STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	**06/12/2015**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0280 **Level of harm -** Actual harm **Residents Affected -** Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the emergency room (ER) record and hospital Discharge Summary, and facility policy review it was determined the facility failed to revise the care plan for one (1) of five (5) sampled residents (Resident #1). The facility admitted Resident #1 on [DATE] and care planned the resident for the assistance of one staff for ambulation and toileting on [DATE]. Interviews with staff revealed Resident #1 continuously got out of bed without asking for assistance, and would exit the bathroom into the wrong room and at times was found in the bed in that room. However, the facility failed to revise the care plan to address the resident's safety due to getting up without assistance and failed to address the resident's confusion when leaving the bathroom. On [DATE] at approximately 11:55 PM (per Nurse's Notes), Resident #1 was found in the adjacent room (room [ROOM NUMBER]) on the floor. Resident #1 was transferred to the hospital ER where he/she was admitted to the hospital with [REDACTED]. Resident #1 died in the hospital on [DATE]. The findings include: Review of the facility's policy titled, Clinical Quality Assurance and Performance Improvement (QAPI) Daily Review Process, dated [DATE], revealed the Nurse Assessment Coordinator and Assistant Director of Nursing (ADON)/ Director of Nursing (DON)/designee will ensure appropriate updates to the Comprehensive Care Plan and Accunurse Activities of Daily Living (ADL) care plan are carried out and communicated to the direct care staff and Interdisciplinary Team (IDT). Interview with the Director of Nursing (DON), on [DATE] at 10:10 AM, revealed there was no specific policy on Stop and Watch. However, interview with the Education and Training Director (ETD), on [DATE] at 2:05 PM, revealed the facility used Interact, (Interventions to Reduce Acute Care Transfers), a quality improvement program that focused on the management of acute change in resident condition. It included clinical and educational tools and strategies for use in every day practice in long-term care facilities. The ETD said one of the educational tools within the Interact system was Stop and Watch notepads used by direct care staff to report changes in residents' condition to licensed nurses. The ETD said she expected care plan interventions to be added for changes in condition, behavior changes, and if residents were not following directions. The ETD said the Stop and Watch process was covered during orientation. Record review revealed the facility admitted Resident #1 on [DATE], with [DIAGNOSES REDACTED]. Review of an Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 as alert and oriented to person, place, time, and purpose with no memory problem. Review of Resident #1's Comprehensive Plan of Care, dated [DATE], revealed the resident was at risk for fall/injury related to generalized weakness and compression fracture, with an intervention to refer to a plan of care in the voice-assisted, hands free documentation and communication system (AccuNurse Activities of Daily Living Care Plan) Review of the Activities of Daily Living (ADL) Plan of Care, dated [DATE], revealed the resident required one (1) person physical assistance for ambulation, bathing and dressing. Toileting cautions listed on the plan of care included assistance needed for toileting transfer, do not leave unattended in bathroom and high risk for falls. Review of a Nursing Note, dated [DATE] at 1:44 AM, revealed Resident #1 was found on the floor in the adjoining room (room [ROOM NUMBER]). The resident told staff he/she went to the bathroom and exited the wrong door into the wrong room. The resident stated he/she fell on to his/her back and when trying to get up rolled onto his/her right side. The resident was assessed with [REDACTED]. The Primary Care Physician was notified and the resident was sent to the ER for evaluation. Review of Resident #1's ER record, dated [DATE], revealed, Clinical Impression 1. Fall from slipping, tripping or stumbling, 2. Closed left [MEDICAL CONDITION]. Review of the resident's Hospital Discharge Summary, dated [DATE], revealed the resident was admitted and surgery was planned; however, the resident's condition declined and it was determined the resident would not survive surgery. Palliative care was provided and the resident expired on [DATE]. Interview with Certified Nurse Aide (CNA) #5, on [DATE] at 8:10 AM, revealed she worked the North Unit and had witnessed Resident #1 out of bed unassisted and reminded the resident to use the call light. The CNA worked on [DATE] from 11:00 PM to 7:00 AM and was told in report that Resident #1 was weak and that he/she could go to the bathroom on his/her own. The CNA said she was passing ice and when she entered Resident #1's room (108) she realized Resident #1 was not in the bed or in the bathroom. The CNA stated she told Licensed Practical Nurse (LPN) #2 and the two (2) of them split-up to do room checks. CNA #5 stated she opened the door to room [ROOM NUMBER], flipped on the light switch and saw Resident #1 lying on his/her side on the floor near the sink. CNA #5 stated the resident said he/she was in the bathroom, went out of the wrong bathroom door, was weak and fell . The resident said he/she did not know the time of the fall; the resident was complaining of left hip and lower back pain. CNA #5 stated LPN #2 came in and said not to move the resident. LPN #2 called the ambulance and the ambulance arrived between 11:45 PM and 12:00 AM. The resident was transferred to the hospital. Interview with LPN #2, on [DATE] at 8:55 AM, revealed she worked at the facility for five (5) years and floated to all units and shifts as needed. LPN #2 stated she worked on [DATE] from 11:00 PM to 7:00 AM on the North Unit. She stated she completed a bed check at 10:50 PM and Resident #1 was in the bed. The LPN said she was at the nurse's station completing paper work when CNA #5 asked her to come to room [ROOM NUMBER] because Resident #1 was not in his/her bed or bathroom. LPN #2 stated she and the CNA divided all the rooms and began searching for Resident #1 and after approximately ten (10) minutes CNA #5 yelled she found Resident #1 in room [ROOM NUMBER], on the floor. The LPN stated Resident #1 was on the floor on his/her right side, holding his/her left leg. LPN #2 said the resident told her that he/she went to the bathroom alone, went out the wrong bathroom door, turned back toward the bathroom, realized he/she was going to fall and grabbed toward the sink and fell . The LPN said she did not move the resident due to the resident's history of fractures. CNA #5 remained with the resident while she (LPN #2) went to the nurse's station to call the doctor, family, on-call administration, and Emergency Medical Services (EMS). Interview with CNA #9, on [DATE] at 3:20 PM, revealed she previously worked full time on night shift until three (3) months ago and now worked an as needed schedule. The CNA said Resident #1 was care planned for assistance of one (1) and had a bad habit of getting out of bed at night and getting into an unoccupied bed in the adjacent room. CNA #9 said there was a resident in the bed near the door but the window bed was unoccupied and she had witnessed Resident #1 in the unoccupied bed. The CNA said she heard other staff say, keep an eye on the resident because he/she got turned around, and went into room [ROOM NUMBER]. CNA #9 said she told LPN #5 the night she found Resident #1 in the unoccupied bed in the adjacent room and LPN #5 said the resident just got turned around. In addition, CNA #9 said a couple nights prior to finding Resident #1 in the adjacent room in an unoccupied bed she saw Resident #1 walking down the hallway and she told LPN #5. CNA #9 said they usually began using bed alarms when a resident was getting out of bed without using the call light.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0280 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Interview with LPN #5, on [DATE] at 9:20 AM, revealed she remembered someone telling her Resident #1 was in an unoccupied bed in an adjacent room but she did not remember if she was working and she was unsure if she would have documented the incident. LPN #5 said Resident #1 was confused at times and might have gone out the wrong bathroom door because he/she was in a new environment. LPN #5 stated she did not remember anyone telling her the resident was walking down the hallway unassisted. Interview with CNA #7, on [DATE] at 2:25 PM, revealed Resident #1 would not call for assistance prior to getting out of bed. CNA #7 said he told a nurse about Resident #1 getting out of bed alone but did not remember which nurse he told. The CNA said he did not remember who he told and he did not complete a Stop and Watch form. Interview with CNA #13, on [DATE] at 10:30 AM, revealed she usually worked day shift on the South Unit but worked on the North unit on [DATE] and [DATE]. The CNA said Resident #1 was an assist of one. The CNA stated she witnessed the resident in the bathroom unassisted and re-educated him/her on use of the call light. CNA #13 said she did not tell the Charge Nurse the resident was out of bed unassisted. Interview with LPN #7 on [DATE] at 12:00 PM, revealed she expected staff to notify the Charge Nurse when a resident was care planned for assistance with ambulation and repeatedly getting out of bed without assistance. Interview with LPN #8, on [DATE] at 11:15 AM, revealed the CNAs should notify the Charge Nurse when a resident, who was care planned for one assist, was out of bed unassisted to ensure appropriate interventions were care planned to prevent falls. In addition, the LPN said she expected staff to complete a Stop and Watch form and consider additional interventions when needed. Interview with LPN #4 on [DATE] at 5:30 PM, revealed she expected staff to notify her when a resident was care planned for assistance of one (1) person, and was observed out of bed without assistance. The LPN said additional interventions should be added to keep it from happening again. Interview with LPN #6, on [DATE] at 11:20 AM, revealed she expected staff to tell her when a resident was observed out of bed without assistance and care planned for one (1) person assist. In addition, the LPN said she would add a bed alarm or fall mat alarm if a resident was repeatedly observed out of bed without assistance. Interview with Registered Nurse (RN) #1, on [DATE] at 11:35 AM, revealed she was the Unit Manager on the North Unit until about three (3) months ago and currently worked as a Charge Nurse on the South Unit on twelve (12) hour day shifts. The RN said she expected staff to encourage use of the call light and consider a bed alarm when a resident was care planned for a one (1) person assist and witnessed out of bed without assistance. Interview with the Unit Manager (UM) of the North and South Units, on [DATE] at 12:25 PM, revealed she was hired on [DATE]. The UM said staff should notify the nurse if a resident was getting up unassisted and was care planned for one (1) person assist. She said other interventions would be considered to ensure the resident's safety. Further review of Resident #1's Comprehensive Plan of Care, dated [DATE], revealed there was no documented evidence the facility revised the care plan to address the resident's ambulating without assistance and the resident's confusion when leaving the bathroom. Interview with the Director of Nursing (DON), on [DATE] at 3:30 PM, revealed CNAs should complete a Stop and Watch form to alert other staff of a change in behavior. The DON said they had been using the Stop and Watch system for about a year and the CNAs were good about using the system. Interview with the Administrator, on [DATE] at 12:50 PM, revealed she expected the CNAs to complete a Stop and Watch form if they witnessed a change in the resident. In addition, the Administrator said she had total responsibility over the building.
F 0281 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and procedure, and review of Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure services provided by the facility met the professional standards of quality for one (1) of four (4) sampled residents (Resident #1). The facility failed to ensure Resident # 1 received [MEDICATION NAME]-[MEDICATION NAME] (for pain) in accordance with the Physicians' Orders. In addition, Medication Cart B, located on the skilled hallway, was observed to be unattended and unlocked. The finding include: Review of the facility's policy entitled Medication Administration, undated, revealed the licensed nurse and/or medication assistant should check to ensure the right medication, right dose, right dosage form, right route, right resident and right time prior to administration of medication. Further review revealed the Medication Administration Record (MAR) should be read for ordered medication, dose, dosage form, route, and time. The medication administration and the reason for administration and effectiveness of as needed (PRN) medications should be documented on the MAR as soon as medications are given. In addition, the licensed nurse and/or medication assistant should never leave the medication cart open and unattended. 1. Review of KBN AOS #14 Patient Care Orders, last revised 10/14/15, revealed licensed staff should administer medication prescribed by the Physician/Advanced Practice Registered Nurse and prepare and give the medication in the prescribed dosage, route, and frequency. Record review revealed the facility admitted Resident #1 on 04/14/15, with [DIAGNOSES REDACTED]. Review of an Admission Data Set, dated 04/15/15, revealed the facility assessed Resident #1 as alert and oriented to person, place, time, and purpose with no memory problem. Review of Resident #1's Physician Order, dated 04/16/15, revealed an order to change [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg (narcotic pain medication) to two (2) tablets every six (6) hours as needed (PRN) for pain. Review of Resident #1's April 2015 Medication Administration Record (MAR), revealed an order dated 04/16/15 for [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg, give two (2) tablets by mouth every six (6) hours as needed for pain. Further review of the MAR and the controlled substance sign out sheet revealed licensed staff administered the medication every four (4) hours verses every six (6) hours as ordered on [DATE] at 8:00 PM; on 04/17/15 at 12:00 AM; and, on 04/17/15 at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. Interview with Licensed Practical Nurse (LPN) #1, on 06/03/15 at 4:45 PM, revealed she reviewed Resident #1's April 2015 MAR, physician's orders [REDACTED]. The LPN stated she had made a medication error as she had administered the medication in four (4) hours instead of (6) hours as ordered. Interview with the Educator and Training Director (ETD), on 06/08/15 at 2:05 PM, revealed when the eMAR (electronic Medication Administration Record) was used correctly the computer would not allow the nurse to sign out a controlled substance until the appropriate time had elapsed. She said the facility began using eMAR in March 2015 and some staff was not using the system correctly at first. Interview with the Medical Director, at 06/11/15 at 7:30 AM, revealed staff should administer medications as ordered by the MD. He stated he was not aware of any medication errors pertaining to Resident #1. 2. Observation on 06/04/15 at 9:25 AM revealed Medication Cart B, located on the Skilled Unit hallway, was unlocked and unattended. The medication nurse, LPN #8 was observed to be across the hallway in resident room [ROOM NUMBER], at this time. LPN #7 was observed to be walking down the hallway and went over to the medication cart, locked the cart, then entered room [ROOM NUMBER] and informed LPN #8 she had locked the medication cart. Observation of the Medication Cart B, on 06/04/15 at 9:53 AM with the UM of the Skilled unit, revealed insulin syringes, lancets and needles were in the top drawer of the medication cart. In addition, when the UM opened the narcotic drawer the top was not locked. The UM informed LPN #8 that the narcotic box should be locked even when the medication cart was locked. Interview with LPN #8, on 06/04/15 at 9:58 AM, revealed she thought she locked the medication cart when she left the cart and went into room [ROOM NUMBER]. In addition, LPN #8 said she thought the narcotic box was locked and she was not used to this cart. The LPN said she passed medications on all units and Medication Cart B was not different from any of the other medication carts in the facility. Interview with the UM of Skilled Unit, on 06/04/15 at 9:45 AM, revealed the medication nurse should lock the medication cart

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F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) when she walked away. The UM said leaving a medication unlocked was a potential problem because someone could get into the cart and wanderer's could access the medication cart. The UM said there were thirty six (36) residents on the skilled units A/B; and, five (5) wanderers. The UM said the narcotic box should be locked at all times unless the nurse was removing a medication from the box. Interview with the Director of Nursing (DON), on 06/08/15 at 10:00 AM, revealed staff were to follow the physician's orders [REDACTED]. Interview with the Administrator on 06/12/15 at 12:50 PM, revealed staff should follow the medication administration policy, keep medication carts and narcotic lids locked and administer medications according to physician's orders [REDACTED].
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of a hospital radiology report, a facility Incident Report, facility Fall Investigation, facility policy and Manufacturer's instructions for the sit to stand lift, it was determined the facility failed to ensure services were provided by qualified persons for one (1) of five (5) sampled residents (Resident #4) related to the use of a Sit to Stand Lift. On 06/03/15, Resident #4 was assisted with a Sit to Stand lift in the shower room; however, the Certified Nurse Aide (CNA) failed to ensure the safety belt was applied snugly according to manufacturer directions. Resident #4 slipped from the sling onto his/her knees, was assisted to the floor with the resident's right leg bent at an approximate forty five (45) degree angle and his/her right foot was beneath the wheelchair. Three (3) CNAs then lifted the resident and placed him/her in a wheelchair without having a licensed staff assess the resident. Resident #4 was not assessed by licensed staff until the resident was returned to his/her bedroom. The facility failed to ensure staff was qualified to use the lift in a safe manner. Resident #4 was transferred to the hospital emergency room (ER) where he/she was admitted to the hospital with [REDACTED]. The findings include: Review of the facility's policy entitled, Safe Patient Handling and Movement Policy, last revised 10/31/13, revealed documentation to include the facility intended residents were cared for safely and mechanical lifting equipment should be used to prevent manual lifting and handling of residents. Staff should complete and document training initially and annually as needed; all transfers with mechanical lifts should be done with a minimum of two (2) persons or as specified in resident's Plan of Care and injuries resulting from resident handling and movement should be reported pursuant to the facility policy. Review of the facility document titled, Resident Handling Observation Instructions, undated, revealed the facility should complete a minimum of two (2) observations each month to comply with Occupational Safety and Health Administration (OSHA) and State Patient Handling laws. In addition, the document provided instructions of how to complete the Resident Handling Observation Form. Further review of the document revealed all new hires must be observed conducting a resident transfer with and without a lift and kept in the employee file.!!! Review of the facility's procedure titled, Procedure For Using Sit to Stand Lift, undated, revealed documentation to include fasten the safety belt around resident's waist and adjust to a snug but comfortable fit. Review of the Manufacturer User Manual for the Sit to Stand Lift, last revised 2010, revealed the belt should be snug, otherwise the resident could slide out of the sling during transfer, possibly causing injury and residents were not to be raised to a full standing position while using the transfer sling as injury may occur. In addition, the user manual revealed, individuals that use the standing resident sling must be able to support the majority of their own weight, otherwise injury may occur. Record review revealed the facility admitted Resident #4 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Review of Resident #4's Comprehensive Care Plan, dated 02/03/15, revealed the resident was a high risk for falls and injury and should be transferred with Sit to Stand lift. Review of the AccuNurse plan of care custom notes (CNA care plan) revealed Resident #4 required a Sit to Stand Lift to transfer from 09/08/12 through 06/08/15. Interview with CNA #21, on 06/10/15 at 3:50 PM, and review of his/her written statement dated 06/03/15, revealed Resident #4 was injured on 06/03/15 at approximately 5:00-5:30 PM. The CNA said she and CNA #20 used the Sit to Stand Lift to transfer the resident from his/her recliner to the wheelchair and from the wheelchair to the shower chair; however, after the shower the CNAs used the Sit and Stand Lift to stand the resident while they dried him/her in the shower room and the resident's legs buckled and his/her feet came off the platform. The CNA said she thought the sling belt was fastened but not tight enough because the sling slid upward under the resident's arms when his/her feet slid back. The CNA said she thought the belt was too loose because the sling was moving upward and the resident was moving downward. She said they were unable to place the wheelchair beneath him/her so they lowered the resident to the floor with the resident's right leg bent. CNA #21 said she, CNA #20 and CNA #22 lifted the resident from the floor to his/her wheelchair, pushed the resident in the wheelchair to his/her room and transferred the resident back to bed using the Sit to Stand Lift. The CNA said she told Licensed Practical Nurse (LPN) #1 the resident complained of knee pain and the LPN asked him/her where the pain was and the resident pointed to his/her knee. The CNA said by 6:45 PM the resident's upper right leg was swollen compared to his/her upper left leg. CNA #21 said she asked the oncoming nurse, LPN #9, to check on Resident #4. Review of CNA #21's personnel record revealed the Resident Handling Observation form, dated 02/11/15, was blank and signed by the CNA. There was a form with step by step instructions of the use of the sit to stand lift; however, further review revealed there was no documented evidence CNA 21 had been observed conducting a resident transfer with and without a lift per the facility Resident Handling Observation Instructions . Interview with CNA #20, on 06/11/15 at 3:15 PM, revealed CNA #20 had never used a Sit to Stand Lift at this facility or any other place where she had worked. The CNA said during classroom orientation she reviewed and signed a form with written systematic instructions for use of a Sit to Stand Lift. CNA #20 said she was not required to return demonstrate the proper use of the Sit to Stand lift for skills check-off and had no hands on experience in using the Sit to Stand Lift. CNA #20 said she was in training and observed and assisted CNA #21 on 06/03/15. CNA #20 said she assisted CNA #21 using the Sit to Stand Lift to transfer Resident #4 from his/her recliner to the wheelchair and from the wheelchair to the shower chair. CNA #20 said they finished the shower and put a gown on the resident and CNA #20 fastened the standing sling loops to the Sit to Stand arm pegs then fastened the safety belt around the resident's waist. The CNA indicated she should have fastened the safety belt around the resident's waist before she fastened the standing sling loops to the Sit to Stand arm pegs and she did not tighten the belt. The CNA said they lifted the resident to a full upright position and when the resident's knees buckled, they lowered the resident to his/her knees. The CNA said the sling slipped upward underneath the resident's arms. CNA #20 stated she, CNA #21 and CNA #22 then lifted the resident from the floor to the wheelchair, pushed the resident to his/her room and used the Sit to Stand Lift to transfer the resident from the wheelchair to the bed. The CNA said LPN #1 came into the resident's room and asked the resident if he/she was in pain. Review of CNA #20's personnel record, revealed no documented evidence of the CNA #20 receiving/attending Resident Handling Observation in her record. There was a form with step by step instructions of the use of the sit to stand lift; however, further review revealed there was no documented evidence CNA 20's had been observed conducting a resident transfer with and without a lift per the facility Resident Handling Observation Instructions. Interview with CNA #22, on 06/11/15 at 4:20 PM, revealed she was asked to assist CNA #20 and CNA #21. CNA #22 said Resident #4 said, They broke my leg, they broke my leg. She said her and the other two CNA's lifted the resident from the floor to the wheelchair, rolled the resident to his /her room, and used the Sit to Stand Lift to transfer the resident from the wheelchair to the bed. CNA #22 revealed Resident #4 was crying with pain. In addition, CNA #22 said prior to this the resident used to self propel short distances in his/her wheelchair, went to the dining room for meals and enjoyed looking out the window. The CNA said now the resident was a complete feed, was in bed all of the time, and seemed to be in pain or sleeping most of the time. Interview with LPN #1, on 06/12/15 at 9:25 AM, revealed on 06/03/15 at approximately 6:00-6:30 PM, a CNA told her Resident #4 fell . The LPN said she assumed the resident fell in his/her room because the Sit to Stand Lift was in the resident's

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F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) room. LPN #1 said she assessed the resident's vital signs and range of motion and documented the information on an incident report. Further review of Resident #4's Departmental Notes, dated 06/04/15, revealed LPN #9 documented on 06/04/15 at 1:48 AM that CNA #21 asked her to evaluate Resident #4's right knee due to swelling and pain at approximately 7:30 PM on 06/03/15. The LPN documented CNA #21 informed her that Resident #4 had fallen to his/her knees during transfer from lift to shower chair. Further review revealed LPN #9 documented she found the resident's knee swollen and extremely tender to touch and movement, she notified the physician, the Assistant Director of Nursing (ADON), a family member and Emergency Medical Services. The resident was transferred to the emergency room (ER). Interview with LPN #9, on 06/12/15 at 11:30 AM, revealed she worked 06/03/15 from 7:00 PM until 7:00 AM. The LPN said CNA #21 approached her as soon as she entered the facility and requested she assess Resident #4 because the resident's knee was swollen and the resident was complaining of pain. LPN #9 said that during report LPN #1 had told her the resident had fallen. LPN #9 stated she finished report and then assessed Resident #4. LPN #9 stated the resident's upper right leg was swollen and he/she was complaining of pain. LPN #9 revealed she notified the physician, called EMS and the resident was transferred to the ER at approximately 8:00 PM. Review of a hospital radiology report, dated 06/03/15, revealed Resident #4 was diagnosed with [REDACTED]. Further record review revealed Resident #4 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #4's Comprehensive Care Plan, dated 06/06/15, was reviewed. Also, the reports noted the resident was placed on End of Life care related to [DIAGNOSES REDACTED]. Review of Resident #4's physician's orders [REDACTED]. Observation on 06/12/15 at 8:50 AM, revealed Resident #4 lying on the bed with eyes closed. Interview with RN #2 on 06/12/15 at 8:50 AM, revealed Resident #4 was not eating well, was declining and that the Resident's condition had deteriorated since earlier in the week. Review of the facility's Fall Investigation Worksheet completed by the Assistant Director of Nursing (ADON), dated 06/04/15, revealed Resident #4 fell during a transfer from the shower chair to the wheelchair using a Sit to Stand Lift and based on the fall investigation, Resident #4 was deemed unsafe for a Sit to Stand Lift and progressed to a Sling Lift for further transfers. The family requested comfort care measures. Interview with CNA #8, on 06/10/15 at 3:10 PM, revealed staff should not use a Sit to Stand lift if a resident was unable to hold the handle. She said the sling should catch a resident if they let go of the handle or slip and a resident could slip if the sling was not snug. CNA #8 said she had used the Sit to Stand lift to transfer Resident #8 and never had any problems. The CNA said there has not been any additional inservices or training since Resident #8 returned from the hospital. In addition, CNA #8 said Resident #8 used to feed self in the dining room and self propel in the wheelchair and now he/she moaned often and would rarely eat. Interview with CNA #23, on 06/10/15 at 2:35 PM, revealed there were four (4) Sit to Stand lifts and were stored in the shower rooms. The CNA said they used the under arm sling with the Sit to Stand lift. In addition, CNA #23 said she only received verbal instruction in training on the use of lifts. Interview with the Unit Manager of Skilled Unit on 06/15/15 at 7:50 AM, revealed she began working at the facility the first of June, 2015. She said it was her understanding Resident #4 was being transferred using the Sit to Stand lift and the resident's knees buckled and he/she was lowered to the floor. The Unit Manager said the staff were trained to use the lift with verbal instruction in the classroom. She said staff should be trained using a visual and hands on inservice. In addition, the UM said a nurse should assess before a resident is moved following a fall. Interview with the Director of Nursing (DON), on 06/11/15 at 10:10 AM, revealed she had CNA # 20 and CNA #21 return demonstrate the use of the Sit to Stand Lift and re-educated the two CNA's on 06/10/15. The DON said the CNAs' were very competent and the return demonstration revealed the sling was not tight enough and both CNAs' agreed. The DON said she showed the CNAs' how snug the sling should be fastened. The DON said training prior to using a lift should include education, a demonstration and staff return demonstrate and the person providing the education should sign the skills checklist when the return demonstration was correct. The DON said it was the facility's policy for staff to view a demonstration of the use of the lift and then do a return demonstration. She said the ETD was responsible and ultimately the DON was responsible. On 06/11/15 at 11:00 AM, the DON stated CNAs #20, CNAs #21 and CNAs #22 should not have moved Resident #4 prior to a nursing assessment following the assisted fall. Interview with the Administrator, on 06/12/15 at 12:50 PM, revealed the facility provided lift demonstration during orientation and there was no return demonstration by the orientates at that time but at some point during their first thirty (30) days of employment they were asked to return demonstrate the use of the lift for the skills check off. She said the orientates received hands on training when they worked on the nursing units. The Administrator said they were planning to implement hands on training during orientation.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation; interview; record review; review of the facility policy, Fall Investigation, and Incident Report; and review of the hospital emergency room (ER) record, Discharge Summary and Radiology Report; it was determined the facility failed to ensure adequate supervision to prevent accidents for two (2) of five (5) sampled residents (Residents #1 and #4). On [DATE], Certified Nurse Aide (CNAs) #20 and CNAs #21 transferred Resident #4 with a Sit to Stand Lift (mechanical lift) in the shower room. The facility failed to ensure Resident #4 was assessed for the use of the lift; and, failed to ensure the CNAs were trained and able to use the Sit to Stand Lift safety by return demonstration. Resident #4 slipped from the sling onto his/her knees with his/her leg bent at an approximate forty five (45) degree angle and his/her right foot beneath the wheelchair. CNAs #20 failed to apply the safety belt appropriately. Three (3) Certified Nurse Aides (CNAs) then lifted Resident #4 and placed the resident in his/her wheelchair without having licensed staff assess the resident prior to the transfer and wheeled the resident to his/her room and transferred the resident with the Sit to Stand Lift again. Resident #4 was transferred to the hospital emergency room (ER) and admitted with a [DIAGNOSES REDACTED]. Resident #4 returned to the facility on [DATE] on comfort measures. During the facility's investigation, the facility failed to identify that the resident had not been assessed for the use of the lift and the CNAs did not apply the belt correctly. Refer to F282 The facility failed to have an effective system in place to ensure Resident #1 received adequate supervision while ambulating and toileting. The facility readmitted Resident #1 on [DATE]. Licensed Practical Nurse (LPN) #8 failed to conduct the fall assessment per facility instructions. Resident #1 was care planned for one (1) person physical assist while ambulating and toileting. Interviews with staff revealed Resident #1 had difficulty walking, continuously got out of bed without asking for assistance, and would exit the bathroom into the wrong room and at times was found in another room, on the bed. However, staff failed to use the facility's Stop and Watch form to make licensed staff aware of the resident's actions to ensure Resident #1 had adequate supervision when ambulating. On [DATE] at approximately 11:15 PM, Resident #1 was found in an adjacent room (Room #106) at approximately 11:38 PM, on the floor. Resident #1 was transferred to the hospital ER where he/she was admitted to the hospital with [REDACTED]. Resident #1 died in the hospital on [DATE]. Refer to F280 The findings include: 1. Review of the facility's policy titled, Safe Patient Handling and Movement Policy, last revised [DATE], revealed the facility intended for residents to be cared for safely and mechanical lifting equipment should be used to prevent manual lifting and handling of residents. Staff should complete and document training initially and annually as needed, all transfers with mechanical lifts should be done with a minimum of two (2) persons or as specified in the resident's plan of care. Injuries resulting from resident handling and movement should be reported pursuant to the facility policy. Review of the facility's document, Resident Handling Observation Instructions, undated, revealed the facility should complete a minimum of two (2) observations each month to comply with Occupational Safety and Health Administration (OSHA) and State Patient Handling laws. In addition, the document provided instructions to complete the Resident Handling Observation Form. Further review of the document revealed All new hires must be observed conducting a resident transfer with and without a lift and kept in the employee file.

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) Review of the facility's procedure titled, Procedure For Using Sit to Stand Lift , undated, revealed to fasten the safety belt around resident's waist and adjust to a snug but comfortable fit. Review of the Manufacturer User Manual for the Sit to Stand Lift, last revised 2010, revealed the belt should be snug, otherwise the resident could slide out of the sling during transfer, possibly causing injury; and, residents were not to be raised to a full standing position while using the transfer sling as injury may occur. In addition, the user manual revealed, individuals that use the standing resident sling must be able to support the majority of their own weight, otherwise injury may occur. Record review revealed the facility admitted Resident #4 on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Interviews on [DATE] with the Quality Assurance (QA) Nurse at 4:00 PM, and with the Regional Director of Clinical Operations at 4:30 PM and further record review revealed there was no documented evidence of a Safety Device Assessment for the use of the Sit to Stand Lift for Resident #4. Review of Resident #4's Comprehensive Care Plan, dated [DATE], revealed the resident was a high risk for falls and injury and should be transferred with a Sit to Stand lift. The AccuNurse Plan of Care custom notes revealed Resident #4 required a Sit to Stand Lift to transfer from [DATE] through [DATE]. Interviews with CNAs #21 on [DATE] at 3:50 PM and CNAs #20 on [DATE] at 3:15 PM, revealed on [DATE] at approximately 6:,[DATE]:30 PM Resident #4 was injured. The CNAs stated they used the Sit to Stand Lift to transfer the resident from his/her recliner to the wheelchair, from the wheelchair to the shower chair; and, after the shower the CNAs used the Sit and Stand Lift to stand the resident while they dried him/her in the shower room. The CNAs revealed CNAs #20 fastened the standing sling loops to the Sit to Stand arm pegs then fastened the safety belt around the resident's waist but she did not tighten the belt. The CNAs stated they lifted the resident to a full upright position and when the resident's knees buckled, his/her feet came off the platform so they lowered the resident to his/her knees. The CNAs stated the sling slipped upward underneath the resident's arms because the safety belt was not fastened snugly. However, the Manufacturer User Manual for the Sit to Stand Lift specifically states the belt should be snug, otherwise the resident could slide out of the sling during transfer causing injury; and residents were not to be raised to a full standing position while using the transfer sling as injury may occur. The CNAs stated they asked CNAs #22 for assistance and they lifted the resident from the floor to his/her wheelchair, pushed the resident in the wheelchair to his/her room and transferred the resident back to bed using the Sit to Stand Lift without having licensed staff assess the resident prior to transfer. The CNAs stated they told LPN #1 the resident complained of knee pain and the LPN asked the resident where the pain was and the resident pointed to his/her knee. The CNAs said by 6:45 PM the resident's upper right leg was swollen compared to his/her upper left leg and CNAs #21 asked the oncoming nurse, LPN #9, to check on Resident #4. Review of the Incident Report for Resident #4, dated [DATE] at 6:00 PM, revealed the resident's knees buckled during a sit to stand lift transfer to the resident's bed and the staff assisted the resident to the floor. Further review of the report revealed the resident sustained [REDACTED]. The immediate action taken was to assist the resident to bed. Further review revealed the report was prepared by LPN #1, and witnessed by CNAs #21. however, interview with CNAs #21, on [DATE] at 3:50 PM, revealed the incident report was not accurate as Resident #4 sustained the fall in the shower room and complained of pain to the left knee. Interview with Licensed Practical Nurse (LPN) #1, on [DATE] at 9:25 AM, revealed a CNAs told her Resident #4 fell . The LPN said she assumed the resident fell in his/her room because the Sit to Stand Lift was in the room and had she known the resident fell in the shower room, she would have treated the situation differently. She stated at the time of the fall she should have asked the CNAs how his/her knees buckled and how his/her feet went out and where the resident fell because it did not make sense to her, she said at the end of the day, after eleven (11) hours of a twelve (12) hour shift she was exhausted. LPN #1 said she assessed the resident's vital signs and range of motion and documented the information on an incident report. The LPN said she normally would have documented in the Nursing Notes but the day was crazy busy and by the end of the twelve (12) hour shift she was exhausted. The LPN said she should have reprimanded the CNAs for moving the resident and not following protocol. Further review of Resident #4's Departmental Notes, dated [DATE], and interview with LPN #9, on [DATE] at 11:30 AM, revealed on [DATE] at approximately 7:30 PM, CNAs #21 approached LPN #9 as soon as she entered the facility and asked her to evaluate Resident #4's right knee due to swelling and pain. CNAs #21 informed LPN #9 that Resident #4 had fallen to his/her knees during a transfer from the lift to shower chair. LPN #9 assessed the resident and determined the resident's knee was swollen and extremely tender to touch or movement so she notified the physician, the Assistant Director of Nursing (ADON), a family member and Emergency Medical Services (EMS). The resident was transferred to the ER approximately 8:00 PM. Review of a hospital Radiology Report, dated [DATE], revealed Resident #4 was diagnosed with [REDACTED]. Interview with a hospital Radiologist, on [DATE] at 10:40 AM, revealed the resident had sustained a displaced fracture of the distal femur near the knee. The Radiologist said this type of fracture occurred due to trauma, osteoporosis, a bone lesion, or a twist. In addition, the Radiologist said it would not take much to result in a fracture if a resident had osteoporosis. Further record review revealed Resident #4 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's Comprehensive Care Plan, dated [DATE], revealed the resident was placed on End of Life care related to [DIAGNOSES REDACTED]. Review of Resident #4's Physician's Orders, dated [DATE], revealed the resident's pain was uncontrolled and his/her pain medication was changed to Roxanol (for pain) 20 mg/ml, give 0.5 ml (10 mg) sublingually every two (2) hour as needed for pain. Observation on [DATE] at 8:50 AM, revealed Resident #4 lying in bed with eyes closed. Interview with RN #2 on [DATE] at 8:50 AM, revealed Resident #4 was not eating well, was declining and Resident #4's condition had deteriorated since earlier in the week. Further interview with CNAs #20, on [DATE] at 3:15 PM, revealed she had never used a Sit to Stand Lift at this facility or any other place where she had worked. The CNAs said during classroom orientation she reviewed and signed a form with written systematic instructions for use of a Sit to Stand Lift but she was not required to do a return demonstration of the proper use of the Sit to Stand lift for skills check-off. Review of Resident #20's and Resident 21's personnel records, revealed there was no Resident Handling Observation in Resident #20's record and a blank form in Resident #21's record. There was a form with step by step instructions of the use of the sit to stand lift in both personnel records; however, further review revealed there was no documented evidence CNAs #20 and CNAs #21 had been observed conducting a resident transfer with and without a lift at the time of hire per the facility's Resident Handling Observation Instructions. Review of the facility's Fall Investigation Worksheet completed by the Assistant Director of Nursing (ADON), dated [DATE], revealed Resident #4 fell during a transfer from the shower chair to the wheelchair using a Sit to Stand Lift and based on the fall investigation, Resident #4 was deemed unsafe for a Sit to Stand Lift and progressed to a Sling Lift for further transfers. The family requested comfort care measures. Further review revealed there was no evidence the facility identified a device assessment had not been conducted and no evidence the facility had identified the aides had not received hands on training on the use of a lift or had to complete a demonstration of the use of the lift. Further interview with the QA Nurse, on [DATE] at 9:30 AM, revealed there were twenty-eight (28) residents out of one-hundred twenty (120) residents who were transferred using a lift and ten (10) out of the (28) residents were transferred using a Sit to Stand Lift. The QA Nurse stated, prior to [DATE], two (2) of the (28) residents had been assessed for the safe use of the lift. Interview with the Director of Nursing (DON), on [DATE] at 10:10 AM, revealed the facility had determined the root cause of Resident #4's fall/fracture was a status change and the resident could no longer bear weight. She stated the sling should hold a resident if their legs slipped and she believed Resident #4's sling was not tight enough. She said on [DATE], CNAs #20 and CNAs #21 demonstrated use of the Sit to Stand lift and the CNAs told the DON the sling was not snug when they attempted to transfer Resident #4 from the shower chair. The DON said this should have been investigated on Thursday [DATE]. She said the investigation was ongoing and the root cause was the resident's inability to stand up and bear weight and the improper application of the sling contributed to the assisted fall. She said according to the incident report the fall happened in the resident's room; however, the investigation revealed the fall happened in the shower room. Interview with the DON, on [DATE] at 10:55 AM, revealed the CNAs told her the reason they did not notify the nurse prior to moving the resident was because they did not realize it was considered a fall since they lowered the resident to the floor. She

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) said staff should never move a resident after a fall, assisted-fall etc, they should get a nurse. The DON said she expected staff to be trained on lifts on hire and as needed and she assumed new hires did hands on training and that was her expectation because that was their policy and procedure. Interview with the Administrator, on [DATE] at 12:50 PM, revealed use of the lift was demonstrated during classroom orientation then sometime during the first thirty (30) days of training the employee should be observed using the lift and a skills check off completed by the trainer. In addition, the Administrator said the staff received hands on training when they worked on the floor. The Administrator said there was no hands on training during orientation and they were planning to implement hands on training during orientation. In addition, the Administrator said lift assessments were completed sporadically in the past and now they were going to be more consistent. 2. Review of the facility's policy titled, Fall Assessment/Intervention Process, dated ,[DATE], revealed residents were to be assessed on admission for fall risk and appropriate interventions initiated to reduce the risk of injuries with falls. Further review revealed the Admission Nurse should evaluate the resident for fall risks, complete the Get Up and Go Assessment and initiate appropriate interventions to the fall care plan to minimize the risk for falls. Interview with the DON, on [DATE] at 10:10 AM, revealed there was no specific policy on Stop and Watch. However, interview with the Education and Training Director (ETD), on [DATE] at 2:05 PM, revealed the facility used Interact, (Interventions to Reduce Acute Care Transfers), a quality improvement program that focused on the management of acute change in resident condition. It included clinical and educational tools and strategies for use in every day practice in long-term care facilities. The ETD said one of the educational tools within the Interact system were Stop and Watch notepads used by direct care staff to report changes in residents' condition to licensed nurses. The ETD said she expected care plan interventions to be added for changes in condition, behavior changes, and if residents were not following directions. The ETD said the Stop and Watch process was covered during orientation. Record review revealed the facility admitted Resident #1 on [DATE], with [DIAGNOSES REDACTED]. Review of an Admission Assessment, dated [DATE], revealed the facility assessed Resident #1 as alert and oriented to person, place, time, and purpose, with no memory problem. Review of the facility's Electronic Documentation system revealed instructions for the Get Up and Go Assessment to include: 1. Have the person sit in the chair with their back to the chair and their arms resting on the arm rests. 2. Ask the person to stand up from a standard chair and walk a distance of ten (10) feet. 3. Have the person turn around, walk back to the chair, and sit down again. Timing begins when the person starts to rise from the chair and ends when he or she returns to the chair and sits down. Review of the Timed Get Up and Go Assessment, dated [DATE], revealed LPN #8 had marked Resident #1 as less than twenty (20) seconds, mostly independent. Interview with LPN #8, on [DATE] at 11:15 AM, revealed she completed Resident #1's Timed Get Up and Go Assessment. LPN #8 stated she has worked at the facility for six (6) or seven (7) years, and worked on all units as a Charge Nurse. She said the Charge Nurse was responsible for completing a four (4) page head to toe Admission Assessment in the electronic documentation system which included the Timed Get Up and Go Assessment. The LPN said the Timed Get Up and Go assessment was used as the fall risk assessment and the nurse should document if a resident was a one (1) or two (2) person assist. LPN #8 stated the Timed Get Up and Go Assessment was not timed. She stated you just look at how the resident's body is and how they move and check the appropriate box. However, review of the instructions for the Get up and Go Assessment revealed timing begins when the person starts to rise from the chair and ends when he or she returns to the chair and sits down. The LPN stated the box next to the comment, less than twenty (20) seconds mostly independent indicated a resident would require assist of one (1) person. Review of Resident #1's Comprehensive Plan of Care, dated [DATE], revealed the resident was at risk for fall/injury related to generalized weakness and compression fracture, with an intervention to refer to a plan of care in the voice-assisted, hands free documentation and communication system (AccuNurse Activities of Daily Living Care Plan). Review of the Activities of Daily Living (ADL) Plan of Care, dated [DATE], revealed the facility assessed the resident to require assistance of one (1) person physical assist for ambulation, bathing, dressing and toileting, and cautions to include assistance needed for toileting transfer, do not leave unattended in bathroom and high risk for falls. Review of a Nursing Note, dated [DATE] at 1:44 AM, revealed Resident #1 was found on the floor in the adjoining room and stated he/she went to the bathroom and when he/she finished he/she got turned around and went into the wrong room. The resident stated he/she fell on to his/her back and when trying to get up rolled onto his/her right side. The resident was assessed with [REDACTED]. The Primary Care Physician was notified and the resident was sent to the ER for evaluation. Ambulance here at 12:15 AM to transport the resident. Review of Resident #1's ER record, dated [DATE], revealed Clinical Impression 1. Fall from slipping, tripping or stumbling, 2. Closed left hip fracture. Review of the Resident's Hospital Discharge Summary, dated [DATE], revealed the resident was admitted and surgery was planned; however, the resident's condition declined and it was determined the resident would not survive surgery. Palliative care was provided and the resident expired on [DATE]. Interview with CNAs #1, on [DATE] at 3:35 PM, revealed Resident #1 was in the bed asleep during the final bed check on [DATE] around 10:00 or 10:30 PM. The CNAs said Resident #1's roommate was outside on smoke break when she made rounds. Interview with Resident #1's Roommate, on [DATE] at 11:00 AM, revealed Resident #1 was in pain and moaned at night. The Roommate said Resident #1 would get out of bed to go to the bathroom during the day and night and he/she did not remember hearing a staff member encouraging Resident #1 to call for assistance prior to getting out of bed. The Roommate said he/she and Resident #1 would have conversations and the resident seemed confused at times. Further interview revealed on the evening of [DATE], the Roommate saw Resident #1 out of bed and pacing back and forth from bed 1 to bed 2 and then went into the bathroom and shut the door behind him/her. The Roommate said he/she fell asleep after he/she heard the bathroom door shut and was told the next morning Resident #1 was transferred to the hospital. Interviews on [DATE] with CNAs #5 at 8:10 AM and LPN #2 at 8:55 AM, revealed on [DATE] around 11:00 PM, CNAs #5 began to pass ice water sometime after 11:00 PM; and, when she entered Resident #1's room (108) she observed Resident #1 was not in the bed or in the bathroom. CNAs #5 told LPN #2 and the two (2) of them split-up to do room checks. CNAs #5 opened the door to room 106, flipped on the light switch and found Resident #1 lying on his/her side on the floor near the sink. LPN #2 and CNAs #5 stated the resident said he/she was in the bathroom, got turned around and went out of the wrong bathroom door. The resident told them he/she was weak and fell . The resident complained of left hip and lower back pain. LPN #2 and CNAs #5 did not move the resident, LPN #5 called an ambulance and the ambulance arrived between 11:45 PM and 12:00 AM. Interviews with CNAs #9, on [DATE] at 3:20 PM, CNAs #13 on [DATE] at 10:30 AM, CNAs #7 on [DATE] at 2:25 PM, CNAs #8 on [DATE] at 3:10 PM, and CNAs #10 on [DATE] at 10:20 AM revealed Resident #1 was care planned for assistance of one (1) staff for ambulation but would get out of bed without calling for assistance; and, would get confused after using the bathroom, would exit the bathroom into the adjacent room, and get in the unoccupied bed in that room. The CNAs stated they did not complete a Stop and Watch notepad to notify the licensed staff of the resident's ambulation without assistance or going into the adjacent room. Interviews with LPN #7 on [DATE] at 12:00 PM, LPN #8 on [DATE] at 11:15 AM, LPN #4 on [DATE] at 5:30 PM, and LPN #6 on [DATE] at 11:20 AM, revealed they were not aware of Resident #1 getting up without assistance. The LPNs stated the CNAs should notify the Charge Nurse when a resident was care planned for assistance with ambulation and was repeatedly getting out of bed without assistance to ensure appropriate interventions were added to the care plan to prevent falls. LPN #7 said she expected staff to complete a Stop and Watch form. Interviews on [DATE] with Registered Nurse (RN) #1, South Unit Charge Nurse at 11:35 AM, and Unit Manager of North and South Units at 12:25 PM, revealed they expected staff to report the resident's getting up without assistance so other interventions such as a bed alarm could be considered. Interview with the Staff Education/Trainer (EDT) on [DATE] at 2:05 PM, revealed the Accunurse Care Plan was initiated by the Admission Nurse and the CNAs should access the Accunurse Care Plan via headset for the resident's ADL's and assistance needed. The EDT said staff should reinforce use of the call light when a resident was getting out of bed without assistance and the CNAs should report to the Charge Nurse. The EDT said the Charge Nurse should relay in report and document in the Nurse's Notes and the Shift to Shift report when a resident was found in the wrong bed. Interview with the Director of Nursing (DON), , revealed Resident #1 was care planned appropriately for his/her diagnoses. The DON stated she was not sure who initiated the ADL Plan of Care in the Accunurse and she said the one (1) person physical assist for toileting might have been changed after Resident #1 was transferred to the hospital, it might have been

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) added in anticipation for his/her return to the facility. The DON said there was absolutely no way to determine when one (1) person physical assist was added in accunurse to Resident #1's plan of care. However, interview, on [DATE] at 4:15 PM, with the Senior Clinical Account Manager of the company that makes the Accunurse System, revealed the Accunurse was a system facilities used for CNAs to check resident's Activities of Daily Living care plan via headset. She stated that all updates to an Accunurse Plan of Care were dated and timed stamped in the system. Review of the Plan of Care updates for Resident #1 revealed all care plan updates were entered on [DATE] between 8:27 AM and 8:50 AM. Further interview with DON, on [DATE] at 3:30 PM, revealed Resident #1 had been in the facility for almost two (2) weeks and made progress with therapy, and had not stumbled or walked off balance. The DON said she was not sure why some of the CNAs thought Resident #1 was an assist of one (1). In addition, the DON said she assessed Resident #1 the morning after he/she was admitted and the resident was verystable, but she did not document her assessment. The DON stated there was no indication the resident was a fall risk because his/her previous fractures were pathologic in nature. The DON said Resident #1 was alert and oriented and not showing any signs of fall risk. Further interview with the DON, on [DATE] at 8:50 AM, revealed there was no assessment policy and all residents were care planned as an assist of one (1) on admission and then reviewed during the twenty four (24) hour meeting the next morning. The DON said the Accunurse assessment did not accurately reflect Resident #1's level of function as Resident #1 was able to ambulate without assistance. However, interview with the Physical Therapist, on [DATE] at 11:30 AM, revealed the initial assessment on [DATE] revealed Resident #1 exhibited a forward lean of the trunk, inadequate hip and trunk extension, pain and muscle weakness and was at risk for falls. The Therapist stated he would recommend assistance when out of bed until the resident's balance improved. Further interview with the DON, on [DATE] at 3:30 PM, revealed she was not aware of any occasion when Resident #1 was found in room 106 in an unoccupied bed. The DON stated the CNAs should complete a Stop and Watch form in addition to telling the Charge Nurse if a resident was found in an unoccupied bed and getting up without assistance. The DON said they had been using the Stop and Watch system for about a year and the CNAs were good about using the system. Interview with the Medical Director on [DATE] at 7:30 AM, revealed he was Resident #1's physician when the resident was in the facility. The Medical Director stated when a resident was care planned for one (1) person assist then that was what should be done. Interview with the Administrator, on [DATE] at 12:50 PM, revealed she expected the CNAs to complete a Stop and Watch form if they witnessed a change in the resident. In addition, the Administrator said she had total responsibility over the building.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to ensure their system to identify weight loss was effective for one (1) of three (3) sampled residents (Resident #9). Staff had documented Resident #9 had a weight loss of thirty-four (34) pounds from May through July 2015. The staff failed to obtain a monthly weight in June 2015 and failed to reweigh and assess the resident when the significant weight loss was identified to determine if the weight was accurate and/or if the resident needed a change in condition plan to address the resident's weight loss management. The findings include: Review of the facility's policy, Guidelines for Obtaining Accurate Resident Weights, dated 08/12/14, revealed the Interdisciplinary Team would develop a change of condition plan for any resident with weight variances greater than five (5) percent in thirty (30) days; 7.5 percent in ninety (90) days; and, ten (10) percent in one-hundred eighty (180) days. Interview with the Director of Nursing (DON), on 07/28/15 at 2:22 PM, revealed the facility's protocol was for the Certified Nurse Aides (CNAs) or nurses to obtain the weights and the DON would enter in the information, if a re-weight was needed the computer would prompt the nurse to take action or do a re-weigh which would indicate the need for an assessment. Record review revealed the facility admitted Resident #9 on 09/08/14 and he/she was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/08/15, revealed the facility assessed Resident #9's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicates the resident was interviewable. In addition, the MDS revealed the resident was assessed as having problems with swallowing and had a mechanically altered diet. Review of the Comprehensive Care Plan, dated 03/14/15, revealed the resident was at risk for altered nutrition related to [MEDICAL CONDITIONS] disease, and vitamin deficiency with interventions for staff to obtain and monitor the resident's weights weekly times four (4) weeks and monthly thereafter if stable. Review of Resident #9's Weight Change History Record revealed the resident weighed 160 pounds on 05/07/15 and weighed 125.6 pounds on 07/17/15. There was no monthly weight obtained in June 2015, (per the care plan, a weight should have been obtained); and, there was no documented evidence staff reweighed the resident per facility protocol, to determine if the weight was accurate, when it was identified that the resident had a weight loss of approximately thirty-four (34) pounds. In addition, review of the Nurse's Notes and Dietary Notes for July 2015 revealed there was no documented evidence the Physician or Dietician was made aware of the thirty-four (34) pound weight loss (over a 20% weight loss in two {2} months) and no evidence the Interdisciplinary Team did a change of condition plan related to the weight change. Observation of Resident #9's being weighed, on 07/28/15 at 8:27 AM, revealed the resident weighed 142.4 pounds which still indicated a seventeen (17) pound weight loss (over ten percent{10%} in two {2} months). Interview with Certified Nursing Assistant (CNA) #1, on 07/30/15 at 2:45 PM revealed the CNA was given a list of residents to weight and if there was a weight that looks to be an error the nurses would get a re-weigh of the resident. Interview with CNA #2, on 07/30/15 at 3:05 PM, revealed the CNAs received a paper, from nursing, listing the residents that needed weights. She further stated if there was a weight that looked to be an error they would re-weigh the resident and make sure that the scale has been zeroed out before weighing the resident again. CNA #2 stated the CNAs were inserviced during their orientation with the Education Training Director on how to properly weigh residents and to go to their nurse if there were any issues with the weights. Interview with the Registered Dietician (RD), on 07/28/15 at 12:34 PM, revealed she had not been an RD at the facility for very long and she had only been to the facility twice. She stated Resident #9 was flagged for her to review quarterly and was not on the monthly reviews. She reviewed the weights and stated if Resident #9 weighed 160 pounds in May 2015 and then weighed 125.6 in July, then staff should have reweighed the resident to validate if there was a weight loss, and then implement interventions for weight loss if needed. Interview with the Director of Nursing (DON), on 07/28/15 at 2:22 PM, revealed she had been at the facility since 07/06/15 but the previous DON was in the facility until 07/18/15 and was inputting the weights into the computer at that time. The DON stated she could not explain why there were not any reweighs for Resident #9, after the resident's weight was down to 125.6 pounds in July. The DON said it appeared there was no action taken by the previous DON when the reweigh was needed. The DON reviewed the documentation and stated no action had been taken because a reweigh had not been done and no weights were documented for June. She further stated it was a breakdown in the system and she was concerned for the residents. In addition, she stated she questioned all the weights done in June and entered in by the previous DON.
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure residents were free of any significant medication errors for one (1) of three (3) sampled resident (Resident #9). The facility failed to administer Resident #9's [MEDICATION NAME] ([MEDICAL CONDITION] medication) for sixty (60) days. The findings include: Review of the facility policy titled, Medication Administration, dated 12/12, revealed medications should be administered as prescribed in accordance with the manufacturer's specifications and good nursing principles and practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. BUILDING _____ B. WING _____	06/12/2015

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) Record review revealed the facility admitted Resident #9 on 09/08/14 with [DIAGNOSES REDACTED].#9 was admitted to the hospital on [DATE] and returned to the facility on [DATE] Review of the Hospital Physician's Discharge Orders, dated 05/29/15, revealed an order for [REDACTED]. for June and July 2015. Review of the May, June, and July 2015 Medication Administration Record [REDACTED]. Interview with Registered Nurse (RN) #1, who readmitted the resident, on 07/28/15 at 5:05 PM, revealed she entered the resident's orders into the computer system upon his/her return to the facility on [DATE], but she was not certain if another nurse assisted her or not. She stated she may have missed reactivating the [MEDICATION NAME], but she was not sure if she was the one who missed it. RN #1 stated there was a two (2) nurse check in place so orders were looked at by a second pair of eyes, but she could not remember if this was done or not. Interview with the Educational Training Director (ETD), on 07/29/15 at 8:10 AM, revealed she occasionally assisted the nurses. She stated there was a two (2) nurse check to make sure they did not miss any information from the checklist during the readmission process; however, she did not assist with Resident #9's readmission. Interview with the Advanced Registered Nurse Practitioner (ARNP), on 07/28/15 at 2:15 PM revealed she was unaware Resident #9 was not receiving his/her [MEDICATION NAME] as prescribed by the physician. She stated not having that medication for that amount of time could be tricky , and could effect the resident in a multitude of ways, including weight and mental concerns. She said she expected the facility to provide medications as they were prescribed. Review of a Medical Laboratory Report, dated 07/09/15, revealed Resident #9's [MEDICAL CONDITION] Stimulating Hormone (TSH) level was 2.5 MIU/DL (normal 0.3-5.6 MUI/dl). The physician was notified and orders were received to discontinue the order for [MEDICATION NAME] and retest in one (1) month. Interview with the Director of Nursing (DON), on 07/28/15 at 2:41 PM, revealed she expected staff to double check the information entered into the computer to ensure it was correct so there were no transcription errors. She stated she was not the DON at the time, but the medication was probably missed because Resident #9 was out of the facility for less than three (3) days. She stated if the resident had been treated as a readmit there would have been a two (2) nurse check on the medications then there would not have been the transcription error of not reactivating the [MEDICATION NAME]. She stated when a resident leaves the facility and goes to the hospital their system cannot hold medication so the medication(s) were deactivated until the resident returned to the facility, then the admission's nurse would reactivate the medication. She stated Resident #9 missed his/her medications for almost two (2) months because the medication was not reactivated. The DON stated a second nurse check was not conducted to ensure all medications were reactivated. In addition, she stated the nurse from that hall should have known the resident well enough to realize the resident was not receiving his/her [MEDICATION NAME] as normally prescribed and they should have contacted the physician.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility education review, it was determined the facility failed to ensure their system to obtain needed medication was effective for one (1) unsampled resident (Resident D). The facility failed to ensure Unsampled Resident D's Levothyroxine (thyroid medication) was available for administration for two (2) days. The findings include: Interview with the Regional Quality Manager (RQM), on 08/05/15 at 1:00 PM, revealed process for ordering medication was provided in training on 06/30/15 and provided this training documentation to the surveyor. Review of training provided by the facility pharmacy, on 06/30/15, revealed to reorder medication staff should submit the reorder request electronically through the electronic Medication Administration Record [REDACTED]. In addition, staff can pull the reorder sticker and fax it to the pharmacy, three (3) days before the quantity is exhausted. Staff should allow up to twenty-four (24) hours for delivery Record review revealed the facility admitted Unsampled Resident D on 05/16/15 with [DIAGNOSES REDACTED]. Review of the July 2015 physician's orders [REDACTED]. Observation of the North Hall Medication Cart, on 07/31/15 at 1:25 PM, revealed Unsampled Resident D had no Levothyroxine 0.088 milligrams (mg) in the medication cart drawer. Review of Unsampled Resident D's Electronic-MAR revealed on 07/30/15 at 5:15 AM Licensed Practical Nurse (LPN) #4 documented the medication was not available for administration and the pharmacy was notified. Interview (Post Survey) with the Licensed Practical Nurse (LPN) #4, on 08/11/15 at 7:40 PM, revealed she did not recall reordering Unsampled Resident D's Levothyroxine or writing on the E-MAR it was not available and the pharmacy notified. She stated staff was supposed to reorder medication through the computer by clicking the box and/or faxing the sticker from the medication package. She stated this was supposed to be done five (5) to seven (7) days prior to the running out of the medication. LPN #4 stated she normally ordered medication through the computer and faxed the sticker to ensure the medication would be delivered. She stated if she identified a medication was not available for administration she would check the Emergency Drug Kit (EDK) and call the pharmacy so the medication could be sent in the next hour or two (2). She did not recall if she checked the EDK for Unsampled Resident D's Levothyroxine. She stated she received training from a Pharmacist when the new pharmacy went into effect on 07/01/15. Interview with LPN #2, on 08/05/15 at 3:20 PM, revealed if a medication was not available for administration staff should check the EDK and call pharmacy so the medication could be sent. She stated if the medication was not available to be administered during the allowable timeframe according to the physician's orders [REDACTED]. She said staff was supposed to reorder the medication approximately three (3) days before the medication supply ran out through the EMAR system by clicking a button, or by faxing the sticker from the medication package to the pharmacy. She stated she received training from a Pharmacist when the new pharmacy went into effect on 07/01/15. Review of a Pharmacy Shipping Manifest, dated 07/31/15 at 10:15 PM, revealed the Levothyroxine was delivered to the facility on [DATE] after 10:15 PM. Interview with the Regional Quality Manager (RQM), on 08/05/15 at 1:00 PM, revealed the facility had changed over to a new pharmacy on 07/01/15 and training had been conducted with staff on 06/30/15. She stated staff should have ensured medications were available for administration by either ordering the medication three (3) days prior to the last dose through the E-Mar system or faxing the sticker per the training provided by the new pharmacy. She was unable to provide documentation the Levothyroxine had been ordered prior to 07/31/15. She stated the medication listed on the 07/31/15 after 10:15 PM manifest was ordered after an audit was conducted on the medication cart that afternoon due to the State Survey Surveyor identified that the medication was not available in the medication cart.