STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Rivers Nursing and Rehabilitation Center	2420 West Third Street 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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was implemented for one (1) of five (5) sampled residents (Resident #1). The facility care planned Resident #1 to require total assistance of two (2) staff for incontinent care. However, Certified Nursing Assistant (CNA) #5 provided incontinent care for Resident #1 alone, and without the care planned assistance of two (2) staff members on 11/02/2021. During the provision of incontinent care by CNA #5 Resident #1 rolled off the bed onto the floor, hitting his/her knees on the nightstand. At approximately 12:30 PM, Resident #1 complained of pain and was assessed to have bruising and swelling to his/her left knee. Resident #1 was transferred to the hospital emergency room (ER) for evaluation, and diagnosed with a closed nondisplaced fracture of the left patella (knee) and a nondisplaced fracture of head of right radius. Resident #1 was placed in a left knee immobilizer and a right arm splint and sling, and returned to the facility on [DATE] at 9:30 PM. The findings include: Review of the facility's policy titled, Comprehensive Care Plans Standard of Practice, dated 10/2020, revealed the facility would develop an individualized comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs. Per review of the policy, the facility's Interdisciplinary Team (IDT), in coordination with the resident, family and/or representative would develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning the resident might be expected to attain. Review of Resident #1's medical record revealed the facility admitted him/her on 09/18/2015, with diagnoses which included Cerebellar Stroke Syndrome, Hemiplegia, Following Unspecified Cerebrovascular Disease Affecting Right Dominant Side, and Chronic Obstructive Pulmonary Disease. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 08/09/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated he/she was moderately cognitively impaired. Review of the MDS Assessment further revealed the facility also assessed Resident #1 to require total assistance of two (2) staff for bed mobility, toileting, and transfers. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Rivers Nursing and Rehabilitation Center	2420 West Third Street Owensboro, KY 42301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Comprehensive Care Plan, dated 04/20/2020, revealed the facility had care planned the resident for risk of falls related to his/her impaired mobility, being non-ambulatory, and requiring assistance with transfers. Continued review revealed the interventions included: ensuring the resident had a safe environment, free of clutter with adequate lighting; mechanical lift for transfers with total assist of two (2) staff; provide the resident with a soft touch call light within reach; and notify the Physician and family as needed. Additional review of the risk for falls care plan revealed an intervention for a perimeter defined mattress dated 11/02/2021. Further review of Resident #1's care plan revealed the facility also care planned Resident #1 for his/her activities of daily living (ADLs) related to impaired mobility, diagnosis of Hemiplegia on the right side, and contractures. Review of the ADL care plan revealed interventions which included providing total assistance of two (2) staff with incontinent care and transfers, and assist with his/her daily grooming and hygiene which were initiated on 04/20/2020. In addition, further review of the ADL care plan revealed an intervention initiated on 06/13/2022, to assist the resident with turning and repositioning per assist of two (2) staff. Review of the facility's documentation dated 11/02/2021, noted by Licensed Practical Nurse (LPN) #2 revealed at 6:15 AM that morning, a Certified Nursing Assistant (CNA) changed Resident #1 resulting in the resident rolling out of his/her bed due to the head of the bed not being locked. Continued review revealed Resident #1's knees hit the nightstand during the fall. Per review, Resident #1 had been assessed to have bruising to his/her bilateral knees; however, his/her range of motion was assessed as within normal limits. Review of the hospital Emergency Department (ED) record, dated 11/02/2021, revealed Resident #1 had been diagnosed with a nondisplaced fracture of the head of the right radius, and a nondisplaced fracture of the left patella (kneecap). Review further revealed Resident #1's left knee was placed in an immobilizer and his/her right arm was splinted and placed in a sling. Interview on 08/23/2022 at 11:20 AM, with CNA #6 revealed CNA #5 had told her Resident #1 had rolled off his/her bed, and there had been only one (1) staff providing care for the resident at the time of the fall. Per CNA #6, Resident #1 was supposed to have assistance provided by two (2) staff as per his/her care plan. Interview on 08/16/2022 at 7:22 PM, with LPN #1 revealed she had been providing care for Resident #1's roommate, when CNA #5 had provided the resident's care without another staff member's assistance. LPN #1 stated she heard a noise and then CNA #5 yelled for her. Continued interview revealed when she went to Resident #1's side of the room, she observed the resident lying on the floor. LPN #1 further stated she thought Resident #1 was an assist of two (2) staff for care and did not know why CNA #5 provided the care by herself. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Twin Rivers Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 West Third Street Owensboro, KY 42301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/18/2022 at 4:45 PM, with LPN #2 revealed when she received report on 11/02/2021 from LPN #1 she was informed of Resident #1's fall, and she and LPN #1 went to the resident's room together to assess him/her. Per LPN #2, the resident had slight bruising and some redness to his/her knees bilaterally. Continued interview revealed around lunch time that day she was asked to check on Resident #1 and she had assessed the resident and observed increased swelling. LPN #2 stated the Advanced Practice Registered Nurse (APRN) was in the facility and assessed Resident #1, and gave an order for the resident to be sent to the hospital ED for evaluation. She stated she could not recall much about the care plan but knew Resident #1 required total care, was basically bed bound and had contractures. LPN #2 revealed she did not know what intervention had been put in place for Resient #1 as he/she went to the hospital. Further interview revealed she ensured the staff were following residents' care plans by giving them reminders about care and letting them know she was available if they needed help. Interview on 08/19/2022 at 8:40 AM, with the MDS Nurse revealed residents' care plans were how the care was personalized to each resident. She stated the admission nurse initiated the residents' care plans. Continued interview revealed the floor nurses updated residents' care plans and the interdisciplinary team (IDT) reviewed Physician's Orders daily and updated the care plans if needed during the meeting. According to the MDS Nurse, the Resident Care Profile on the Kiosk was for staff to review regarding residents' care plan interventions. She stated if a resident required assistance of two (2) staff that information should be noted on the resident's care plan. Interview on 08/18/2022 at 2:30 PM, with CNA #8 revealed residents' care profiles on the kiosk helped staff to know how to properly care for residents. She stated the profiles were residents' care plans and were for staff to review to know how to care for the residents. Per interview, Resident #1 required total assistance of two (2) staff for bed mobility and incontinent care. CNA #8 stated Resident #1 preferred to stay in bed; however, was assist of two (2) staff and a mechanical lift for transfers. Further interview revealed she knew of Resient #1's fall, but had not been working at the time of the fall. Interview on 08/15/2022 at 4:18 PM and on 08/19/2022 at 10:42 AM, with the Director of Nursing (DON), revealed at the time of Resident #1's fall she had been in the Assistant Director of Nursing (ADON) position. The DON stated initially she had identified the root cause of Resident #1's fall as CNA #5 providing the resident's care by herself. Continued interview with DON revealed however, she went back and looked at everything again and determined the root cause had been due to the Resident #1's legs sliding off the bed. According to the DON, her expectations were for all her staff to follow each resident's care plan. The DON further revealed she could not say whether or not Resident #1 would have experienced the fall from his/her bed had another staff been on the other side of the bed to assist. Interview on 08/26/2022 at 2:52 PM, with the Administrator, revealed he expected his staff to follow residents' plans of care. The Administrator stated staff should refer to the resident care profiles on the kiosk to know residents' care needs. Contined interview revealed staff should direct residents' care based on the information from the care profiles on the kiosk. The Administrator further stated multiple adverse consequences could occur if residents' care plans were not followed.

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NAME OF PROVIDER OR SUPPLIER Twin Rivers Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 West Third Street Owensboro, KY 42301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of five (5) sampled residents received adequate supervision and assistive devices to prevent accidents (Resident #1). The facility assessed and care planned Resident #1 as a risk for falls and required the assistance of two (2) staff members for bed mobility and incontinent care. However, on [DATE], at 6:15 AM, Certified Nursing Assistant (CNA) #5 provided the resident incontinent care without assistance from another staff member as per the care plan. Subsequently, during the incontinent care being provided by CNA #5, Resident #1 rolled off the side of the bed onto the floor. Resident #1 sustained fractures to his/her right radius (smaller of the two [2] bones in the lower arm) and left knee. The findings include: Review of the facility's policy titled, Falls Standard of Practice, dated ,d+[DATE], revealed the facility would ensure compliance with the regulatory intent of F689. Per review, the facility would ensure the residents ' environment remained free of accident hazards as possible; and each resident received adequate supervision and assistance devices necessary to prevent accidents. Continued review revealed on admission and readmission, quarterly and annually, each resident would have a Falls Risk Assessment completed by a licensed nurse. Review further revealed on completion of the Fall Risk Assessments, immediate reasonable interventions were to be initiated to reduce the risk for falls. In addition, policy review revealed at the time of a fall or after assessing and caring for a resident after a fall, an Incident Report and Investigation were to be initiated to determine appropriate interventions. Review of Resident #1's medical record revealed the facility admitted him/her on [DATE], with diagnoses which included: Hemiplegia, following Unspecified Cerebrovascular Disease Affecting Right Dominant Side; Cerebellar Stroke Syndrome; and Chronic Obstructive Pulmonary Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #1 dated [DATE], revealed the facility assessed the resident as moderately cognitively impaired, as evidenced by the Brief Interview for Mental Status (BIMS) score of eleven (11). Continued review of the MDS Assessment's, Section G. Activities of Daily Living section, revealed the facility assessed Resident #1 to require extensive assistance of two (2) staff for bed mobility and total assist of two (2) staff for toileting and transfers. Review of the facility's Fall Risk Assessment, dated [DATE] for Resident #1, revealed the document noted a resident who scored a ten (10) or higher on the Assessment was at risk for falls. Per review, Resident #1's total score was thirteen (13) indicating the resident was a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Comprehensive Care Plan, dated [DATE], revealed the facility had care planned the resident as at risk for falls related to impaired mobility and requiring assistance with transfers and non-ambulatory. Continued review revealed interventions which included: total mechanical lift for transfers; total assist of two (2) staff members; ensure a safe environment free of clutter with adequate lighting; clean spills up promptly; provide soft touch call light within reach; and notify Physician and family as needed. Continued review revealed on [DATE], and intervention for a perimeter defined mattress was initiated. Further review of the care plan revealed the facility also care planned Resident #1 to require total assistance with all Activities of Daily Living (ADLs) related to impaired mobility, contractures, and a diagnosis of right sided hemiplegia (one-sided paralysis). Further review of the ADL care plan revealed interventions which included: assisting the resident with daily grooming and hygiene; total assist of two (2) with incontinent care initiated on [DATE]. Review of the facility's Resident Care profile for Resident #1 dated [DATE], revealed the resident was to be transferred using a mechanical lift with assist of two (2) staff. Observation of Resident #1, on [DATE] at 8:47 AM, revealed the resident lying on his/her bed and observed to have upper extremity contractures to both arms. Interview at the time of observation with Resident #1 revealed the resident recalled sustaining the fall and stated he/she broke his/her knee and elbow. However, Resident #1 was unable to recall how many staff had provided care for him/her at the time of the fall. Review of the Progress Note dated [DATE] at 7:39 AM and signed by Licensed Practical Nurse (LPN) #1, revealed the resident rolled out of his/her bed and was lowered to the floor by Certified Nursing Assistant (CNA) #5 during care. Continued review revealed the resident hit his/her knees on the nightstand next to the bed causing some bruising. Review of the facility's Fall Management Form, dated [DATE] and initiated by Licensed Practical Nurse (LPN) #3, revealed at 6:15 AM, a Certified Nursing Assistant (CNA) #5 was changing resident and resident rolled out of the bed onto the floor, as head of bed was not locked. Further review revealed the CNA was able to lower Resident #1 to the floor, but both knees hit the nightstand. Further review revealed Resident #1 had bruising to both knees and range of motion was assessed as within normal limits. Review of CNA #5's written statement, from the facility's investigation dated [DATE], revealed the CNA had been providing care for Resident #1, with the bed locked at the end. Continued review of CNA #5's statement revealed as she was turning Resident #1 during incontinent care, the resident threw his/her leg over the side of the bed and rolled from the bed to the floor. Further review of CNA #5's statement revealed the nurse was in the room at the time; however, had been providing care for the resident's roommate. Review of LPN #1's written statement, also from the facility's investigation, dated [DATE], revealed she had been in Resident #1's room providing care for the resident's roommate when Resident #1 fell from his/her bed. Further review of LPN #1's written statement revealed the privacy curtain had been pulled between the residents' beds and therefore, she had not witnessed the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital Emergency Department (ED) medical record dated [DATE], revealed Resident #1 had sustained a closed nondisplaced fracture of the left patella (kneecap) and a nondisplaced fracture of the head of the right radius. Further review revealed Resident #1 had been placed in a left knee immobilizer and a right arm splint and sling and returned to the facility on [DATE] at 9:30 PM. Interview with CNA #5 could not be accomplished as the CNA was deceased at the time of the survey. Interview with Certified Nursing Assistant (CNA) #6, on [DATE] at 11:30 AM, revealed she received report from CNA #5 on [DATE], and CNA #5 had told her Resident #1 had rolled off the bed. She stated she was told that only one (1) staff had been providing care for Resident #1 at the time of the fall, even though the resident was supposed to be assist of two (2) staff for care. Continued interview revealed Resident #1 seemed his/her usual self that morning and had no complaints at the beginning of her shift. CNA #6 revealed however, around lunch time that day Resident #1 started complaining of knee pain, and she observed the resident's left knee was swollen. Further interview revealed she went and told the nurse, LPN #2 about Resident #1's left knee, and the nurse went and assessed the resident. Interview further revealed CNA #6 believed the Advanced Practice Registered Nurse (APRN) went to assess Resident #1 as well. In addition, CNA #6 further revealed she got Resident #1 ready to go to the ED. Interview with LPN #1, on [DATE] at 7:22 PM, revealed she had been in Resident #1's room providing care for the resident's roommate, when CNA #5 was providing care for Resident #1 without assistance from another staff person. She stated she heard a noise and CNA #5 yelled for her. LPN #3 stated she went over to Resident #1's side of the room and CNA #5 had hold of the draw sheet and Resident #1 was lying on the floor by the right side of the bed. Continued interview revealed Resident #1's knees had hit the nightstand during the fall. She stated she and CNA #5 assisted Resident #1 up off the floor, prior to assessing the resident, and back to bed where she then assessed the resident for injuries. Per LPN #1, upon her assessment Resident #1 had no swelling or bruising observed. Further interview revealed Resident #1 had upper extremity contractures and the resident had no complaints with range of motion of his/her lower extremities. She further stated she gave report to the oncoming nurse, LPN #2 and they went to Resident #1's room together and assessed the resident. Interview with Licensed Practical Nurse (LPN) #2 on [DATE] at 4:45 PM, revealed she had received report from LPN #1 on [DATE], regarding Resident #1's fall. She stated they went together to Resident #1's room to assess the resident together. Continued interview revealed Resident #1 had some redness and slight bruising to both knees; however, there had been no swelling or edema. LPN #2 stated she could not recall the time, but she assessed Resident #1 again while administering medications and the resident had slight puffiness to both knees, but there had been nothing that really concerned her at the time. Per the interview with LPN #2, the puffiness appeared to be tissue trauma. Further interview revealed around lunch time staff asked her to go check on Resident #1, and she had done so. LPN #2 stated Resident #1 had increased swelling to the left knee. In addition, LPN #2 revealed the APRN had been in the facility and assessed Resident #1. Interview further revealed the APRN gave an order for Resident #1 to be sent to the hospital ED for an evaluation as she thought there could be a left knee fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the APRN on [DATE] at 11:42 AM, revealed she vaguely remembered Resident #1's fall and subsequent injuries. She stated she had been in the facility that day and remembered Resident #1 had some swelling and bruising to his/her knee. Further interview revealed she could not recall how much swelling or bruising; however, she thought there had been a possibility of a fracture, so she sent Resident #1 to the ED for an evaluation. Interview with the Director of Nursing (DON) on [DATE] at 10:42 AM, revealed she had been the Assistant Director of Nursing (ADON) at the time of Resident #1's fall. The DON stated the initial root cause of Resident #1's fall had been determined to be CNA #5 providing the resident's care by herself without another staff person. Continued interview with the DON revealed however, she went back and looked at everything and ultimately determined the root cause of Resident #1's fall had been due to the resident's legs sliding off the bed during care. However, review of the resident's ADL care plan revealed the resident's interventions included a total assist of two (2) with incontinent care that was initiated on [DATE]. Continued interview with the DON revealed it was her expectation that staff followed the residents ' care plans when providing care. The DON revealed she could not say whether Resident #1 would have fallen from the bed had another staff been on the other side of the bed. Interview with the Administrator on [DATE] at 2:52 PM, revealed he expected staff to follow the plans of care for the residents. He stated staff should reference the Resident Care Profiles on the Kiosk (computerized electronic record) and direct the residents' care based on the information on the profile. He further revealed there could be multiple adverse consequences if residents' care plans were not followed.