STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. Building B. Wing	04/26/2018

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 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 35617 Based on interview, it was determined the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the residents on the weekends. The findings include: Interview with the Administrator, on 04/25/18 at 2:29 PM, revealed the facility did not have a policy in regard to mail delivery; however, the facility followed the Federal regulations related to mail delivery. Interview with Resident Council members during a Resident Council meeting, on 04/25/18 at 1:33 PM, revealed the facility had not delivered mail to the residents on the weekends for several months. Interview with the Activity Director, on 04/26/18 on 9:14 AM, revealed she nor her Activity Assistants knew where the mail was on the weekend to deliver it to the residents. She stated she was not sure how long it had been since mail had been delivered to the residents on the weekends. She stated she had been the Activity Director for approximately six (6) months, and it had not been delivered to the residents on the weekends since she had been in this position. She stated it was a requirement and just did not realize it had not been delivered by the weekend Activity Assistants. Further interview with the Administrator, on 04/25/18 at 2:29 PM, revealed he was not aware the residents' mail had not been delivered to them on the weekends. He stated it was unacceptable for the mail to have not been delivered to the residents on the weekend, and will be fixed immediately.

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

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38981 Based on interview, record review, and review of Kentucky Board of Nursing (KBN) AOS #14 Patient Care Orders, it was determined the facility failed to ensure services being provided meet professional standards of quality, in regard to following the Physician's Orders for one (1) of twenty-six (26) sampled residents (Resident #16). Resident #16's April 2018 Physician's Orders revealed to weigh the resident weekly on Mondays and fax the results to the Advanced Practice Registered Nurse (ARNP); however, review of the Dietary Data Set and Progress Notes revealed the resident was weighed monthly. The findings include: Review of KBN AOS #14 Patient Care Orders, last revised October, 2017, revealed a Registered Nurse (RN) will administer medications and treatments as subscribed by a Physician, Physician's Assistant, Dentist, or ARNP. Record review revealed the facility admitted Resident #16 on 01/02/18 with diagnoses which included Cerebral Vascular Accident, Vascular Dementia with Behavioral Disturbance, Congestive Heart Failure, and Hypothyroidism. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 01/20/18, revealed the facility assessed Resident #16's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was interviewable. Review of the Comprehensive Care Plan, dated 01/12/18, revealed the resident was at risk for alteration in nutrition with a history of weight loss. Review of the goal revealed he/she would remain free of dehydration for ninety (90) days. Review of the listed approaches included weekly weights for four (4) weeks, then monthly if stable. Review of the April 2018 Physician's Order revealed to weigh the resident weekly on Mondays and fax results to the ARNP. However, review of the Weight Change Comparison revealed the resident was weighed on 12/13/17 with a weight of 173.4 pounds, and not again until 03/07/18 when his/her weight was 167.0 pounds. Review of the facility's Dietary Data Set and Progress Notes, dated 12/05/17, revealed the resident's most recent weight was obtained on 11/15/17. Review of the Progress Notes, dated 01/12/18, revealed the resident's most recent weight was obtained on 01/05/18. Review of the Progress Notes, dated 02/10/18, revealed the resident's most recent weight was obtained on 12/13/17; and review of the Progress notes, dated 04/13/18, revealed the resident's most recent weight was obtained on 03/17/18. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Director of Nursing (DON), on 04/26/18 at 12:44 PM, revealed Restorative Nursing was responsible for obtaining weights as ordered. However, the facility did not currently have anyone in the Restorative Department, as one (1) aide was terminated and the other had recently resigned. She stated no one else had been made responsible for getting the weights, and his/her weekly weights had not been completed as ordered. The DON further stated it was her expectations for the resident to be weighed as ordered.

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38981 Based on observation, interview, record review, and review of [NAME], Manual of Nursing Practice, it was determined the facility failed to provide Oxygen (O2) therapy, per the Physician's Order for one (1) of twenty-six (26) sampled residents (Resident #16). Observation, on 04/24/18 at 11:47 AM, revealed Resident #16 was in the dining room wearing O2 tubing connected to a portable O2 tank. The nasal cannula was observed to the right side of the resident's face, not in his/her nares. Further observation revealed the O2 tank was empty. The resident's O2 saturation level (SaO2) was checked and revealed it was 86 percent (%). The findings include: Interview with the Director of Nursing (DON), on 04/26/18 at 12:47 PM, revealed the facility goes by Physician's Orders and Standards of Practice according to [NAME] for oxygen use. Review of the facility's procedure manual, [NAME], Manual of Nursing Practice, Ninth Edition, revealed oxygen is used to treat or prevent symptoms and manifestation of hypoxia with symptoms including Tachypnea (fast respirations) and SaO2 less than 88%. Oxygen should be set to the flow rate at the prescribed liters per minute. Tips of the cannula should be placed in the resident's nose. Assess SaO2 and the functioning of the equipment at regular intervals. Record review revealed the facility admitted Resident #16 on 01/02/14 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Further review revealed the resident was hospitalized with Bilateral Pneumonia on 01/02/18. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 01/20/18, revealed the facility assessed Resident #16's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was interviewable. In addition, further review revealed the resident required extensive to total assistance of two (2) persons for activities of daily living and used O2. Review of the Comprehensive Care Plan, dated 12/02/17, revealed the resident had a potential for alteration in O2 exchange related to COPD. The goal was for the resident to have no shortness of breath or cyanosis for ninety (90) days. Approaches included O2 as ordered, change tubing/devices per protocol; observe for cyanosis, shortness of breath or change in level of consciousness; and O2 saturation as ordered. Review of the April 2018 Physician's Order revealed to administer O2 at two (2) liters to maintain O2 at 88%; Atrovent Inhaler two (2) puffs into the lungs twice daily; Albuterol Sulfate 2.5 milligrams (mg) per 3 milliliters (ml) solution, give contents of 1 vial via mini-nebulizer every six (6) hours for congestion. Review of the Treatment Administration Record (TAR), dated April, 2018, revealed a treatment to monitor O2 saturation with and without O2 and record weekly was added to the TAR on 04/24/18. Additional treatments included to check O2 saturation daily; and O2 at two (2) liters to maintain O2 at 88%. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation, on 04/24/18 at 11:47 AM, revealed Resident #16 was up in a wheelchair in the dining room with O2 tubing around each ear, a nasal cannula to the right side of his/her face not in the nares, and tubing connected to a portable O2 tank on back of the resident's chair. Further observation revealed the O2 gauge needle was in the red, indicating the tank was empty. A spot check of SaO2 per LPN #2 revealed the resident's SaO2 was at 86%. Interview with Resident #16, on 04/24/18 at 11:50 AM, revealed he/she felt a little bit short of breath. Resident #16 stated he/she was not aware the nasal cannula was not in his/her nares nor that the O2 tank was empty. Interview with Licensed Practical Nurse (LPN) #2, on 04/24/18 at 11:50 AM, revealed O2 canisters were filled every two (2) hours by the Nurse or Certified Nurse Assistant (CNA) who recognized the canister was low. LPN #2 stated the cannisters were used when residents were out of bed and the resident had been out of bed since 9:30 AM that morning. LPN #2 further stated O2 checks were supposed to be completed periodically by Nursing, but did not know when it was checked last. LPN #2 stated she was assigned to care for Resident #16, and she checked the resident's SaO2 when the nebulizer treatment was given at approximately 6:00 AM. The LPN stated staff know how long the portable O2 tanks last and they just check them periodically. Interview with the Assistant Director of Nursing (ADON) #4, on 04/26/18 at 8:27 AM, revealed she expected the Nurses and/or CNAs to check O2 tanks, before taking residents to the dining room. The ADON stated if there was not enough O2 in the portable tank for the entire meal, she expected the Nurse and/or CNA to change the tank for a full one. Further interview with the DON, on 04/26/18 at 12:47 PM, revealed the portable tanks should be monitored frequently, by the Nurse or the CNA placing the resident on the portable O2 canister, every three to four (3-4) hours to make sure they were full. The DON stated the O2 tank should have been checked before taking the resident to the dining room, and if the gauge was in the red, the tank should have been filled.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 35617 Based on observation, interview, and record review, it was determined the facility failed to ensure a resident, who displays or is diagnosed with Dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being, for two (2) of twenty-six (26) sampled residents (Residents #10 and #107). The findings include: Interview with the Director of Nursing (DON), on 04/26/18 at 1:36 PM, revealed the facility did not have a specific policy on Dementia care for the residents with Dementia. 1. Observation of Resident #10, on 04/24/18 at 11:35 AM, and on 04/26/18 at 3:16 PM and 4:30 PM, revealed Resident #10 was lying in his/her bed on his/her back with the privacy curtain pulled and the television was turned on at the bedside. Record review revealed the facility admitted Resident #10 on 12/13/16 with a diagnosis to include Unspecified Dementia with Behavioral Disturbance. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/28/18, revealed the facility was unable to assess the resident for a Brief Interview for Mental Status (BIMS) score due to he/she was rarely/never understood, which indicated the resident was severely cognitively impaired and was not interviewable. Review of Resident #10's Comprehensive Care Plan, dated 12/13/16, 12/22/16, 02/09/17, 10/13/17, and 10/20/17, revealed no evidence of any specific treatment and services being completed to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being related to his/her Dementia diagnosis. 2. Observation of Resident #107, on 04/24/18 at 4:19 PM, revealed he/she was in bed with his/her eyes closed. Further observation, on 04/25/18 at 9:12 AM and 2:33 PM, and on 04/26/18 at 10:59 AM, revealed Resident #107 was sitting in his/her wheelchair at the bedside watching television. Record review revealed the facility admitted Resident #107 on 10/11/13 with a diagnosis of Unspecified Dementia with Behavioral Disturbance. Review of the Quarterly MDS assessment, dated 04/10/18, revealed the facility assessed Resident #107's cognition as impaired with a BIMS score of six (6), which indicated the resident was not interviewable. Review of Resident #107's Comprehensive Care Plan revealed there was no documented evidence of initiation of a care plan addressing the resident's diagnosis of Dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with the DON, on 04/26/18 at 1:36 PM revealed she expected the State and Federal guidelines to be followed at the facility in regard to the Dementia care regulations for residents with a Dementia diagnosis. 38981

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35617 Based on interview and record review, it was determined the facility failed to ensure residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record, for one (1) of twenty-six (26) residents (#78). The findings include: Record review revealed the facility admitted Resident #78 on 04/25/17 with diagnoses which included Vascular Dementia without Behavioral Disturbance, Essential Hypertension, and Anxiety. Review of the monthly Physician's Order sheet, dated April 2018, and signed on 04/05/18 by the Physician, revealed Resident #78's current active diagnoses included Cerebral Infarction, Abnormal Posture, Difficulty in Walking, Muscle Weakness, Other Lack of Coordination, Chronic Obstructive Pulmonary Disease (COPD), Gastro-esophageal Reflux Disease (GERD), Dysphagia, and Constipation. Further review of the Physician's Orders revealed Resident #78 had current orders for Risperdal (antipsychotic) 1 milligram (mg) to be given by mouth (po) at every hour of sleep (HS) and a current order for Haloperidol (antipsychotic) 0.5 mg to be given po at every HS. Review of Resident #78's Medication Administration Record (MAR), dated April 2018, revealed he/she was administered both of these medications every day at 8:00 PM as ordered per the Physician's Orders. Interview with the Social Services Director (SSD), on 04/26/18 at 9:21 AM, revealed he had been at the facility since November 2017 and had been working hard on ensuring residents have appropriate diagnoses for antipsychotic medication use. He stated he was in the process of auditing all residents with psychotropic medications and making an action plan to ensure they have appropriate diagnoses for the psychotropic medications they were taking, and if they actually needed the medication. Further interview with the SSD, on 04/26/18 at 9:24 AM, revealed he had identified that Resident #78 did not have an appropriate diagnosis for the antipsychotic medication, and had made this information known to the Administrator and Director of Nursing (DON). He stated they were aware he had identified a problem. He stated as a professional, it was very important the facility fix this issue and ensure the facility staff were all on board with ensuring residents who received psychotropic medications needed the medication, and had a real and appropriate diagnosis for the psychotropic medication use. He stated he expected the facility to ensure residents have the appropriate diagnoses for psychotropic medications. He stated the facility did not have a specific policy related to appropriate diagnoses for psychotropic medication use, but the facility followed the Federal regulations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #78's Advanced Registered Nurse Practitioner (ARNP), on 04/26/18 at 3:18 PM, revealed she was not aware Resident #78 did not have an appropriate diagnosis for the antipsychotic medication use and expected the facility to let her know if a resident had antipsychotic medications in use with no appropriate diagnosis. She stated Resident #78 had not had any adverse side effects or adverse outcomes from the antipsychotic medication use. Interview with the DON, on 04/26/18 at 9:52 AM, revealed she expected all residents who had psychotropic medication have an appropriate diagnosis to support the medication use.