responsibility over the building.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</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, review of the facility's policy and procedure, and review of Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure services provided by the facility met the professional standards of quality for one (1) of four (4) sampled residents (Resident #1). The facility failed to ensure Resident # 1 received Oxycodone-Acetaminophen (for pain) in accordance with the Physicians' Orders. In addition, Medication Cart "B", located on the skilled hallway, was observed to be unattended and unlocked.</p> <p>The finding include:</p> <p>Review of the facility's policy entitled "Medication Administration", undated, revealed the licensed</p>	{F 281}	<ol style="list-style-type: none"> Resident #1 discharged from the center on April 26, 2015 to the hospital for hip fracture. The skilled "B" cart was locked by the nurse on June 4, 2015 as observed by the Administrator. The Quality Assurance nurse validated by observation that the skilled "B" medication cart was locked on 6/4/15 and 6/5/15. A 100% audit was completed on all current resident's PRN narcotics on June 5, 2015 by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and MDS Coordinators to ensure the proper time codes were present in the electronic MAR system. The Quality Assurance nurse validated by observation that all medication carts and narcotic box carts were locked on 6/4/15 and 6/5/15. There were no concerns identified. By 7/15/15 the Director of Nursing, Quality Assurance Nurse, Assistant Director of Nursing or Unit Managers will conduct an audit of all narcotics administered in the past fourteen days to ensure they are administered per physician order. The Administrator will oversee the audits. Any concerns identified will be 		

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{F 281}	<p>Continued From page 11</p> <p>nurse and/or medication assistant should check to ensure the right medication, right dose, right dosage form, right route, right resident and right time prior to administration of medication. Further review revealed the Medication Administration Record (MAR) should be read for ordered medication, dose, dosage form, route, and time. The medication administration and the reason for administration and effectiveness of as needed (PRN) medications should be documented on the MAR as soon as medications are given. In addition, the licensed nurse and/or medication assistant should never leave the medication cart open and unattended.</p> <p>1. Review of KBN AOS #14 Patient Care Orders, last revised 10/14/15, revealed licensed staff should administer medication prescribed by the Physician/Advanced Practice Registered Nurse and prepare and give the medication in the prescribed dosage, route, and frequency.</p> <p>Record review revealed the facility admitted Resident #1 on 04/14/15, with diagnoses which included Osteoporosis and Compression Fracture of the back with uncontrolled pain and anxiety. Review of an Admission Data Set, dated 04/15/15, revealed the facility assessed Resident #1 as alert and oriented to person, place, time, and purpose with no memory problem.</p> <p>Review of Resident #1's Physician Order, dated 04/16/15, revealed an order to change oxycodone-acetaminophen 5-325 mg (narcotic pain medication) to two (2) tablets every six (6) hours as needed (PRN) for pain.</p> <p>Review of Resident #1's April 2015 Medication Administration Record (MAR), revealed an order</p>	{F 281}	<p>address by immediate re-education of the nurse who administered the medication.</p> <p>3. All licensed nurses will be re-educated by the Education Training Director, Director of Nursing, Assistant Director of Nursing, or Unit Manager regarding locking of medication cart and narcotic boxes at all times if not in attendance of cart by July 7, 2015. All licensed nurses will be re-educated regarding medication administration by the Education Training Director, Director of Nursing, Assistant Director of Nursing, or Unit Manager by July 7, 2015. The Administrator will oversee and validate all education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, or Unit Managers will audit medication carts including narcotic boxes (5) times per week x 4 weeks, (3) times per weeks x 4 weeks, and (2) times per weeks x 4 weeks to ensure the medication cart is locked. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit 5 PRN medication regimens per week x 12 weeks to ensure the medication is administered as ordered. 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</p>		

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{F 281}	<p>Continued From page 12</p> <p>dated 04/16/15 for oxycodone-acetaminophen 5-325 mg, give two (2) tablets by mouth every six (6) hours as needed for pain. Further review of the MAR and the controlled substance sign out sheet revealed licensed staff administered the medication every four (4) hours verses every six (6) hours as ordered on 04/16/15 at 8:00 PM; on 04/17/15 at 12:00 AM; and, on 04/17/15 at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/03/15 at 4:45 PM, revealed she reviewed Resident #1's April 2015 MAR, Physician's Orders and controlled substance sign out sheet and confirmed she had signed out oxycodone-acetaminophen 5-325 mg on 04/17/15 at 9:00 AM and 1:00 PM. The LPN stated she had made a medication error as she had administered the medication in four (4) hours instead of (6) hours as ordered.</p> <p>Interview with the Educator and Training Director (ETD), on 06/08/15 at 2:05 PM, revealed when the eMAR (electronic Medication Administration Record) was used correctly the computer would not allow the nurse to sign out a controlled substance until the appropriate time had elapsed. She said the facility began using eMAR in March 2015 and some staff was not using the system correctly at first.</p> <p>Interview with the Medical Director, at 06/11/15 at 7:30 AM, revealed staff should administer medications as ordered by the MD. He stated he was not aware of any medication errors pertaining to Resident #1.</p> <p>2. Observation on 06/04/15 at 9:25 AM revealed Medication Cart "B", located on the Skilled Unit</p>	{F 281}	<p>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. The Administrator will oversee monitoring through Quality Assurance.</p> <p>Compliance date: 7/22/15</p>	
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{F 281}	<p>Continued From page 13</p> <p>hallway, was unlocked and unattended. The medication nurse, LPN #8 was observed to be across the hallway in resident room 450, at this time. LPN #7 was observed to be walking down the hallway and went over to the medication cart, locked the cart, then entered room 450 and informed LPN #8 she had locked the medication cart.</p> <p>Observation of the Medication Cart "B", on 06/04/15 at 9:53 AM with the UM of the Skilled unit, revealed insulin syringes, lancets and needles were in the top drawer of the medication cart. In addition, when the UM opened the narcotic drawer the top was not locked. The UM informed LPN #8 that the narcotic box should be locked even when the medication cart was locked.</p> <p>Interview with LPN #8, on 06/04/15 at 9:58 AM, revealed she thought she locked the medication cart when she left the cart and went into room 450. In addition, LPN #8 said she thought the narcotic box was locked and she "was not used to this cart". The LPN said she passed medications on all units and Medication Cart "B" was not different from any of the other medication carts in the facility.</p> <p>Interview with the UM of Skilled Unit, on 06/04/15 at 9:45 AM, revealed the medication nurse should lock the medication cart when she walked away. The UM said leaving a medication unlocked was a potential problem because someone could get into the cart and wanderer's could access the medication cart. The UM said there were thirty six (36) residents on the skilled units A/B; and, five (5) wanderers. The UM said the narcotic box should be locked at all times unless the nurse</p>	{F 281}			

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{F 281}	Continued From page 14 was removing a medication from the box.	{F 281}			
{F 282} SS=G	<p>Interview with the Director of Nursing (DON), on 08/08/15 at 10:00 AM, revealed staff were to follow the Physician's Orders and nursing staff were to ensure medication carts were locked whenever they walked away from the cart.</p> <p>Interview with the Administrator on 06/12/15 at 12:50 PM, revealed staff should follow the medication administration policy, keep medication carts and narcotic lids locked and administer medications according to Physician's Orders.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of a hospital radiology report, a facility Incident Report, facility Fall Investigation, facility policy and Manufacturer's instructions for the sit to stand lift, it was determined the facility failed to ensure services were provided by qualified persons for one (1) of five (5) sampled residents (Resident #4) related to the use of a Sit to Stand Lift.</p> <p>On 06/03/15, Resident #4 was assisted with a Sit to Stand lift in the shower room; however, the Certified Nurse Aide (CNA) failed to ensure the safety belt was applied snugly according to</p>	{F 282}	<ol style="list-style-type: none"> 1. Resident #4 was re-admitted to center on 6/5/15 with orders for palliative care. He/She had orders for bed rest only. On 6/10/15 the Director of Nursing re-educated CNA # 20 and CNA# 21 with return demonstration related to use of the full body lift and sit to stand lift. An observation by Director of Nursing on 6/12/15 noted that CNA # 20 and 21 were using the full body lift and sit to stand lift appropriately. On 8/11/15, the Assistant Director of Nursing re-educated CNA# 20 and # 21 on not moving a resident after a fall until assessed by a nurse. 2. A 100% chart audit was completed by the Director of Nursing, Assistant Director of Nursing, Quality Assurance RN, Unit Managers, and MDS RN on residents that require a lift. A lift assessment was completed on all residents who require a lift for 		

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{F 282}	<p>Continued From page 15</p> <p>manufacturer directions. Resident #4 slipped from the sling onto his/her knees, was assisted to the floor with the resident's right leg bent at an approximate forty five (45) degree angle and his/her right foot was beneath the wheelchair. Three (3) CNAs then lifted the resident and placed him/her in a wheelchair without having a licensed staff assess the resident. Resident #4 was not assessed by licensed staff until the resident was returned to his/her bedroom. The facility failed to ensure staff was qualified to use the lift in a safe manner. Resident #4 was transferred to the hospital Emergency Room (ER) where he/she was admitted to the hospital with a diagnosis of right distal femoral meta biophysical fracture (Right Femur Fracture).</p> <p>The findings include:</p> <p>Review of the facility's policy entitled, "Safe Patient Handling and Movement Policy", last revised 10/31/13, revealed documentation to include the facility intended residents were cared for safely and mechanical lifting equipment should be used to prevent manual lifting and handling of residents. Staff should complete and document training initially and annually as needed; all transfers with mechanical lifts should be done with a minimum of two (2) persons or as specified in resident's Plan of Care and injuries resulting from resident handling and movement should be reported pursuant to the facility policy.</p> <p>Review of the facility document titled, "Resident Handling Observation Instructions", undated, revealed the facility should complete a minimum of two (2) observations each month to comply with Occupational Safety and Health Administration (OSHA) and State Patient</p>	{F 282}	<p>transfers on 6/10/15 by the Director of Nursing, Assistant Director of Nursing, Quality Assurance RN or Unit Managers. All identified residents who use a mechanical lift were deemed safe to use the assigned lift.</p> <p>3. All Certified Nursing Assistants and Licensed Nursing Staff were re-educated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on using the full body lift and sit to stand lift with return demonstration by July 8, 2015. All certified nursing assistants were re-educated to not move a resident after a fall by the Education Training Director, Director of Nursing, Assistant Director of Nursing, or Unit Manager by July 8, 2015. No staff will work past July 8, 2015 without receiving this education. The Administrator will oversee and validate education.</p> <p>4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe 5 mechanical lift transfers per weeks x 12 weeks. The Director of Nursing, Assistant Director of</p>		

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(F 282)	<p>Continued From page 16</p> <p>Handling laws. In addition, the document provided instructions of how to complete the "Resident Handling Observation Form". Further review of the document revealed "all new hires must be observed conducting a resident transfer with and without a lift and kept in the employee file".III</p> <p>Review of the facility's procedure titled, "Procedure For Using Sit to Stand Lift", undated, revealed documentation to include "fasten the safety belt around resident's waist and adjust to a snug but comfortable fit".</p> <p>Review of the Manufacturer User Manual for the Sit to Stand Lift, last revised 2010, revealed the belt should be snug, otherwise the resident could slide out of the sling during transfer, possibly causing injury and residents were not to be raised to a full standing position while using the transfer sling as injury may occur. In addition, the user manual revealed, individuals that use the standing resident sling must be able to support the majority of their own weight, otherwise injury may occur.</p> <p>Record review revealed the facility admitted Resident #4 on 07/01/12 with diagnoses which included Disc Degeneration and Osteoporosis. Review of the annual Minimum Data Set (MDS), dated 04/23/15, revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable.</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 02/03/15, revealed the resident was a</p>	(F 282)	<p>Nursing, or Unit Managers will audit 5 residents per week x 12 weeks to ensure lift assessment is accurate and complete. 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: 7/22/15</p>		

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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 R 06/12/2015
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 17</p> <p>high risk for falls and injury and should be transferred with Sit to Stand lift. Review of the AccuNurse plan of care custom notes (CNA care plan) revealed Resident #4 required a Sit to Stand Lift to transfer from 09/08/12 through 08/08/15.</p> <p>Interview with CNA #21, on 06/10/15 at 3:50 PM, and review of his/her written statement dated 06/03/15, revealed Resident #4 was injured on 06/03/15 at approximately 5:00-5:30 PM. The CNA said she and CNA #20 used the Sit to Stand Lift to transfer the resident from his/her recliner to the wheelchair and from the wheelchair to the shower chair; however, after the shower the CNA's used the Sit and Stand Lift to stand the resident while they dried him/her in the shower room and the resident's legs buckled and his/her feet came off the platform. The CNA said she thought the sling belt was fastened but not tight enough because the sling slid upward under the resident's arms when his/her feet slid back. The CNA said she thought the belt was too loose because the sling was moving upward and the resident was moving downward. She said they were unable to place the wheelchair beneath him/her so they lowered the resident to the floor with the resident's right leg bent. CNA #21 said she, CNA #20 and CNA #22 lifted the resident from the floor to his/her wheelchair, pushed the resident in the wheelchair to his/her room and transferred the resident back to bed using the Sit to Stand Lift. The CNA said she told Licensed Practical Nurse (LPN) #1 the resident complained of knee pain and the LPN asked him/her where the pain was and the resident pointed to his/her knee. The CNA said by 6:45 PM the resident's upper right leg was swollen compared to his/her upper left leg. CNA #21 said she asked the</p>	{F 282}			

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(F 282)	<p>Continued From page 18</p> <p>oncoming nurse, LPN #9, to check on Resident #4.</p> <p>Review of CNA #21's personnel record revealed the Resident Handling Observation form, dated 2/11/15, was blank and signed by the CNA. There was a form with step by step instructions of the use of the sit to stand lift; however, further review revealed there was no documented evidence CNA 21's had been observed conducting a resident transfer with and without a lift per the facility "Resident Handling Observation Instructions".</p> <p>Interview with CNA #20, on 06/11/15 at 3:15 PM, revealed CNA #20 had never used a Sit to Stand Lift at this facility or any other place where she had worked. The CNA said during classroom orientation she reviewed and signed a form with written systematic instructions for use of a Sit to Stand Lift. CNA# 20 said she was not required to return demonstrate the proper use of the Sit to Stand lift for skills check-off and had no "hands on" experience in using the Sit to Stand Lift. CNA #20 said she was in training and observed and assisted CNA #21 on 06/03/15. CNA #20 said she assisted CNA #21 using the Sit to Stand Lift to transfer Resident #4 from his/her recliner to the wheelchair and from the wheelchair to the shower chair. CNA #20 said they finished the shower and put a gown on the resident and CNA #20 fastened the standing sling loops to the Sit to Stand arm pegs then fastened the safety belt around the resident's waist. The CNA indicated she should have fastened the safety belt around the resident's waist before she fastened the standing sling loops to the Sit to Stand arm pegs and she did not tighten the belt. The CNA said they lifted the resident to a full upright position</p>	(F 282)			

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{F 282}	<p>Continued From page 19</p> <p>and when the resident's knees buckled, they lowered the resident to his/her knees. The CNA said the sling slipped upward underneath the resident's arms. CNA #20 stated she, CNA #21 and CNA #22 then lifted the resident from the floor to the wheelchair, pushed the resident to his/her room and used the Sit to Stand Lift to transfer the resident from the wheelchair to the bed. The CNA said LPN #1 came into the resident's room and asked the resident if he/she was in pain.</p> <p>Review of CNA #20's personnel record, revealed no documented evidence of the CNA #20 receiving/attending Resident Handling Observation in her record. There was a form with step by step instructions of the use of the sit to stand lift; however, further review revealed there was no documented evidence CNA 20's had been observed conducting a resident transfer with and without a lift per the facility "Resident Handling Observation Instructions".</p> <p>Interview with CNA #22, on 06/11/15 at 4:20 PM, revealed she was asked to assist CNA #20 and CNA #21. CNA #22 said Resident #4 said, "They broke my leg, they broke my leg". She said her and the other two CNA's lifted the resident from the floor to the wheelchair, rolled the resident to his /her room, and used the Sit to Stand Lift to transfer the resident from the wheelchair to the bed. CNA #22 revealed Resident #4 was crying with pain. In addition, CNA #22 said prior to this the resident used to self propel short distances in his/her wheelchair, went to the dining room for meals and enjoyed looking out the window. The CNA said now the resident was a complete feed, was in bed all of the time, and seemed to be in pain or sleeping most of the time.</p>	{F 282}			

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(F 282)	<p>Continued From page 20</p> <p>Interview with LPN #1, on 06/12/15 at 9:25 AM, revealed on 06/03/15 at approximately 6:00-6:30 PM, a CNA told her Resident #4 fell. The LPN said she assumed the resident fell in his/her room because the Sit to Stand Lift was in the resident's room. LPN #1 said she assessed the resident's vital signs and range of motion and documented the information on an incident report.</p> <p>Further review of Resident #4's Departmental Notes, dated 06/04/15, revealed LPN #9 documented on 06/04/15 at 1:48 AM that CNA #21 asked her to evaluate Resident #4's right knee due to swelling and pain at approximately 7:30 PM on 06/03/15. The LPN documented CNA #21 informed her that Resident #4 had fallen to his/her knees during transfer from lift to shower chair. Further review revealed LPN #9 documented she found the resident's knee swollen and extremely tender to touch and movement, she notified the physician, the Assistant Director of Nursing (ADON), a family member and Emergency Medical Services. The resident was transferred to the Emergency Room (ER).</p> <p>Interview with LPN #9, on 06/12/15 at 11:30 AM, revealed she worked 06/03/15 from 7:00 PM until 7:00 AM. The LPN said CNA #21 approached her as soon as she entered the facility and requested she assess Resident #4 because the resident's knee was swollen and the resident was complaining of pain. LPN #9 said that during report LPN #1 had told her the resident had fallen. LPN #9 stated she finished report and then assessed Resident #4. LPN #9 stated the resident's upper right leg was swollen and he/she was complaining of pain. LPN #9 revealed she</p>	(F 282)			

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(F 282)	<p>Continued From page 21</p> <p>notified the physician, called EMS and the resident was transferred to the ER at approximately 8:00 PM.</p> <p>Review of a hospital radiology report, dated 06/03/15, revealed Resident #4 was diagnosed with a right distal femoral meta diaphyseal fracture (fracture thigh near knee).</p> <p>Further record review revealed Resident #4 was readmitted to the facility on 06/05/15 with diagnosis to include Right Distal Femur Fracture with Bent Knee Immobilize to Right Leg. Resident #4's Comprehensive Care Plan, dated 06/06/15, was reviewed. Also, the reports noted the resident was placed on End of Life care related to diagnosis of femur fracture and should receive comfort care and was bedrest only.</p> <p>Review of Resident #4's physician's orders, dated 06/08/15, revealed the resident's pain was uncontrolled and his/her pain medication was changed to Roxanol 20 mg/ml, give 0.5 ml (10 mg) sublingually every two (2) hour as needed for pain. Observation on 06/12/15 at 8:50 AM, revealed Resident #4 lying on the bed with eyes closed. Interview with RN #2 on 06/12/15 at 8:50 AM, revealed Resident #4 was not eating well, was declining and that the Resident's condition had deteriorated since earlier in the week.</p> <p>Review of the facility's Fall Investigation Worksheet completed by the Assistant Director of Nursing (ADON), dated 06/04/15, revealed Resident #4 fell during a transfer from the shower chair to the wheelchair using a Sit to Stand Lift and based on the fall investigation, Resident #4 was deemed unsafe for a Sit to Stand Lift and progressed to a Sling Lift for further transfers. The family requested comfort care measures.</p>	(F 282)		

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{F 282}	<p>Continued From page 22</p> <p>Interview with CNA #8, on 06/10/15 at 3:10 PM, revealed staff should not use a Sit to Stand lift if a resident was unable to hold the handle. She said the sling should catch a resident if they let go of the handle or slip and a resident could slip if the sling was not snug. CNA #8 said she had used the Sit to Stand lift to transfer Resident #8 and never had any problems. The CNA said there has not been any additional inservices or training since Resident #8 returned from the hospital. In addition, CNA #8 said Resident #8 used to feed self in the dining room and self propel in the wheelchair and now he/she moaned often and would rarely eat.</p> <p>Interview with CNA #23, on 06/10/15 at 2:35 PM, revealed there were four (4) Sit to Stand lifts and were stored in the shower rooms. The CNA said they used the under arm sling with the Sit to Stand lift. In addition, CNA #23 said she only received verbal instruction in training on the use of lifts.</p> <p>Interview with the Unit Manager of Skilled Unit on 06/15/15 at 7:50 AM, revealed she began working at the facility the first of June, 2015. She said it was her understanding Resident #4 was being transferred using the Sit to Stand lift and the resident's knees buckled and he/she was lowered to the floor. The Unit Manager said the staff were trained to use the lift with verbal instruction in the classroom. She said staff should be trained using a visual and hands on inservice. In addition, the UM said a nurse should assess before a resident is moved following a fall.</p> <p>Interview with the Director of Nursing (DON), on 06/11/15 at 10:10 AM, revealed she had CNA #</p>	{F 282}			

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{F 282}	Continued From page 23 20 and CNA #21 return demonstrate the use of the Sit to Stand Lift and re-educated the two CNA's on 06/10/15. The DON said the CNA's were "very competent" and the return demonstration revealed the sling was not tight enough and both CNA's agreed. The DON said she showed the CNA's how snug the sling should be fastened. The DON said training prior to using a lift should include education, a demonstration and staff return demonstrate and the person providing the education should sign the skills checklist when the return demonstration was correct. The DON said it was the facility's policy for staff to view a demonstration of the use of the lift and then do a return demonstration. She said the ETD was responsible and ultimately the DON was responsible. On 06/11/15 at 11:00 AM, the DON stated CNA #20, CNA #21 and CNA #22 should not have moved Resident #4 prior to a nursing assessment following the "assisted fall". Interview with the Administrator, on 06/12/15 at 12:50 PM, revealed the facility provided lift demonstration during orientation and there was no return demonstration by the orientates at that time but at some point during their first thirty (30) days of employment they were asked to return demonstrate the use of the lift for the skills check off. She said the orientates received hands on training when they worked on the nursing units. The Administrator said they were planning to implement hands on training during orientation. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	{F 282}			
F 323 SS=G		F 323	I. Resident #4 was re-admitted to center on 6/5/15 with orders for palliative care. He/She had orders for bed rest only. Resident #1 discharged from the center on 4/27/15 to the hospital for hip fracture. On 6/10/15 the Director of Nursing		

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F 323	<p>Continued From page 24</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation; Interview; record review; review of the facility policy, Fall Investigation, and Incident Report; and review of the hospital Emergency Room (ER) record, Discharge Summary and Radiology Report; it was determined the facility failed to ensure adequate supervision to prevent accidents for two (2) of five (5) sampled residents (Residents #1 and #4).</p> <p>On 08/03/15, Certified Nurse Aide (CNA) #20 and CNA #21 transferred Resident #4 with a Sit to Stand Lift (mechanical lift) in the shower room. The facility failed to ensure Resident #4 was assessed for the use of the lift; and, failed to ensure the CNAs were trained and able to use the Sit to Stand Lift safety by return demonstration. Resident #4 slipped from the sling onto his/her knees with his/her leg bent at an approximate forty five (45) degree angle and his/her right foot beneath the wheelchair. CNA #20 failed to apply the safety belt appropriately. Three (3) Certified Nurse Aides (CNAs) then lifted Resident #4 and placed the resident in his/her wheelchair without having licensed staff assess the resident prior to the transfer and wheeled the resident to his/her room and transferred the resident with the Sit to Stand Lift again.</p> <p>Resident #4 was transferred to the hospital Emergency Room (ER) and admitted with a diagnosis of right distal femoral meta diaphyseal</p>	F 323	<p>re-educated CNA # 20 and # 21 with return demonstration related to use of the full body lift and sit to stand lift. An observation by the Director of Nursing on 6/12/15 noted that CNA # 20 and 21 were using the full body lift and sit to stand lift appropriately. On 8/11/15, the Assistant Director of Nursing re-educated CNA# 20 and # 21 on not moving a resident after a fall until assessed by a nurse.</p> <p>2. A 100% chart audit was completed by the Director of Nursing, Assistant Director of Nursing, Quality Assurance RN, Unit Managers and MDS RN on residents that require a mechanical lift. A lift assessment was completed on all residents who require a lift for transfers on 8/10/15 by the Director of Nursing, Assistant Director of Nursing, Unit Managers or Quality Assurance Nurse with no concerns identified. Fall Risk Data Assessments were completed on all residents in the building on 6/11/15 by the Director of Nursing, Assistant Director of Nursing, Quality Assurance RN, Unit Managers, and MDS RN. The scores were compared to previous assessments completed and interventions reviewed to assure fall interventions appropriate. The Administrator</p>		

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F 323	<p>Continued From page 25</p> <p>fracture (right femur fracture). Resident #4 returned to the facility on 04/05/15 on comfort measures. During the facility's investigation, the facility failed to identify that the resident had not been assessed for the use of the lift and the CNA did not apply the belt correctly. Refer to F2B2</p> <p>The facility failed to have an effective system in place to ensure Resident #1 received adequate supervision while ambulating and toileting. The facility readmitted Resident #1 on 04/14/15. Licensed Practical Nurse (LPN) #8 failed to conduct the fall assessment per facility instructions. Resident #1 was care planned for one (1) person physical assist while ambulating and toileting. Interviews with staff revealed Resident #1 had difficulty walking, continuously got out of bed without asking for assistance, and would exit the bathroom into the wrong room and at times was found in another room, on the bed. However, staff failed to use the facility's Stop and Watch form to make licensed staff aware of the resident's actions to ensure Resident #1 had adequate supervision when ambulating. On 04/26/15 at approximately 11:15 PM, Resident #1 was found in an adjacent room (Room #106) at approximately 11:38 PM, on the floor. Resident #1 was transferred to the hospital ER where he/she was admitted to the hospital with a diagnosis of acute, displaced left subcapital femoral neck fracture (left hip fracture). Resident #1 died in the hospital on 04/29/15. Refer to F2B0</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, "Safe Patient Handling and Movement Policy", last revised 10/31/13, revealed the facility intended for residents to be cared for safely and mechanical</p>	F 323	<p>will oversee and validate all education.</p> <p>3. All Certified Nursing Assistants and Licensed Nursing Staff were re-educated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager on using the full body lift and sit to stand lift with return demonstration by July 8, 2015. All certified nursing assistants were re-educated to not move a resident after a fall by the Education Training Director, Director of Nursing, Assistant Director of Nursing, or Unit Manager by July 8, 2015. No staff will work past July 8, 2015 without receiving this education. The Administrator will oversee and validate education.</p> <p>4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe 5 mechanical lift transfers per weeks x 12 weeks. The Director of Nursing, Assistant Director of Nursing, or Unit Managers will audit 5 residents per week x 12 weeks to ensure lift assessment accurate and complete. 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</p>		

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F 323	<p>Continued From page 26</p> <p>lifting equipment should be used to prevent manual lifting and handling of residents. Staff should complete and document training initially and annually as needed, all transfers with mechanical lifts should be done with a minimum of two (2) persons or as specified in the resident's plan of care. Injuries resulting from resident handling and movement should be reported pursuant to the facility policy.</p> <p>Review of the facility's document, "Resident Handling Observation Instructions", undated, revealed the facility should complete a minimum of two (2) observations each month to comply with Occupational Safety and Health Administration (OSHA) and State Patient Handling laws. In addition, the document provided instructions to complete the "Resident Handling Observation Form". Further review of the document revealed "All new hires must be observed conducting a resident transfer with and without a lift and kept in the employee file".</p> <p>Review of the facility's procedure titled, "Procedure For Using Sit to Stand Lift", undated, revealed to "fasten the safety belt around resident's waist and adjust to a snug but comfortable fit".</p> <p>Review of the Manufacturer User Manual for the Sit to Stand Lift, last revised 2010, revealed the belt should be snug, otherwise the resident could slide out of the sling during transfer, possibly causing injury; and, residents were not to be raised to a full standing position while using the transfer sling as injury may occur. In addition, the user manual revealed, individuals that use the standing resident sling must be able to support the majority of their own weight, otherwise injury</p>	F 323	<p>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: 7/22/15</p>		

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F 323	<p>Continued From page 27 may occur.</p> <p>Record review revealed the facility admitted Resident #4 on 07/01/12 with diagnosis which included Disc Degeneration and Osteoporosis. Review of the Annual Minimum Data Set (MDS) assessment, dated 04/23/15, revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable.</p> <p>Interviews on 06/10/15 with the Quality Assurance (QA) Nurse at 4:00 PM, and with the Regional Director of Clinical Operations at 4:30 PM and further record review revealed there was no documented evidence of a Safety Device Assessment for the use of the Sit to Stand Lift for Resident #4.</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 02/03/15, revealed the resident was a high risk for falls and injury and should be transferred with a Sit to Stand lift. The AccuNurse Plan of Care custom notes revealed Resident #4 required a Sit to Stand Lift to transfer from 09/08/12 through 06/08/15.</p> <p>Interviews with CNA #21 on 06/10/15 at 3:50 PM and CNA #20 on 06/11/15 at 3:15 PM, revealed on 06/03/15 at approximately 6:00-6:30 PM Resident #4 was injured. The CNAs stated they used the Sit to Stand Lift to transfer the resident from his/her recliner to the wheelchair, from the wheelchair to the shower chair, and, after the shower the CNAs used the Sit and Stand Lift to stand the resident while they dried him/her in the shower room. The CNAs revealed CNA #20 fastened the standing sling loops to the Sit to</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>Stand arm pegs then fastened the safety belt around the resident's waist but she did not tighten the belt. The CNAs stated they lifted the resident to a full upright position and when the resident's knees buckled, his/her feet came off the platform so they lowered the resident to his/her knees. The CNAs stated the sling slipped upward underneath the resident's arms because the safety belt was not fastened snugly. However, the Manufacturer User Manual for the Sit to Stand Lift specifically states the belt should be snug, otherwise the resident could slide out of the sling during transfer causing injury; and residents were not to be raised to a full standing position while using the transfer sling as injury may occur. The CNAs stated they asked CNA #22 for assistance and they lifted the resident from the floor to his/her wheelchair, pushed the resident in the wheelchair to his/her room and transferred the resident back to bed using the Sit to Stand Lift without having licensed staff assess the resident prior to transfer. The CNAs stated they told LPN #1 the resident complained of knee pain and the LPN asked the resident where the pain was and the resident pointed to his/her knee. The CNAs said by 6:45 PM the resident's upper right leg was swollen compared to his/her upper left leg and CNA #21 asked the oncoming nurse, LPN #9, to check on Resident #4.</p> <p>Review of the Incident Report for Resident #4, dated 06/03/15 at 6:00 PM, revealed the resident's knees buckled during a sit to stand lift transfer to the resident's bed and the staff assisted the resident to the floor. Further review of the report revealed the resident sustained an abrasion to the left great toe. The immediate action taken was to assist the resident to bed. Further review revealed the report was prepared</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>by LPN #1, and witnessed by CNA #21. however, interview with CNA #21, on 06/10/15 at 3:50 PM, revealed the incident report was not accurate as Resident #4 sustained the fall in the shower room and complained of pain to the left knee.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/12/15 at 9:25 AM, revealed a CNA told her Resident #4 fell. The LPN said she assumed the resident fell in his/her room because the Sit to Stand Lift was in the room and had she known the resident fell in the shower room, she would have treated the situation differently. She stated at the time of the fall she should have asked the CNAs how his/her knees buckled and how his/her feet went out and where the resident fell because it did not make sense to her, she said at the end of the day, after eleven (11) hours of a twelve (12) hour shift she was exhausted. LPN #1 said she assessed the resident's vital signs and range of motion and documented the information on an incident report. The LPN said she normally would have documented in the Nursing Notes but the day was "crazy busy" and by the end of the twelve (12) hour shift she was exhausted. The LPN said she should have reprimanded the CNAs for moving the resident and not following protocol.</p> <p>Further review of Resident #4's Departmental Notes, dated 06/04/15, and interview with LPN #9, on 08/12/15 at 11:30 AM, revealed on 06/04/15 at approximately 7:30 PM, CNA #21 approached LPN #9 as soon as she entered the facility and asked her to evaluate Resident #4's right knee due to swelling and pain. CNA #21 informed LPN #9 that Resident #4 had fallen to his/her knees during a transfer from the lift to shower chair. LPN #9 assessed the resident and determined the resident's knee was swollen and</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>extremely tender to touch or movement so she notified the physician, the Assistant Director of Nursing (ADON), a family member and Emergency Medical Services (EMS). The resident was transferred to the ER approximately 8:00 PM.</p> <p>Review of a hospital Radiology Report, dated 06/03/15, revealed Resident #4 was diagnosed with a right distal femoral meta diaphyseal fracture. Interview with a hospital Radiologist, on 06/12/15 at 10:40 AM, revealed the resident had sustained a displaced fracture of the distal femur near the knee. The Radiologist said this type of fracture occurred due to trauma, osteoporosis, a bone lesion, or a twist. In addition, the Radiologist said it would not take much to result in a fracture if a resident had osteoporosis.</p> <p>Further record review revealed Resident #4 was readmitted to the facility on 06/05/15 with diagnosis to include Right Distal Femur Fracture with Bent Knee Immobilizer to Right Leg. Review of Resident #4's Comprehensive Care Plan, dated 06/08/15, revealed the resident was placed on End of Life care related to diagnosis of femur fracture and should receive comfort care and the resident was bedrest only. Review of Resident #4's Physician's Orders, dated 06/08/15, revealed the resident's pain was uncontrolled and his/her pain medication was changed to Roxanol (for pain) 20 mg/ml, give 0.5 ml (10 mg) sublingually every two (2) hour as needed for pain. Observation on 06/12/15 at 8:50 AM, revealed Resident #4 lying in bed with eyes closed. Interview with RN #2 on 06/12/15 at 8:50 AM, revealed Resident #4 was not eating well, was declining and Resident #4's condition had deteriorated since earlier in the week.</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>Further interview with CNA #20, on 06/11/15 at 3:15 PM, revealed she had never used a Sit to Stand Lift at this facility or any other place where she had worked. The CNA said during classroom orientation she reviewed and signed a form with written systematic instructions for use of a Sit to Stand Lift but she was not required to do a return demonstration of the proper use of the Sit to Stand lift for skills check-off.</p> <p>Review of Resident #20's and Resident 21's personnel records, revealed there was no Resident Handling Observation in Resident #20's record and a blank form in Resident #21's record. There was a form with step by step instructions of the use of the sit to stand lift in both personnel records; however, further review revealed there was no documented evidence CNA #20 and CNA #21 had been observed conducting a resident transfer with and without a lift at the time of hire per the facility's "Resident Handling Observation Instructions".</p> <p>Review of the facility's Fall Investigation Worksheet completed by the Assistant Director of Nursing (ADON), dated 06/04/15, revealed Resident #4 fell during a transfer from the shower chair to the wheelchair using a Sit to Stand Lift and based on the fall investigation, Resident #4 was deemed unsafe for a Sit to Stand Lift and progressed to a Sling Lift for further transfers. The family requested comfort care measures. Further review revealed there was no evidence the facility identified a device assessment had not been conducted and no evidence the facility had identified the aides had not received hands on training on the use of a lift or had to complete a demonstration of the use of the lift.</p>	F 323			

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F 323	Continued From page 32 Further interview with the QA Nurse, on 06/11/15 at 9:30 AM, revealed there were twenty-eight (28) residents out of one-hundred twenty (120) residents who were transferred using a lift and ten (10) out of the (28) residents were transferred using a Sit to Stand Lift. The QA Nurse stated, prior to 06/10/15, two (2) of the (28) residents had been assessed for the safe use of the lift. Interview with the Director of Nursing (DON), on 06/11/15 at 10:10 AM, revealed the facility had determined the root cause of Resident #4's fall/fracture was a status change and the resident could no longer bear weight. She stated the sling should hold a resident if their legs slipped and she believed Resident #4's sling was not tight enough. She said on 06/10/15, CNA #20 and CNA #21 demonstrated use of the Sit to Stand lift and the CNAs told the DON the sling was not snug when they attempted to transfer Resident #4 from the shower chair. The DON said this should have been investigated on Thursday 06/04/15. She said the investigation was ongoing and the root cause was the resident's inability to stand up and bear weight and the improper application of the sling contributed to the assisted fall. She said according to the incident report the fall happened in the resident's room, however, the investigation revealed the fall happened in the shower room. Interview with the DON, on 06/12/15 at 10:55 AM, revealed the CNAs told her the reason they did not notify the nurse prior to moving the resident was because they did not realize it was considered a fall since they lowered the resident to the floor. She said staff should never move a resident after a fall, assisted-fall etc, they should get a nurse. The DON said she expected staff to be trained on lifts on hire and as	F 323			

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F 323	<p>Continued From page 33</p> <p>needed and she assumed new hires did hands on training and that was her expectation because that was their policy and procedure.</p> <p>Interview with the Administrator, on 06/12/15 at 12:50 PM, revealed use of the lift was demonstrated during classroom orientation then "sometime" during the first thirty (30) days of training the employee should be observed using the lift and a skills check off completed by the trainer. In addition, the Administrator said the staff received "hands on" training when they worked on the floor. The Administrator said there was no hands on training during orientation and they were planning to implement hands on training during orientation. In addition, the Administrator said lift assessments were completed sporadically in the past and now they were going to be more consistent.</p> <p>2. Review of the facility's policy titled, "Fall Assessment/Intervention Process", dated 01/2005, revealed residents were to be assessed on admission for fall risk and appropriate interventions initiated to reduce the risk of injuries with falls. Further review revealed the Admission Nurse should evaluate the resident for fall risks, complete the Get Up and Go Assessment and initiate appropriate interventions to the fall care plan to minimize the risk for falls.</p> <p>Interview with the DON, on 08/11/15 at 10:10 AM, revealed there was no specific policy on Stop and Watch. However, interview with the Education and Training Director (ETD), on 06/08/15 at 2:05 PM, revealed the facility used Interact, (Interventions to Reduce Acute Care Transfers), a quality improvement program that focused on the management of acute change in resident</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>condition. It included clinical and educational tools and strategies for use in every day practice in long-term care facilities. The ETD said one of the educational tools within the Interact system were "Stop and Watch" notepads used by direct care staff to report changes in residents' condition to licensed nurses. The ETD said she expected care plan interventions to be added for changes in condition, behavior changes, and if residents were not following directions. The ETD said the Stop and Watch process was covered during orientation.</p> <p>Record review revealed the facility admitted Resident #1 on 04/14/15, with diagnoses which included Osteoporosis and Compression Fracture of the Back with uncontrolled pain and anxiety. Review of an Admission Assessment, dated 04/15/15, revealed the facility assessed Resident #1 as alert and oriented to person, place, time, and purpose, with no memory problem.</p> <p>Review of the facility's Electronic Documentation system revealed instructions for the Get Up and Go Assessment to include: 1. Have the person sit in the chair with their back to the chair and their arms resting on the arm rests. 2. Ask the person to stand up from a standard chair and walk a distance of ten (10) feet. 3. Have the person turn around, walk back to the chair, and sit down again. Timing begins when the person starts to rise from the chair and ends when he or she returns to the chair and sits down." Review of the "Timed Get Up and Go Assessment", dated 04/15/15, revealed LPN #8 had marked Resident #1 as "less than twenty (20) seconds, mostly independent".</p> <p>Interview with LPN #8, on 06/10/15 at 11:15 AM,</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>revealed she completed Resident #1's "Timed Get Up and Go Assessment". LPN #8 stated she has worked at the facility for six (6) or seven (7) years, and worked on all units as a Charge Nurse. She said the Charge Nurse was responsible for completing a four (4) page head to toe Admission Assessment in the electronic documentation system which included the "Timed Get Up and Go Assessment". The LPN said the Timed Get Up and Go assessment was used as the fall risk assessment and the nurse should document if a resident was a one (1) or two (2) person assist. LPN #8 stated the Timed Get Up and Go Assessment was not "timed". She stated "you just look at how the resident's body is and how they move and check the appropriate box". However, review of the instructions for the "Get up and Go Assessment" revealed "timing begins when the person starts to rise from the chair and ends when he or she returns to the chair and sits down". The LPN stated the box next to the comment, "less than twenty (20) seconds mostly independent" indicated a resident would require assist of one (1) person.</p> <p>Review of Resident #1's Comprehensive Plan of Care, dated 04/14/15, revealed the resident was at risk for fall/injury related to generalized weakness and compression fracture, with an intervention to refer to a plan of care in the voice-assisted, hands free documentation and communication system (AccuNurse Activities of Daily Living Care Plan). Review of the Activities of Daily Living (ADL) Plan of Care, dated 04/15/15, revealed the facility assessed the resident to require assistance of one (1) person physical assist for ambulation, bathing, dressing and toileting, and cautions to include "assistance needed for toileting transfer, do not leave</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>unattended in bathroom and high risk for falls".</p> <p>Review of a Nursing Note, dated 04/27/15 at 1:44 AM, revealed Resident #1 "was found on the floor in the adjoining room" and stated he/she went to the bathroom and when he/she finished he/she got turned around and went into the wrong room. The resident stated he/she fell onto his/her back and when trying to get up rolled onto his/her right side. The resident was assessed with no apparent external injuries noted, but the resident was complaining of tenderness to his/her left leg and was unable to move it related to the tenderness. The Primary Care Physician was notified and the resident was sent to the ER for evaluation. Ambulance here at 12:15 AM to transport the resident.</p> <p>Review of Resident #1's ER record, dated 04/27/15, revealed "Clinical Impression 1. Fall from slipping, tripping or stumbling, 2. Closed left hip fracture." Review of the Resident's Hospital Discharge Summary, dated 04/29/15, revealed the resident was admitted and surgery was planned; however, the resident's condition declined and it was determined the resident would not survive surgery. Palliative care was provided and the resident expired on 04/29/15.</p> <p>Interview with CNA #1, on 06/03/15 at 3:35 PM, revealed Resident #1 was in the bed asleep during the final bed check on 04/26/15 around 10:00 or 10:30 PM. The CNA said Resident #1's roommate was outside on smoke break when she made rounds.</p> <p>Interview with Resident #1's Roommate, on 06/04/15 at 11:00 AM, revealed Resident #1 was in pain and moaned at night. The Roommate</p>	F 323		
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F 323	<p>Continued From page 37</p> <p>said Resident #1 would get out of bed to go to the bathroom during the day and night and he/she did not remember hearing a staff member encouraging Resident #1 to call for assistance prior to getting out of bed. The Roommate said he/she and Resident #1 would have conversations and the resident seemed confused at times. Further interview revealed on the evening of 04/26/15, the Roommate saw Resident #1 out of bed and pacing back and forth from bed 1 to bed 2 and then went into the bathroom and shut the door behind him/her. The Roommate said he/she fell asleep after he/she heard the bathroom door shut and was told the next morning Resident #1 was transferred to the hospital.</p> <p>Interviews on 06/05/15 with CNA #5 at 8:10 AM and LPN #2 at 8:55 AM, revealed on 04/26/15 around 11:00 PM, CNA #5 began to pass ice water sometime after 11:00 PM; and, when she entered Resident #1's room (108) she observed Resident #1 was not in the bed or in the bathroom. CNA #5 told LPN #2 and the two (2) of them split-up to do room checks. CNA #5 opened the door to room 106, flipped on the light switch and found Resident #1 lying on his/her side on the floor near the sink. LPN #2 and CNA #5 stated the resident said he/she was in the bathroom, got turned around and went out of the wrong bathroom door. The resident told them he/she was weak and fell. The resident complained of left hip and lower back pain. LPN #2 and CNA #5 did not move the resident, LPN #5 called an ambulance and the ambulance arrived between 11:45 PM and 12:00 AM.</p> <p>Interviews with CNA #9, on 06/07/15 at 3:20 PM, CNA #13 on 06/05/15 at 10:30 AM, CNA #7 on</p>	F 323		

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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 06/12/2015
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 323	<p>Continued From page 38</p> <p>06/07/15 at 2:25 PM, CNA #8 on 06/07/15 at 3:10 PM, and CNA #10 on 06/05/15 at 10:20 AM revealed Resident #1 was care planned for assistance of one (1) staff for ambulation but would get out of bed without calling for assistance; and, would get confused after using the bathroom, would exit the bathroom into the adjacent room, and get in the unoccupied bed in that room. The CNAs stated they did not complete a Stop and Watch notepad to notify the licensed staff of the resident's ambulation without assistance or going into the adjacent room.</p> <p>Interviews with LPN #7 on 06/05/15 at 12:00 PM, LPN #8 on 06/10/15 at 11:15 AM, LPN #4 on 06/07/15 at 5:30 PM, and LPN #6 on 06/05/15 at 11:20 AM, revealed they were not aware of Resident #1 getting up without assistance. The LPNs stated the CNAs should notify the Charge Nurse when a resident was care planned for assistance with ambulation and was repeatedly getting out of bed without assistance to ensure appropriate interventions were added to the care plan to prevent falls. LPN #7 said she expected staff to complete a Stop and Watch form.</p> <p>Interviews on 06/05/15 with Registered Nurse (RN) #1, South Unit Charge Nurse at 11:35 AM, and Unit Manager of North and South Units at 12:25 PM, revealed they expected staff to report the resident's getting up without assistance so other interventions such as a bed alarm could be considered.</p> <p>Interview with the Staff Education/Trainer (EDT) on 06/08/15 at 2:05 PM, revealed the Accunurse Care Plan was initiated by the Admission Nurse and the CNAs should access the Accunurse Care Plan via headset for the resident's ADL's and</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>assistance needed. The EDT said staff should reinforce use of the call light when a resident was getting out of bed without assistance and the CNAs should report to the Charge Nurse. The EDT said the Charge Nurse should relay in report and document in the Nurse's Notes and the Shift to Shift report when a resident was found in the wrong bed.</p> <p>Interview with the Director of Nursing (DON), , revealed Resident #1 was care planned appropriately for his/her diagnoses. The DON stated she was not sure who initiated the ADL Plan of Care in the Accunurse and she said the one (1) person physical assist for toileting might have been changed after Resident #1 was transferred to the hospital. It might have been added in anticipation for his/her return to the facility. The DON said there was "absolutely no way" to determine when one (1) person physical assist was added in accunurse to Resident #1's plan of care. However, interview, on 06/09/15 at 4:15 PM, with the Senior Clinical Account Manager of the company that makes the Accunurse System, revealed the Accunurse was a system facilities used for CNAs to check resident's Activities of Daily Living care plan via headset. She stated that all updates to an Accunurse Plan of Care were dated and timed stamped in the system. Review of the Plan of Care updates for Resident #1 revealed all care plan updates were entered on 04/15/15 between 8:27 AM and 8:50 AM.</p> <p>Further interview with DON, on 06/08/15 at 3:30 PM, revealed Resident #1 had been in the facility for almost two (2) weeks and made progress with therapy, and had not stumbled or walked off balance. The DON said she was not sure why</p>	F 323		

07/29/2015 12:46 #730 P.042/043

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F 323	<p>Continued From page 40</p> <p>some of the CNAs thought Resident #1 was an assist of one (1). In addition, the DON said she assessed Resident #1 the morning after he/she was admitted and the resident was "very" stable, but she did not document her assessment. The DON stated there was no indication the resident was a fall risk because his/her previous fractures were pathologic in nature. The DON said Resident #1 was alert and oriented and not showing any signs of fall risk. Further interview with the DON, on 06/11/15 at 8:50 AM, revealed there was no assessment policy and all residents were care planned as an assist of one (1) on admission and then reviewed during the twenty four (24) hour meeting the next morning. The DON said the Accunurse assessment did not accurately reflect Resident #1's level of function as Resident #1 was able to ambulate without assistance. However, interview with the Physical Therapist, on 06/08/15 at 11:30 AM, revealed the initial assessment on 04/15/15 revealed Resident #1 exhibited a forward lean of the trunk, inadequate hip and trunk extension, pain and muscle weakness and was at risk for falls. The Therapist stated he would recommend assistance when out of bed until the resident's balance improved.</p> <p>Further interview with the DON, on 06/08/15 at 3:30 PM, revealed she was not aware of any occasion when Resident #1 was found in room 106 in an unoccupied bed. The DON stated the CNAs should complete a Stop and Watch form in addition to telling the Charge Nurse if a resident was found in an unoccupied bed and getting up without assistance. The DON said they had been using the Stop and Watch system for about a year and the CNAs were good about using the system.</p>	F 323			

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F 323	Continued From page 41 Interview with the Medical Director on 06/10/15 at 7:30 AM, revealed he was Resident #1's physician when the resident was in the facility. The Medical Director stated when a resident was care planned for one (1) person assist then that was what should be done. Interview with the Administrator, on 06/12/15 at 12:50 PM, revealed she expected the CNAs to complete a Stop and Watch form if they witnessed a change in the resident. In addition, the Administrator said she had total responsibility over the building.	F 323			

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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 (X6) 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.

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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 		

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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>		

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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	

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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>		

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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>		

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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	

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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>		

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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	

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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 		

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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>		

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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			

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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	

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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>		

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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 admission 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>	

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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	

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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

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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 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			

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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 R 06/10/2015
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}	INITIAL COMMENTS A Revisit was conducted on 06/10/15 and determined the facility was in compliance on 06/05/15, as alleged in the acceptable POC.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 01 - MAIN BUILDING 01	(Y3) Date of Revisit 6/10/2015
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 _____ Reg. # NFPA 101 LSC K0018	Correction Completed 06/05/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0025	Correction Completed 06/05/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0038	Correction Completed 06/05/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0056	Correction Completed 06/05/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0070	Correction Completed 06/05/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 06/05/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>DH</i>	Date: <i>07/10/15</i>	Signature of Surveyor: <i>Deborah A. Herdman, RLS, DR</i>	Date: <i>07/10/15</i>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/30/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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: 1969, 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

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

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

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K 018	Continued From page 3 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. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 025 SS=E	Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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

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

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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		

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NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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

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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>	

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K 038	<p>Continued From page 9 exit interview on 04/30/15.</p> <p>Actual NFPA Standard:</p> <p>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.</p> <p>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.</p> <p>Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p> <p>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</p>	K 038			

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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		

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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. 	

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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

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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		

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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		

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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

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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 	

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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

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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
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NAME OF PROVIDER OR SUPPLIER TWIN RIVERS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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		

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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		
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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		

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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		
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