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	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating complaint #KY22273 and #KY22277 was conducted on 10/07/14 through 10/17/14 to determine the facility's compliance with Federal requirements. Complaints #KY22273 was substantiated with related deficiencies and #KY22277 was unsubstantiated with unrelated deficiencies cited with the highest Scope and Severity of a "F".	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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Malveaux — TITLE: DHA — (X6) DATE: 11-10-14

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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Resident Rights form, it was determined the facility failed to ensure the privacy for one (1) of seven (7) sampled residents (Resident #3). During Resident #4's wound care, staff mentioned Resident #3's first and last name and discussed his/her pressure ulcer status and wound care in the presence of Resident #4. The findings include: Review of the facility's Resident Rights form, not dated, revealed the facility shall protect and promote the rights of each resident, including the right to personal privacy and confidentiality of his or her personal and clinical records. Record review revealed the facility admitted Resident #3 on 03/22/13 with diagnoses which included Osteoporosis, Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease (COPD), 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 cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Observation, on 10/09/14 at 1:45 PM, of wound care for Resident #4, revealed Registered Nurse (RN) #2 stated to the State Surveyor the first and last name of Resident #3. RN #2 stated the	F 164	1. RN #2 received disciplinary action on 10/9/14 related to discussing Resident #3's care in front of Resident #4. RN #2 was reeducated on the HIPPA / Privacy policy. An observation by the Director of Nursing of care being provided to resident # 4 and resident # 3 by RN # 2 on 10/9/14 noted that resident's privacy was maintained. 2. DON observed care provided by RN #2 on 10/9/14. No issues noted. Observations of care on 10/9/14 by the Director of Nursing, Assistant Director of Nursing and Unit Managers was completed with no concerns identified related to resident privacy and HIPPA. 3. All licensed Nursing staff and Certified Nursing Assistants will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding resident personal privacy and confidentiality. This re-education will be completed by 11/26/14. 4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe care being provided (5) times per week for one (1) week and three (3) times per week for three (3) weeks and weekly for two (2) weeks to ensure patient	

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F 164	Continued From page 2 resident had been going to the wound clinic and the treatment was doing really well. She stated, "they are doing good things for [him/her]." Interview with RN #2, on 10/09/14 at 2:10 PM, revealed RN #2 stated Resident #4 was "hard of hearing and you have to get in [his/her] ear and scream for [him/her] to hear." She further stated she did not normally discuss residents' care in front of other residents. RN #2 stated she should not have mentioned the resident in front of other residents. Interview with the Director of Nursing (DON), on 10/13/14 at 4:40 PM, revealed RN #2 received disciplinary action for discussing the care of a resident in the presence of another resident. The DON stated her expectation would be that staff would not discuss residents in the presence of other residents. Interview with the Administrator, on 10/09/14 at 3:54 PM, revealed the staff should never discuss a resident in front of another resident. She stated the staff receive training yearly and RN #2 would receive additional training as well as disciplinary action.	F 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.	11/27/14
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241	1. C.N.A. #1, #2 were reeducated on privacy, dignity and respect while providing care for a resident 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 incontinent care on 10/8/14 to	

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F 241	Continued From page 3 Based on observation, interview, record review, review of the facility's policy and procedures, and review of the facility's Resident Rights form, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one (1) of seven (7) sampled residents (Resident #3). Two (2) Certified Nursing Assistants (CNAs) provided incontinent care for Resident #3 with the privacy curtain partially pulled and the door open. The findings include: Review of the facility's policy and procedure titled, "Privacy Curtains and Room Dividers Procedure", not dated, revealed when providing care for a resident the facility staff was to completely pull the divider curtain to provide for privacy. Review of the facility's Resident Rights form, not dated, revealed each resident shall be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in care for [his/her] personal needs. Record review revealed the facility admitted Resident #3 on 03/22/13 with diagnoses which included Osteoporosis, Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease (COPD), 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 Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was	F 241	ensure that privacy, dignity and respect for the resident was being maintained. No concerns identified. 3. All Certified Nursing Assistants and Licensed Nursing Staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding resident privacy and dignity while providing care. This re-education will be completed by 11/26/14. 4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will observe incontinent care being provided 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.	11/27/14

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F 241	Continued From page 4 interviewable. Observation, on 10/08/14 at 9:40 AM, revealed CNA #1 and CNA #2 provided incontinent care for Resident #3 with the privacy curtain pulled the length of the bed (not pulled completely around the bed) and left the resident's door open. The resident was left in view of anyone who may entered the room or went to the side of the resident's room. Interview with Resident #3, on 10/13/14 at 4:25 PM, revealed he/she was not aware the door was open and the privacy curtain was not pulled completely around the bed. The resident stated the curtain should have been completely closed. Interview with CNA #1, on 10/08/14 at 9:44 AM, and CNA #2 on 10/08/14 at 9:45 AM, revealed they would normally close the resident's door and pull the privacy curtain completely around the bed to provide privacy when performing incontinent care but they forgot too. Interview with the Unit Manager, Registered Nurse (RN) #1, on 10/08/14 at 4:05 PM, revealed the facility's policy said to pull the curtain when providing care and the curtain should have been pulled all the way around the bed. She stated the policy does not specify the door has to be shut but should be at least one or the other. Interview with the Director of Nursing (DON), on 10/08/14 at 4:07 PM, revealed she expected staff to provide each resident full privacy as the policy stated. She stated the curtain should have been pulled completely around the bed or the door shut to the residents room.	F 241		

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F 241	Continued From page 5 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 241		
F 281 SS=F	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 Kentucky Board of Nursing Advisory Opinion Statement, AOS #14, last revised 10/20/10, it was determined the facility failed to have a system in place to ensure orders written on a Progress Note would be transcribed to a Physician's Telephone Order to ensure physician's orders were followed for two (2) of seven (7) sampled residents (Resident #1 and Resident #2). On 09/15/14 at 4:00 PM, Resident #1 was assessed to have lethargy, fever and tachypnea (Rapid breathing) with complaints of feeling bad and was ordered Rocephin (antibiotic) one (1) gram (g) intramuscular (IM) now. Review of the Nurses Notes revealed the Rocephin injection was not received until the next day 09/16/14 at 11:15 AM. On 09/16/14, the facility assessed Resident #2 to have Hematuria (blood in urine) and lethargy (lack of energy) and was ordered an Urinalysis with Culture and Sensitivity. Review of the medical record and interview with the Director of	F 281	1. Medication error form was completed for Resident #1 relating to Rocephin being given the day after the order was written and disciplinary action given on 9/16/14. The Rocephin for resident # 1 was transcribed and given on 9/17/14. Disciplinary action and education relating to following Physician orders was given to licensed staff on 10/13/14 by the Education Training Director. On 10/10/14 the physician was notified of the Urinalysis order not transcribed on resident # 2 by Unit Manager with no further orders noted. 2. DON, ADON and Unit Managers reviewed all Nurse Practitioner and Physician notes for the past 60 days on 10/20/14 to ensure all Physician orders were transcribed. No issues noted. 3. All licensed staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding following Physician orders and transcription to	

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F 281	Continued From page 6 Nursing revealed the order was missed and the Urinalysis with Culture and Sensitivity was never obtained. Interview with the DON, on 10/15/14 at 9:46 AM, revealed the facility did not have a system to ensure the orders written on the Progress Notes by the physician were not missed. The findings include: Review of the Kentucky Board of Nursing Advisory Opinion Statement, AOS #14, last revised 10/20/10, revealed "Registered Nursing Practice" and "Licensed Practical Nurse" were expected to administer medication and treatment as prescribed by physician, physician assistant, dentist or advanced practice registered nurse. 1. Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Diabetes Mellitus, Peripheral Vascular Disease, Hypertension, and Atherosclerotic Cardiovascular Disease. Review of a Quarterly Minimum Data Set (MDS) assessment dated 08/27/14, revealed the facility assessed Resident #1's mental status as cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of "99" which indicated the resident was not interviewable. Review of a Progress Note written by the Advanced Practice Registered Nurse (APRN), dated 09/15/14 at 4:00 PM, revealed Resident #1 was assessed by the ARNP to have dark urine, lethargy, fever, and tachypnea (rapid breathing). Further review of the Progress Note revealed the ARNP documented she wanted a chest x-ray, Complete Blood Count (CBC), Complete	F 281	phone order. This re-education 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 or the Unit Manager will review all 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.	11/27/14

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F 281	Continued From page 7 Metabolic Panel (CMP), Urinalysis with Culture and Sensitivity, and Rocephin one (1) Gram (g) intramuscular (IM) now after labs drawn. Further review revealed Levaquin (an antibiotic) 500 milligrams (mg) per gastrostomy tube (g-tube) daily for ten (10) days. Review of a Telephone Physician's Order, dated 09/15/14 (no time), revealed Physician Orders for the chest x-ray, CBC, CMP, Urinalysis with Culture and Sensitivity and Levaquin were transcribed as ordered; however, the order for the Rocephin injection was missed. Review of the September 2014 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no documented evidence the injection was administered. Review of a Nurses Note, dated 09/16/14 at 11:15 AM, revealed Rocephin 1 g. given as ordered. However, the medication was ordered on 09/15/14 at 4:00 PM. Interview with Licensed Practical Nurse (LPN) #2, on 10/13/14 at 2:38 PM, revealed she discovered the Rocephin injection in Resident #1's medication drawer and realized the injection had been missed. She stated she notified the Unit Manager Registered Nurse (RN #1) and administered the injection as ordered. She further stated she erroneously documented the injection on the wrong resident's MAR. Interview with the Unit Manager RN #1 on 10/13/14 at 3:00 PM revealed she notified the ARNP of the missed order and received a new verbal order to administer the injection as a "now"	F 281		

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F 281	Continued From page 8 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 were not obtained as ordered. Interview with the Unit Manager RN #1, on 10/15/14 at 9:25 AM, revealed when the	F 281		

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F 281	Continued From page 9 physicians make rounds at the facility they document their orders on a Progress Note and fold/flag the page to alert the nurse of new orders. The nurse will transcribe the order onto a carbon copy telephone order. She stated the original order is placed in a bin at the nurse's stations and copies are made and distributed to the Unit Managers, the DON and the MDS Coordinators to ensure appropriate follow up of the orders. She stated the Interdisciplinary Team which included all the Unit Managers, the MDS Coordinators, the Director of Nursing and all Department Heads attended a daily morning meeting where they reviewed all new telephone orders. She further stated they met again each day at approximately 1:30 PM to follow up on the orders. She stated the facility did not have a system in place to ensure the orders were transcribed from the Progress Notes and it was possible for orders to be missed. Interview with the DON, on 10/15/14 at 9:46 AM, revealed the facility did not have a tracking system to ensure the orders written on the Progress Notes by the physician were not missed. She stated she expected the Unit Managers to make rounds with the physician and ensure all new orders were transcribed onto a telephone order for tracking.	F 281	1. On 10/20/14 the Director of Nursing reviewed resident #2 care plans to determine if all care plan interventions were in place and review of the resident and the medical record revealed that all care plan interventions were in place. 2. By 11/24/14 the Director of Nursing, Assistant Director of Nursing, MDS Nurses and Unit Managers reviewed all current resident's care plans to determine if all interventions were being followed. Any concerns identified were immediately corrected. 3. 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 meet the needs of the resident including following physician orders and timely follow up on lab results as well as ongoing assessment This re-education will be completed by 11/26/14.	
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.	F 282	4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will audit five (5) resident care plans per week for twelve (12) weeks to ensure that interventions are followed. The results of these	

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	185087	A. BUILDING _____ B. WING _____	C 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

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F 282	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one (1) of seven sampled residents (Resident #2). Resident #2 was care planned for facility staff to monitor for signs and symptoms of dehydration and to monitor labs as ordered. On 09/16/14 at 9:00 AM, Resident #2's was assessed by the Advanced Practice Registered Nurse (APRN) to have a dry tongue and mouth with poor oral intake and a new order was received to obtain a Basic Metabolic Panel (BMP) "today" to assess for dehydration. The BMP was obtained on 09/16/14 at 2:00 PM; however, the facility did not obtain the results until 09/17/14 at 10:36 AM. The physician was not notified of the results until 4:49 PM approximately six (6) hours later when a new order was received to administer intravenous (IV) fluids. A Nurse's Note, dated 09/17/14, revealed the intravenous fluids were not started until 10:37 PM. There was no documented evidence the resident was monitored for signs and symptoms of dehydration from the time the resident was assessed for having a dry tongue/mouth through the next evening when the resident received the ordered IV fluids (approximately thirty-seven and a half hours). The findings include: 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	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 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.	11/27/2014

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F 282	Continued From page 11 acute and chronic needs of the resident living in the facility. 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 the Comprehensive Care Plan dated 04/01/14, revealed Resident #2 was at risk for alteration in nutrition due to decreased fluid intake and had interventions for facility staff to monitor for signs and symptoms of dehydration and to monitor labs as ordered. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 06/25/14, revealed the facility assessed Resident #2 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of thirteen (13) indicating the resident was interviewable. Review of a Progress Note, dated 09/16/14 at 9:00 AM, revealed the resident had complaints of a swollen tongue and was assessed by the APRN to have signs and symptoms of dehydration. The ARNP noted the resident had a dry mouth, a dry throat and poor oral intake. Review of a Physician's Order, dated 09/16/14, revealed new orders for a Basic Metabolic Panel (BMP) "today". Review of a Laboratory Report, dated 09/17/14 at 10:36 AM, revealed a BMP was collected on 09/16/14 at 2:00 PM with a Blood Urea Nitrogen (BUN) of 47 milligrams per deciliter (mg/dl)	F 282		

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F 282	Continued From page 12 (normal 7-22), a sodium level of 153 millimoles per liter (mmol/l) (normal 136-146 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). 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. Interview with LPN #3, on 10/13/14 at 2:30 PM,	F 282		

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F 282	Continued From page 13 revealed she was the nurse for Resident #2 on 09/16/14. She stated she instructed the CNA's to encourage fluids and to increase oral care to every two (2) hours as ordered. When asked how she monitored Resident #2 throughout her shift she stated she could not recall. She further stated she would have documented any assessments in the Nurse's Notes. Review of the Nurses Notes, dated 09/16/14, revealed there was no documented evidence that Resident #2 was assessed. Interview with the Director of Nursing (DON), on 10/17/14 at 5:30 PM, revealed the nurses provide ongoing assessments per the plan of care and if they had concerns they would notify the physician. Interview with the Administrator, on 10/17/14 at 5:45 PM, revealed Resident #2 was monitored for change of condition as that is the normal routine of the nurse. Interview with the ARNP, on 10/09/14 at 4:45 PM; and, on 10/10/14 at 8:40 AM, revealed she assessed Resident #2 on 10/16/14 for complaints of a swollen tongue and ordered the BMP for possible dehydration. She stated she would have expected the nurses to have followed up on the lab result the same day it was ordered. She further stated the staff cannot assess every patient every shift, everyday, with all the chronic conditions the residents have.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 14 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy and procedures it was determined the facility failed to provide services to attain or maintain the highest practicable physical, mental and psychosocial well-being according to the comprehensive care plan for one (1) of seven (7) sampled residents (Resident #2). The facility failed to provide ongoing assessments of a resident for dehydration from the time he/she was identified as having a dry tongue on 09/16/14 at 9:00 AM until 09/17/14 at 10:37 PM when intravenous fluids were administered. The findings include: Interview with the Director of Nursing (DON), on 10/17/14 at 5:30 PM, revealed the facility had no policy regarding a resident with a significant change in condition. The (DON) stated the expectation was to use the Interact Two (2) System for physician notification and change of condition. She further stated the physician notification and change in condition should be noted in the Nursing Progress Notes. Record review revealed the facility re-admitted Resident #2 on 04/01/14 with diagnoses which included Diabetes Mellitus, Hypertension, Anxiety	F 309	1. Resident #2 was assessed for signs of dehydration by the Unit Manager on 10/14/14. No issues noted. 2. On 10/20/14, the Director of Nursing, Assistant Director of Nursing, Unit Managers and Licensed Staff reviewed all resident's current condition to determine any that needed ongoing assessment. Any requiring ongoing assessment was listed on the every shift documentation list for follow up assessment and documentation 3. All licensed staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding ongoing assessment and use of the daily follow up log for ongoing monitoring. This re-education will be completed by 11/26/14. 4. The Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager will audit five (5) resident records per week for twelve (12) weeks to ensure use of follow up documentation log and ongoing assessment as needed. 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	

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F 309	Continued From page 15 Disorder, Chronic Kidney Disease, Congestive Heart Failure (CHF) Anemia, and Hypothyroidism. Review of the Comprehensive Care Plan, dated 04/01/14, revealed the resident was at risk for alteration in nutrition due to decreased fluid intake. Further review revealed interventions for facility staff to monitor for signs and symptoms of dehydration and to monitor labs as ordered. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 06/25/14, revealed the facility assessed Resident #2 as cognitively intact with a Brief Interview for Mental Status score of thirteen (13) indicating the resident was interviewable. Review of a Progress Note, dated 09/16/14 at 9:00 AM, revealed the resident had complaints of a swollen tongue and was assessed by the Advanced Practitioner Registered Nurse (APRN) to have signs and symptoms of dehydration. The APRN noted the resident had a dry mouth, a dry throat and poor oral intake. Review of a Physician's Order dated 09/16/14, revealed new orders for Basic Metabolic Panel (BMP) "today". Review of a Laboratory Report, dated 09/17/14 at 10:36 AM, revealed a BMP was collected on 09/16/14 at 2:00 PM with a Blood Urea Nitrogen (BUN) of 47 milligrams per deciliter (mg/dl) (normal 7-22), a sodium level of 153 millimoles per liter (mmol/l) (normal 136-146 mmol/L), Chloride 117 mmol/L (normal 96-110 mmol/L). Review of a Physician's Order, dated 09/17/14 (no time), revealed new orders for one half	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.	11/27/2014

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F 309	Continued From page 16 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 the IV (intravenous) was started and one half percent (0.5 %) normal saline was infused. 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 until 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 and the nurse for Resident #2 on 09/17/14. Further interview revealed LPN #1 received the order for the IV fluids, and was the nurse who started the IV. LPN #1 stated she monitored for signs and symptoms of dehydration as she checked on the resident throughout her shift (evening shift 3:00 PM-11:00 PM). She further stated she would have documented her assessments in the Nurse's Notes. However, review of the Nurse's Notes revealed there was no documentation of any assessments Interview with the Director of Nursing (DON), on 10/17/14 at 5:30 PM, revealed the facility used Lippincott as the standards of practice as well as the Interact Two (2) System for notification and changes of condition. She further stated the nurses do provide ongoing assessments per the plan of care and if they had concerns they would notify the physician. She said the nurses always assessed the residents each time they entered the room and she didn't have any concerns there	F 309		

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F 309	Continued From page 17 was no documentation, because it just meant the staff didn't have any concerns. Interview with the Administrator, on 10/17/14 at 5:45 PM, revealed Resident #2 was monitored for change of condition as that was the normal routine of the nurse. She further stated it was acceptable practice to follow up on labs within a twenty-four (24) hour time as long as they were not ordered "STAT" (now). Interview with the ARNP, on 10/09/14 at 4:45 PM; and, on 10/10/14 at 8:40 AM, revealed she assessed Resident #2 on 10/16/14 for complaints of a swollen tongue and ordered the BMP for possible dehydration. She stated she would have expected the nurses to have followed up on the lab result the same day it was ordered. She further stated the staff cannot assess every patient every shift, everyday, with the resident's chronic conditions.	F 309		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to obtain laboratory services to meet the needs of the resident for one (1) of seven (7) sampled residents (Resident #2). The physician ordered a Urinalysis with Culture and Sensitivity for Resident #2 and the facility failed to obtain the labs.	F 502	1. The Nurse Practitioner was notified of the missed Urinalysis on 10/10/14 by Unit Manager with no further orders noted. 2. Unit Managers reviewed all physician orders for the past 30 days to ensure that lab work completed and results received as ordered. No issues noted.	

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F 502	Continued From page 18 The findings include: 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 Significant Change Minimum Data Set (MDS) assessment, dated 09/23/14, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of eleven (11) indicating the resident was interviewable. Review of a Progress Note, dated 09/16/14, revealed the Advanced Practitioner Registered Nurse wrote an order to obtain an Urinalysis and a Culture and Sensitivity. Review of the Laboratory Reports, since 09/16/14, revealed there was no documented evidence of the results of the Urinalysis or the Culture and Sensitivity requested by the Nurse Practitioner on 09/16/14. Interview with the Director of Nursing (DON), on 10/10/14 at 2:25 PM, revealed the Urinalysis and Culture and Sensitivity was ordered but it was not gotten. The DON stated the order had been missed by the nurse because she had failed to note the order and notify the laboratory of the order. She revealed the facility did not have a tracking system for laboratory orders; however, the expectation was that any orders written by the physician on a Progress Note were to be transcribed onto a Telephone Order. She stated there was a tracking system in place to monitor	F 502	3. All licensed staff will be reeducated by the Education Training Director, Director of Nursing, Assistant Director of Nursing or the Unit Manager regarding following physician orders and timely follow up on lab results. This re-education 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 or the Unit Manager will audit physician orders to ensure orders are implemented as written (5) times per week for one (1) week and three (3) times per week for three (3) weeks and weekly for two (2) weeks to ensure all labs are completed timely and results followed up on timely. 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	

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F 502	Continued From page 19 telephone orders. Interview with the Advanced Practice Registered Nurse (APRN), on 10/13/14 at 4:45 PM, revealed she expected facility staff to follow all orders.	F 502	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.	11/27/2014