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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING_

PRIMITED: 10/31/2014 FORM APPROVED OMBINO. 0938-0391

OCMPLETED

10/17/2014

185087 B. WNG

NAME OF PROVIDER OR SUPPLIER

TWIN RIVERS NURSING AND BEHAR CEN

STREET ADDRESS, CITY, STATE 2000 OF S 2420 W. 3RD ST.

TWIN RIVERS NURSING AND REHAB CENTER			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 PREFD TAG				
F 000	INITIAL COMMENTS	FO	Submission of this plan of correction is not a legal admission			
	An Abbreviated Survey investigating complaint		that a deficiency exists or that this statement of deficiency was			
	#KY22273 and #KY22277 was conducted on		correctly cited, and is also not to be			
	10/07/14 through 10/17/14 to determine the		construed as an admission of			
	facility's compliance with Federal requirements.		interest against the facility, the			
	Complaints #KY22273 was substantiated with		Administrator or any employees,			
	related deficiencies and #KY22277 was unsubstantiated with unrelated deficiencies cited		agents, or other individuals who			
		1	draft or may be discussed in this			
F 164	with the highest Scope and Severity of a "F",	1	response and plan of correction. In addition, preparation of this plan of			
C	483.10(e), 483.75(i)(4) PERSONAL	F1	correction does not constitute an			
SS=D	PRIVACY/CONFIDENTIALITY OF RECORDS		admission or agreement of any kind			
	The resident has the sight to recover to the second	1	by the facility of the truth of any			
	The resident has the right to personal privacy and confidentiality of his or her personal and clinical	4	facts alleged or see the correctness			
	records.		of any allegation by the survey			
	records,		agency. Accordingly, the facility			
	Personal privacy includes accommodations,	1	has prepared and submitted this			
	medical treatment, written and telephone		plan of correction prior to resolution			
İ	communications, personal care, visits, and		of any appeal which may be filed			
	meetings of family and resident groups, but this		solely because of the requirements under state and federal law that			
]	does not require the facility to provide a private		mandate submission of a plan of			
Ì	room for each resident.		correction within ten (10) days of			
- 1	Format of and the state of the		the survey as a condition to			
- 1	Except as provided in paragraph (e)(3) of this	1	participate in Title 18, and Title 19			
	section, the resident may approve or refuse the	İ	programs. The submission of the			
	release of personal and clinical records to any		plan of correction within this time frame should in no way be			
- 1	Individual outside the facility.		construed or considered as an			
	The resident's right to refuse release of personal		agreement with the allegations of			
	and clinical records does not apply when the		noncompliance or admission by the			
	resident is transferred to another health care		facility. The plan of correction			
	institution; or record release is required by law.	}	constitutes a written allegation of			
	measured or record release is required by idw.	ł	submission of substantial			
	The facility must keep confidential all Information		compliance with Federal Medicare			
	contained in the resident's records, regardless of		Requirements.			
İ	the form or storage methods, except when					
	release is required by transfer to another]				
	healthcare institution; law; third party payment					
	ama kand halinent	1				

LABORATORY DIFFECTOR'S OR PROVIDER SYPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XII) DATE

Any deficiency statement ending with an asteriak (*) 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,

		D HUMAN SERVICES MEDICAID SERVICES					FOR	D: 10/31/2014 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY
		185087	B. WNG					C /17/2014
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, Z	IP CODE	10/	11/2014
TWIN RIVI	ERS NURSING AND REH	AB CENTER			W. 3RD ST. NSBORO, KY 42301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	TE	(XS) COMPLETION DATE
	by: Based on observation and review of the facili was determined the fa privacy for one (1) of s (Resident #3). During staff mentioned Reside and discussed his/her wound care in the present the findings include: Review of the facility's dated, revealed the facility's dated, revealed the facility or her personal privacion her personal and clicked Resident #3 on 03/22/included Osteoporosis Chronic Obstructive Propersion, Anxiety, Neressure Ulcer/Hip, St Annual Minimum Date dated 08/21/14, reveal Resident #3's cognition Interview for Mental St (15) which indicated the interviewable. Observation, on 10/08	is not met as evidenced i, interview, record review ity's Resident Rights form, it cility failed to ensure the seven (7) sampled residents in Resident #4's wound care, ent #3's first and last name pressure ulcer status and sence of Resident #4. Resident Rights form, not cility shall protect and each resident, including the eay and confidentiality of his nical records. In the facility admitted is with diagnoses which in Chronic Pain Syndrome, ulmonary Disease (COPD), leurogenic Bladder, and age IV (4). Review of an Set (MDS) assessment, ed the facility assessed in as intact with a Brief atus (BIMS) score of fifteen e resident was	F	184	1. RN #2 receive action on 10/8 discussing Re in front of Res was reeducate Privacy policy by the Director care being profession 10/9/14 no resident's prive maintained. 2. DON observe by RN #2 on 1 issues noted. care on 10/9/1 of Nursing, As of Nursing and was completed concerns identified Nursing be resident privacy. 3. All licensed Nursing be reeducated Education Train Director of Nursing and Education Train Director of Nursing Director of Nursing Bersonal privacy confidentiality. education will be 11/26/14. 4. The Education Director,	ed disciplinary 2/14 related to sident #3's car ident #4. RN # ed on the HIPP . An observation ovided to reside ent #3 by RN # ted that acy was ed care provide 10/9/14. No Observations of 4 by the Direct istant Director di Unit Manager d with no fied related to y and HIPPA. rsing staff and ng Assistants w by the ning Director, sing, Assistant ding resident by and This re- ne completed by Training or of Nursing, tor of Nursing, tor of Nursing, tor of Nursing, tor of Nursing er will observe rided (5) times ne (1) week and per week for	#2 PA/ on ent 22 d d of for r s	
	care for Resident #4, re (RN) #2 stated to the S	evealed Registered Nurse State Surveyor the first and #3. RN #2 stated the			three (3) weeks two (2) weeks t	and weekly fo o ensure patie	r nt	

CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		185087 B. WING			C 10/17/2014		
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	10/1//	2014
TWIN RIV	ERS NURSING AND REH	AB CENTER			20 W. JRD ST. NENSBORO, KY 42301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E CO	(X6) OMPLETION DATE
F 164	the treatment was doin "they are doing good to "they are doing good to Interview with RN #2, revealed RN #2 stated hearing and you have scream for [him/her] to she did not normally diffront of other residents not have mentioned the residents. Interview with the Direct 10/13/14 at 4:40 PM, in disciplinary action for cresident in the presence DON stated her expect would not discuss residenter residents. Interview with the Adm 3:54 PM, revealed the a resident in front of an the staff receive training receive additional training action. 483.15(a) DIGNITY AN INDIVIDUALITY The facility must promore manner and in an environment of the staff receive training action.	ng to the wound clinic and ng really well. She stated, hings for [him/her]." on 10/09/14 at 2:10 PM, Resident #4 was "hard of to get in [his/her] ear and hear." She further stated scuss residents' care in RN #2 stated she should e resident in front of other ctor of Nursing (DON), on evealed RN #2 received liscussing the care of a set of another resident. The faction would be that staff dents in the presence of inistrator, on 10/09/14 at staff should never discuss other resident. She stated g yearly and RN #2 would ng as well as disciplinary D RESPECT OF	F 2	164	confidentiality is maintained. 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. 1. C.N.A. #1, #2 were reeducated on privacy, dignity and respect while providing care for a reside on 10/8/14 by the DON. An observation of care being provided to resident # 3 was made by the Director of Nursing on 10/9/14 and no breaches of privacy or dignity were observed. 2. The Director of Nursing and Unit Managers observed resident	nt	/27/14
	This REQUIREMENT is by:	s not met as evidenced			incontinent care on 10/8/14 to		

will be held to review concerns

for further recommendations as

Quality Assurance Committee will consist of at a minimum the

Nursing, the Assistant Director of

Director with the Medical Director

Nursing and the Social Services

needed. The members of the

Administrator, the Director of

attending at least quarterly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 185087 **B. WING** 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TWIN RIVERS NURSING AND REHAB CENTER 2420 W. 3RD ST. OWENSBORO, KY 42301 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 241 Continued From page 3 ensure that privacy, dignity and F 241 Based on observation, interview, record review, respect for the resident was being maintained. No concerns review of the facility's policy and procedures, and identified. review of the facility's Resident Rights form, it All Certified Nursing Assistants was determined the facility failed to promote care and Licensed Nursing Staff will for residents in a manner and in an environment be reeducated by the Education that maintains or enhances each resident's Training Director, Director of dignity and respect in full recognition of his or her Nursing, Assistant Director of individuality for one (1) of seven (7) sampled Nursing or the Unit Manager residents (Resident #3). Two (2) Certified regarding resident privacy and Nursing Assistants (CNAs) provided incontinent dignity while providing care. This care for Resident #3 with the privacy curtain re-education will be completed by partially pulled and the door open. 11/26/14. The Education Training Director, The findings include: Director of Nursing, Assistant Director of Nursing or the Unit Review of the facility's policy and procedure titled, Manager will observe incontinent "Privacy Curtains and Room Dividers Procedure", care being provided five (5) times not dated, revealed when providing care for a per week for one (1) week and three (3) times per week for three resident the facility staff was to completely pull (3) weeks and weekly for two (2) the divider curtain to provide for privacy. weeks. The results of these observations will be reviewed Review of the facility's Resident Rights form, not with the Quality Assurance dated, revealed each resident shall be treated Committee for a minimum of with consideration, respect, and full recognition of three (3) months and until the their dignity and individuality, including privacy in Quality Assurance Committee treatment and in care for [his/her] personal ascertains continuous needs. compliance. If at any time a concern is identified, a Quality Record review revealed the facility admitted Assurance Committee meeting

Resident #3 on 03/22/13 with diagnoses which

Depression, Anxiety, Neurogenic Bladder, and

Pressure Ulcer/Hip, Stage IV (4). Review of an Annual Minimum Data Set (MDS) assessment,

dated 08/21/14, revealed the facility assessed

Resident #3's as cognitively intact with a Brief

(15) which indicated the resident was

Interview for Mental Status (BIMS) score of fifteen

included Osteoporosis, Chronic Pain Syndrome,

Chronic Obstructive Pulmonary Disease (COPD),

11/27/14

		ID HUMAN SERVICES					D: 10/31/2014
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
	_	185087	B. WNG				C
NAME OF P	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	17/2014
THE PARTY IN CO.				1	2420 W. 3RD ST.		
1 ANIM MIA	ERS NURSING AND REH	AB CENTER			OWENSBORO, KY 42301		
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES					
PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPL	
F 241	Continued From page		ĺ				
7 271		4	F:	241			
	interviewable,		1				i i
	CNA #1 and CNA #2 p. Resident #3 with the p. length of the bed (not the bed) and left the resident was left in vie entered the room or w resident's room. Interview with Resider PM, revealed he/she v open and the privacy occumpletely around the the curtain should have interview with CNA #1, and CNA #2 on 10/08/they would normally clipull the privacy curtain	at #3, on 10/13/14 at 4:25 vas not aware the door was curtain was not pulled bed. The resident stated been completely closed. on 10/08/14 at 9:44 AM, 14 at 9:45 AM, revealed ose the resident's door and completely around the bed n performing incontinent					
	the facility's policy said providing care and the pulled all the way arous policy does not specify but should be at least of interview with the Direct 10/08/14 at 4:07 PM, reto provide each resider stated. She stated the	08/14 at 4:05 PM, revealed to pull the curtain when curtain should have been nd the bed. She stated the the door has to be shut			N		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED C 185087 B. WNG 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. TWIN RIVERS NURSING AND REHAB CENTER OWENSBORO, KY 42301 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X8) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 5 F 241 Interview with the Administrator, on 10/09/14 at 3:54 PM, revealed she expected staff to close the curtain completely and for staff to provide full privacy for each resident. F 281 483.20(k)(3)(I) SERVICES PROVIDED MEET F 281 PROFESSIONAL STANDARDS SS=F 1. Medication error form was completed for Resident #1 The services provided or arranged by the facility relating to Rocephin being must meet professional standards of quality. given the day after the order was written and disciplinary action given on 9/16/14. The Rocephin for resident # 1 was This REQUIREMENT is not met as evidenced transcribed and given on bv: 9/17/14. Disciplinary action Based on observation, interview, record review, and education relating to and review of the Kentucky Board of Nursing following Physician orders was Advisory Opinion Statement, AOS #14, last given to licensed staff on revised 10/20/10, it was determined the facility 10/13/14 by the Education failed to have a system in place to ensure orders Training Director. On 10/10/14 written on a Progress Note would be transcribed the physician was notified of to a Physician's Telephone Order to ensure the Urinalysis order not physician's orders were followed for two (2) of transcribed on resident # 2 by seven (7) sampled residents (Resident #1 and Unit Manager with no further Resident #2). orders noted. DON, ADON and Unit On 09/15/14 at 4:00 PM, Resident #1 was Managers reviewed all assessed to have lethargy, fever and tachypnea Nurse Practitioner and (Rapid breathing) with complaints of feeling bad Physician notes for the past 60 and was ordered Rocephin (antibiotic) one (1) days on 10/20/14 to ensure all gram (g) intramuscular (IM) now. Review of the Physician orders were Nurses Notes revealed the Rocephin injection transcribed. No issues noted. 3. All licensed staff will be was not received until the next day 09/16/14 at reeducated by the Education 11:15 AM. Training Director, Director of Nursing, Assistant Director of On 09/16/14, the facility assessed Resident #2 to Nursing or the Unit Manager have Hematuria (blood in urine) and lethargy regarding following Physician (lack of energy) and was ordered an Urinalysis orders and transcription to with Culture and Sensitivity. Review of the medical record and interview with the Director of

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					ED: 10/31/201	
		MEDICAID SERVICES					RM APPROVE	_
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		7
	<u> </u>	185087	B. WING				C	
NAME OF P	ROYDER OR SUPPLIER			Sī	REET ADDRESS, CITY, STATE, ZIP CODE	111	0/17/2014	4
TWIN RIV	ERS NURSING AND REH	AB CENTER		24	120 W. 3RD ST. WENSBORO, KY 42301			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	170				1	4
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
	Urinalysis with Culture obtained. Interview with the DOI revealed the facility die ensure the orders writiby the physician were. The findings include: Review of the Kentuck Advisory Opinion State revised 10/20/10, reve Practice" and "License expected to administer as prescribed by physidentist or advanced profile of the profile of th	order was missed and the and Sensitivity was never and Sensitivity was never and Sensitivity was never and Sensitivity was never and Sensitivity was never and the Progress Notes not missed. The Board of Nursing ament, AOS #14, last aled "Registered Nursing and Practical Nurse" were medication and treatment cian, physician assistant, actice registered nurse. The Board of Nursing ament, AOS #14, last aled "Registered Nurse" were medication and treatment cian, physician assistant, actice registered nurse. The Board of Nursing ament and treatment cian, physician assistant, actice registered nurse. The Board of Nursing ament and treatment cian, physician assistant, actice registered nurse. The Board of Nursing ament and treatment cian, physician assistant, actice registered nurse. The Board of Nursing ament and treatment cian, physician assistant, actice registered for the facility admitted its. The Board of Nursing ament and treatment cian, physician assistant, actice registered nurse. The Board of Nursing ament all the physician assistant, actice registered nurse. The Board of Nursing ament all the physician assistant, actice registered nurse. The Board of Nursing ament all the physician assistant, actice registered nurse. The Board of Nursing ament all the physician assistant, actice registered nurse. The Board of Nursing ament all the physician assistant, actice registered nurse. The Board of Nursing ament all the physician and treatment cian, physician assistant, actice registered nurse.	F	281	phone order. This reeducation will be completed by 11/26/14. The Nurse Practitioner will provide a list of residents seen to the Unit Manager after each visit to ensure orders are transcribed appropriately. 4. The Education Training Director, Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing of the Unit Manager will review a resident records after Physician visit to ensure any new orders have been noted and transcribed five (5) times per week for one (1) week and three (3) times per week for three (3) weeks and weekly for two (2) 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.	of or all	11/27/14	

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

PRINTED: 10/31/2014
FORM APPROVED
OMB NO. 0938-0391
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185087	B. WING	B. WING		C 10/17/2014	
	ROVIDER OR SUPPLIER ERS NURSING AND REI	iab center		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301			7772014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(XB) COMPLETION DATE
F 281	and Sensitivity, and fintramuscular (IM) no review revealed Leva milligrams (mg) per g daily for ten (10) days Review of a Telephor 09/15/14 (no time), rethe chest x-ray, CBC, Culture and Sensitivit transcribed as ordere Rocephin Injection with transcribed as ordere Rocephin Injection with Review of the Septem Administration Record documented evidence administered. Review of a Nursea MAM, revealed Roceph However, the medica 09/15/14 at 4:00 PM. Interview with License on 10/13/14 at 2:38 P the Rocephin injection medication drawer and been missed. She sti Manager Registered administered the injection on the wrong Interview with the Unit 10/13/14 at 3:00 PM is interview with 1	P), Urinalysis with Culture Rocephin one (1) Gram (g) we after labs drawn. Further equin (an antibiotic) 500 astrostomy tube (g-tube) a. The Physician's Order, dated exceeded Physician Orders for CMP, Urinalysis with the extension of the exceeded Physician Orders for the excee	F	281			
		ister the injection as a "now"					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2014 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ 185087 B. WING 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. JRD ST. TWIN RIVERS NURSING AND REHAB CENTER OWENSBORO, KY 42301 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÈFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 281 Continued From page 8 F 281 order. 2. Record review revealed the facility re-admitted Resident #2 on 04/01/14 with diagnoses which included Diabetes Mellitus, Hypertension, Anxiety Disorder, Chronic Kidney Disease, Congestive Heart Failure (CHF) Anemia, and Hypothyroidism. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 06/25/14. revealed the facility assessed Resident #2 as cognitively intact with a BIMS score of thirteen (13) indicating the resident was interviewable. Review of a Nurse's Note, dated 09/15/14 at 9:16 PM, revealed the facility assessed Resident #2 to have a small amount of blood in his/her brief and a foul odor to his/her urine. Review of a Progress Note written by the APRN, dated 09/16/14, revealed the resident was assessed to have hematuria and lethargy. Further review of the Progress Note revealed the ARNP wanted a Urinalysis and Culture and Sensitivity for Resident #2. Review of the Laboratory Reports revealed there was no documented evidence for the results of the Urinalysis with Culture and Sensitivity. Interview with the Director of Nursing (DON), on 10/10/14 at 2:25 PM, revealed the order was written by the ARNP on a Progress Note and should have been transcribed by the nurse to a

Physician's Telephone Order. She further stated the order was missed by the nurse and the labs

Interview with the Unit Manager RN #1, on 10/15/14 at 9:25 AM, revealed when the

were not obtained as ordered.

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES					10.0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
	4	185087	B. WING			С	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
TWIN RIV	/ERS NURSING AND REH	AB CENTER		2	2420 W. 3RD ST. DWENSBORO, KY 42301		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)		E ATE	COMPLETION DATE
F 281	fold/flag the page to a The nurse will transcri- copy telephone order, order is placed in a bir copies are made and a Managers, the DON a to ensure appropriate She stated the Interdis included all the Unit M Coordinators, the Dire Department Heads att meeting where they re orders. She further str day at approximately to orders. She stated the system in place to ensi- transcribed from the P possible for orders to to Interview with the DON revealed the facility did system to ensure the c Progress Notes by the missed. She stated sh Managers to make rou ensure all new orders to telephone order for trace 483.20(k)(3)(li) SERVIO PERSONS/PER CARS The services provided must be provided by que	ds at the facility they on a Progress Note and lert the nurse of new orders. be the order onto a carbon She stated the original of at the nurse's stations and distributed to the Unit of the MDS Coordinators follow up of the orders, aciplinary Team which anagers, the MDS ctor of Nursing and all ended a daily morning viewed all new telephone ated they met again each 1:30 PM to follow up on the ended facility did not have a ure the orders were rogress Notes and it was be missed. I, on 10/15/14 at 9:48 AM, I not have a tracking orders written on the physician were not the expected the Unit onds with the physician and were transcribed onto a cking. CES BY QUALIFIED E PLAN or arranged by the facility	F 2	82.	 On 10/20/14 the Director of Nursing reviewed resident # care plans to determine if all care plan interventions were place and review of the resident and the medical record revealed that all care plan interventions were in place. By 11/24/14 the Director of Nursing, Assistant Director of Nursing, MDS Nurses and I Managers reviewed all curre resident's care plans to determine if all interventions were being followed. Any concerns identified were immediately corrected. All licensed staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding following the resident's plan of care to me the needs of the resident including following physician orders and timely follow up or lab results as well as ongoing assessment Thils re-education will be completed by 11/26/14. The Education Training Director, Director of Nursing, Assistant Director of Nursing the Unit Manager will audit fir (5) resident care plans per week for twelve (12) weeks to ensure that interventions are followed. The results of these followed. The results of these 	finit nt	

having a dry tongue/mouth through the next evening when the resident received the ordered IV fluids (approximately thirty-seven and a half

Review of a facility's policy and procedure titled, "Guidelines, Resident Comprehensive Care Plan", dated 09/08, revealed the resident's Comprehensive Care Plan should be viewed as an interdisciplinary approach to managing the

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FORM APPROVI OMB NO, 0938-03	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
				C	
	185087	B. WING		10/17/2014	
NAME OF PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE		
TWIN RIVERS NURSING AND RE	HAB CENTER		1420 W. 3RD ST. DWENSBORO, KY 42301		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
by: Based on Interview determined the facility were provided in accurrence written plan of care in residents (Resident planned for facility symptoms of dehydrordered. On 09/18/1 was assessed by the Registered Nurse (Aland mouth with poor was received to obtain however, the facility 09/17/14 at 10:36 Alanotified of the results six (6) hours later with to administer intravely Note, dated 09/17/14	and record review, it was ty failed to ensure services cordance with each resident's or one (1) of seven sampled \$\frac{42}{2}\$. Resident \$#2 was care aff to monitor for signs and ation and to monitor labs as 4 at 9:00 AM, Resident \$#2's a Advanced Practice PRN) to have a dry tongue oral intake and a new order in a Basic Metabolic Panel	F 282	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 concern for further recommendations an 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.	y ng is as	

hours).

The findings include:

		ND HUMAN SERVICES MEDICAID SERVICES			FOI	RM APPROVED
	OF DEFICIENCIES					NO. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	.E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185087	B. WNG			C 0/17/2014
	ROVIDER OR SUPPLIER ERS NURSING AND REH	IAB CENTER	į	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301	P	3 3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 282	the facility. Record review reveal Resident #2 on 04/01 included Diabetes Metalistic Disorder, Chronic Kidd Heart Fallure (CHF) A Hypothyroidism. Review of the Comprod/04/01/14, revealed Resideration in nutrition and had interventions for signs and symptor monitor labs as order Review of a Quarterly assessment, dated of assessed Resident #2 Brief interview for Methirteen (13) indicating interviewable. Review of a Progress 9:00 AM, revealed the aswollen tongue and to have signs and symptom to have signs a	eds of the resident living in ed the facility re-admitted /14 with diagnoses which ellitus, Hypertension, Anxiety Iney Disease, Congestive Anemia, and ehensive Care Plan dated esident #2 was at risk for due to decreased fluid Intake is for facility staff to monitor ms of dehydration and to ed. / Minimum Data Set (MDS) 8/25/14, revealed the facility 2 as cognitively intact with a intal Status (BIMS) score of g the resident was Note, dated 09/16/14 at a resident had complaints of was assessed by the APRN inptoms of dehydration. The dent had a dry mouth, a dry	F 283			
	09/16/14 at 2:00 PM v	with a Blood Urea Nitrogen as per decliter (mg/di)				0

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 185087 B. WING 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. TWIN RIVERS NURSING AND REHAB CENTER OWENSBORO, KY 42301 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 282 Continued From page 12 F 2B2 (normal 7-22), a sodium level of 153 millimoles per liter (mmol/l) (normal 136-148 mmol/L), Chloride 117 mmol/L (normal 96-110 mmol/L) which indicated the resident was possibly dehydrated. Review of a Physician's Order, dated 09/17/14 (no time), revealed new orders for one half percent (0.5%) Normal Saline at seventy (70) cubic centimeters (cc) per hour for six (6) hours. then decrease the rate to fifty (50) cc per hour. Review of a Nurses Note dated 09/17/14 at 10:37 PM revealed IV started and one half percent (0.5 %) normal saline infusing. Review of Resident #2's September 2014 Medication Administration Record (MAR), and Nurse's Notes dated 09/16/14 and 09/17/14 revealed there was no documented evidence the resident was monitored for signs and symptoms of dehydration from 09/16/14 at 9:00 AM through 09/17/14 at 10:37 PM. Interview with Licensed Practical Nurse (LPN) #1, on 10/09/14 at 3:25 PM, revealed she was the nurse on duty on 09/17/14 and the nurse responsible for Resident #2. Further Interview revealed she received the order for the IV fluids. and was the nurse who started the IV. LPN #1

stated she monitored Resident #2 for signs and symptoms of dehydration as she checked on him/her throughout her shift (3:00 PM -11:00 PM).

Interview with LPN #3, on 10/13/14 at 2:30 PM,

She further stated she documented her assessments in the Nurse's Notes. However, review of the Nurses' Notes revealed no documented evidence of any assessments.

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/31/2014 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		186087	B. WING		40	C /17/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10	11112014
TWIN RIV	ERS NURSING AND REH	AB CENTER		1420 W. 3RD ST. DWENSBORO, KY 42301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	YULD BE	(XS) COMPLETION DATE
F 282	09/16/14. She stated encourage fluids and a every two (2) hours as how she monitored Reshift she stated she constated she would have assessments in the Nurses revealed there was not Resident #2 was assessments as the physician. Interview with the Director of the nurse. Interview with the Adm 5:45 PM, revealed Resident #2 was assessments they had concerns the physician. Interview with the Adm 5:45 PM, revealed Resident #2 of the nurse. Interview with the ARN and, on 10/10/14 at 8:assessed Resident #2 of a swollen tongue ampossible dehydration. expected the nurses to lab result the same darfurther stated the staff patient every shift, eveconditions the resident	nurse for Resident #2 on she instructed the CNA's to to increase oral care to a ordered. When asked esident #2 throughout her build not recall. She further a documented any urse's Notes. Notes, dated 09/16/14, documented evidence that essed. ctor of Nursing (DON), on revealed the nurses provide per the plan of care and if y would notify the stinistrator, on 10/17/14 at esident #2 was monitored for a that is the normal routine. IP, on 10/09/14 at 4:45 PM; 40 AM, revealed she on 10/16/14 for complaints and ordered the BMP for She stated she would have a have followed up on the yell was ordered. She cannot assess every eryday, with all the chronic is have.	F 282			
	483.25 PROVIDE CAF HIGHEST WELL BEIN		F 309			
	FEMI 16316011(II)US(181	Serve and the racility must]

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DAT	E SURVEY IPLETED
_		185067	B. WING		·	10	C 0/17/2014
NAME OF P	ROVIDER OR SUPPLIER			डा	REET ADDRESS, CITY, STATE, ZIP CODE		# 17/2014
TWIN RIV	ERS NURSING AND REH	AB CENTER			20 W. 3RD ST. WENSBORO, KY 42381		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 309	or maintain the higher mental, and psychosol accordance with the cand plan of care. This REQUIREMENT by: Based on interview, refacility policy and proof the facility failed to promaintain the highest pand psychosocial well comprehensive care psampled residents (Refailed to provide ongoinesident for dehydratic identified as having a 9:00 AM until 09/17/14 Intravenous fluids were the findings include: Interview with the Direct 10/17/14 at 5:30 PM, applicy regarding a residency regarding a residency in condition. The policy regarding a residency in condition. She further notification and changenoted in the Nursing Freecord review reveals.	care and services to attain at practicable physical, in comprehensive assessment is more metal as evidenced ecord review, and review of ecdures it was determined evide services to attain or tracticable physical, mental being according to the elan for one (1) of seven (7) esident #2). The facility ing assessments of a confrom the time he/she was dry tongue on 09/16/14 at at 10:37 PM when a edministered.	F	309	 Resident #2 was asses signs of dehydration by Unit Manager on 10/14/issues noted. On 10/20/14, the Direct Nursing, Assistant Direct Nursing, Unit Managers Licensed Staff reviewed resident's current condit determine any that need ongoing assessment. As requiring ongoing assess was listed on the every adocumentation list for fo assessment and documentation All licensed staff will be reeducated by the Educatraining Director, Directon Nursing, Assistant Directon Nursing or the Unit Manager and use of the daily following for ongoing monitoring This re-education will be completed by 11/26/14. The Education Training Director, Director of Nursing i>	the /14. No lar of ctor of sand dall tion to ded ny sament shift ollow up atlon or of tor of ager sament ow up ng. sing or dit five week ensure nation nent feet of the feet o	
	Resident #2 on 04/01/	ed the facility re-admitted 14 with diagnoses which litus, Hypertension, Anxiety			minimum of three (3) mor	nths	

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

PRINTED: 10/31/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
							;
185087			8. WING	8. WING			17/2014
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
TWIN RIV	ERS NURSING AND REH	AB CENTER			420 W. 3RD ST. DWENSBORO, KY 42301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLÉTION DATE
F 309	Heart Failure (CHF) A Hypothyroldism. Review of the Compro 04/01/14, revealed the alteration in nutrition of intake. Further review facility staff to monitor dehydration and to m. Review of a Quarterly assessment, dated 06 assessed Resident # Brief interview for Me (13) indicating the residual formation of a Progress 9:00 AM, revealed the a swollen tongue and Advanced Practitione to have signs and syr APRN noted the residuant and poor oral in Review of a Physicial revealed new orders (BMP) "today". Review of a Laborato 10:38 AM, revealed at 09/16/14 at 2:00 PM (BUN) of 47 milligram (normal 7-22), a sodioper liter (mmol/l) (nor Chloride 117 mmol/L Review of a Physicial Review of a Physicial at 2:00 PM (BUN) of 47 milligram (normal 7-22), a sodioper liter (mmol/l) (nor Chloride 117 mmol/L	ney Disease, Congestive Anemia, and sehensive Care Plan, dated a resident was at risk for due to decreased fluid a revealed interventions for a for signs and symptoms of conitor labs as ordered. Minimum Data Set (MDS) 2/25/14, revealed the facility 2 as cognitively intact with a notal Status score of thirteen sident was interviewable. Note, dated 09/18/14 at a resident had complaints of was assessed by the r Registered Nurse (APRN) inproms of dehydration. The dent had a dry mouth, a dry	F	309	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.	4	11/27/2014

		ID HUMAN SERVICES						D: 10/31/2014 MAPPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					OMB NO	0. 0938-0391	_	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED				
		185087	B. WNG					C 17/2014		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		100	1172014	ı	
					420 W. 3RD ST.				ı	
TWIN RIVERS NURSING AND REHAB CENTER					WENSBORO, KY 42301				ı	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		· · · · · · · · · · · · · · · · · · ·			11	ĺ	
PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE		(XE) COMPLETION DATE		
F 309	Continued From page	: 16	-	309					D 1	
				308						
								}		
	cubic centimeters (cc) per hour for six (6) hours,					ĺ				
		s to may (50) cc per nour.							l	
	Review of a Nurses N	ote, dated 09/17/14 at	ľ	- 1					ĺ	
	10:37 PM, revealed th	e IV (Intravenous) was					İ		ı	
	started and one half p	ercent (0.5 %) normal							ı	
	saline was infused.									
	Nurse's Notes, dated of revealed there was not resident was monitore of dehydration until Offinterview with License on 10/09/14 at 3:25 Pt	ation Record (MAR), and 09/16/14 and 09/17/14, o documented evidence the old for signs and symptoms 9/17/14 at 10:37 PM, old Practical Nurse (LPN) #1, M, revealed she was the								
	09/17/14. Further Inter	nurse for Resident #2 on view revealed LPN #1 the IV fluids, and was the								
		IV. LPN #1 stated she					11			
	monitored for signs an	id symptoms of dehydration								
	as she checked on the	resident throughout her								
		0 PM-11:00 PM). She	12.							
		ild have documented her		- 1						
		urse's Notes, However,	1	- }						
- 1		Notes revealed there was	1							
	no documentation of a	ny assessments	0							
	Interview with the Dire	ctor of Nursing (DON), on			28					
	10/17/14 at 5:30 PM	revealed the facility used								
	Lippincott as the stand	lards of practice as well as								
	the Interact Two (2) Sy	stem for notification and								
		She further stated the								
		oing assessments per the								
		y had concerns they would								
		She said the nurses always	1							
	assessed the resident	s each time they entered								
	the room and she didn	I't have any concerns there								

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. SUILDING			CMB NO, 0938-0391 (X3) DATE SURVEY COMPLETED		
185087			B. WING		·	C 10/17/2014		
	ROMDER OR SUPPLIER ERS NURSING AND REH	AB CENTER		2420	ET ADDRESS, CITY, STATE, ZIP CODE W. JRD ST. NSBORO, KY 42301		71112914	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(XS) COMPLETION DATE	
F 502 SS=D	Interview with the Adn 5:45 PM, revealed Rechange of condition a routine of the nurse. acceptable practice to twenty-four (24) hour not ordered "STAT" (not ordered "S	n, because it just meant the concerns. Ininistrator, on 10/17/14 at sident #2 was monitored for a that was the normal. She further stated it was a follow up on labs within a time as long as they were low). INP, on 10/09/14 at 4:45 PM; 40 AM, revealed she con 10/16/14 for complaints and ordered the BMP for She stated she would have to have followed up on the lay it was ordered. She if cannot assess every eryday, with the resident's TRATION. TRATION de or obtain laboratory leeds of its residents. The for the quality and timeliness is not met as evidenced and record review it was failed to obtain laboratory leeds of the resident for one led residents (Resident #2). It a Urinalysis with Culture sident #2 and the facility		502	 The Nurse Practitioner was notified of the missed Urinalysis on 10/10/14 by U Manager with no further ord noted. Unit Managers reviewed all physician orders for the pas 30 days to ensure that lab v completed and results recei as ordered. No issues note 	iers st vork ived		

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/31/2014 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185087	B. WING		<u>-</u>		C 17/2014
NAME OF P	ROVIDER OR SUPPLIER		:	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TWIN RIV	ERS NURSING AND REH	AB CENTER			420 W. 3RD ST. DWENSBORO, KY 42301		
(X4) ID	SI MMADV OT	TEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X8) COMPLETION DATE
F 502	Communicatives, page 10		F	3. All licensed staff will be reeducated by the Education Training Director, Director			
	The findings include:				Nursing, Assistant Director of	ľ	
	Record review revealed	ed the facility re-admitted	-		Nursing or the Unit Manager regarding following physician		
		14 with diagnoses which			orders and timely follow up or	n l	
		Ilitus, Hypertension, Anxiety			lab results. This re-education		
	Heart Failure (CHF) A	ney Disease, Congestive	1		will be completed by 11/26/14	4.	
		ew of a Significant Change			The Nurse Practitioner will		
	Minimum Data Set (M	Data Set (MDS) assessment, dated			provide a list of residents see		
		facility assessed Resident			to the Unit Manager after each	ATI	
		erately impaired with a Brief	1		transcribed appropriately.		J
	Interview for Mental S	tatus (BIMS) score of			4. The Education Training	ĺ	
	eleven (11) indicating				Director, Director of Nursing,		
	interviewabie.	34			Assistant Director of Nursing the Unit Manager will audit	or	
]		Note, dated 09/16/14,			physician orders to ensure		
		d Practitioner Registered			orders are implemented as	_	- 1
	Nurse wrote an order is a Culture and Sensitiv	to obtain an Urinalysis and lty.			written (5) times per week fo one (1) week and three (3) times per week for three (3)	,	
	Review of the Laborat	nn Penarte since			weeks and weekly for two (2		
	09/16/14, revealed the	re was no documented			weeks to ensure all labs are		
	evidence of the results	of the Urinalysis or the			completed timely and results	·	1
	Culture and Sensitivity	requested by the Nurse	1		followed up on timely. The		- 1
	Practitioner on 09/16/1				results of these observations will be reviewed with the		İ
1	Interview with the Dire	ctor of Nursing (DON), on			Quality Assurance Committee for a minimum of three (3)	1G	
ŀ		evealed the Urinalysis and					
		was ordered but it was not			months and until the Quality Assurance Committee		Į
	gotten. The DON state	ed the order had been			ascertains continuous		ľ
	missed by the nurse b	ecause she had failed to	1		compliance. If at any time a	ł	l
	note the order and not	ify the laboratory of the	1		concern is identified, a Qualif	ıy İ	ĺ
	order. She revealed the	ne facility did not have a			Assurance Committee meeting	ng I	- 1
	tracking system for lab	oratory orders; however,			will be held to review concern	18	ŀ
	the expectation was th	at any orders written by the					ſ
	physician on a Progres	ss Note were to be]	
	transcribed onto a Tele	phone Order. She stated				1	
	ruere was a tracking sy	stem in place to monitor	1	- 1			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-035									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
185087			B. WNG_		C 10/17/2014				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10	11112014			
TWIN RIV	ERS NURSING AND REH	AB CENTER		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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 502	Nurse (APRN), on 10/	ranced Practice Registered (13/14 at 4:45 PM, revealed staff to follow all orders.	F 5	DEFICIENCY)		11/27/2014			