

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

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3528 DUTCHMANS LANE LOUISVILLE, KY 40205		
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>Amended 08/12/13.</p> <p>A standard recertification survey was conducted 08/13/13 through 08/15/13, and an extended survey was conducted 08/21/13 through 08/22/13.</p> <p>During the annual survey, the State Survey Agency (SSA) notified the facility of Resident #20's abuse allegation on 08/13/13. The facility immediately initiated an investigation and initiated corrective actions based on their findings. After further investigation, the SSA determined immediate jeopardy existed related to abuse and the facility was notified on 08/15/13.</p> <p>Immediate Jeopardy was identified on 08/15/13 and determined to exist on 08/10/13. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care (SQC) on 08/15/13 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) at a scope and severity of a "J".</p> <p>Per the interview, on 08/10/13 Resident #20 reported to Licensed Practical Nurse (LPN) #6 that State Registered Nurse Aide (SRNA) #6 had jerked his/her leg and hurt the resident. The resident stated he/she was scared of SRNA #6 and had requested to LPN #6 the SRNA not care for the resident anymore. However, per the resident's interview and record review, SRNA #6 continued to care for Resident #20 on 08/10/13; providing care to the resident during the day and evening shift, and also worked a double shift on 08/11/13 on another unit. Resident #20 also reported to the SSA that on 08/12/13 Social</p>	F 000	<p>To the best of my knowledge and belief, as an agent of Diversicare of Seneca Place, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

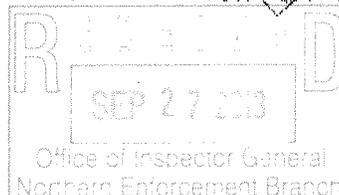
(X6) DATE

Melissa Bender

COT Director

9/19/2013

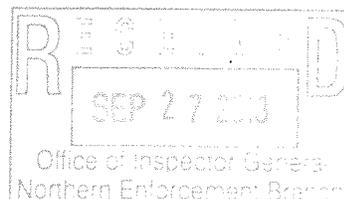
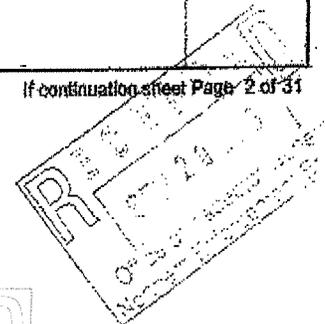
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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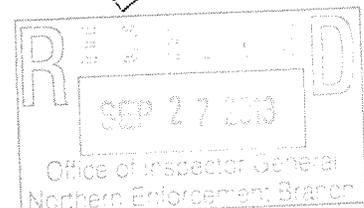
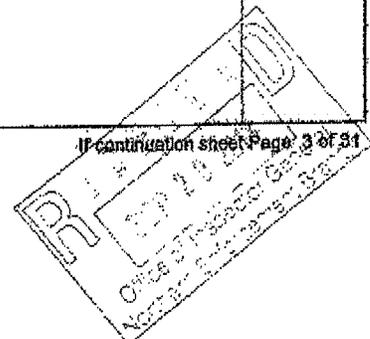
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F 000	<p>Continued From page 1</p> <p>Worker #3 told the resident that LPN #6 was aware of the incident and "would take care of it". Interview with LPN #6 revealed he did not report the allegation of abuse by Resident #20 on 08/10/13 as he denied Resident #20 told him about the abuse. In addition, interview with LPN #2 revealed Resident #20 had also reported the allegation to her the morning of 08/12/13 and she had informed Social Worker #3 that the allegation could be abuse. Interview with Social Worker #3 revealed she was made aware of the allegation on 08/12/13; however, she did not take the necessary steps to protect all residents in the facility, report and investigate the incident, because she thought Resident #20 was "simple-minded" and complained a lot. There was no documented evidence an investigation was initiated for Resident #20's allegation of abuse until 08/13/13 at 8:45 PM, after surveyor intervention.</p> <p>Additional deficiencies were cited as a result of the standard recertification survey at F441 at a scope and severity of a "D" and a Life Safety Code Survey was initiated and concluded on 08/13/13 with deficiencies cited at the highest scope and severity of an "E".</p> <p>The Division of Health Care received an acceptable Allegation of Compliance (AOC) on 08/20/13 alleging the removal of Immediate Jeopardy on 08/15/13. The facility initiated corrective action on 08/13/13 upon being informed of an allegation of unreported abuse. The Immediate Jeopardy was determined to be removed as alleged on 08/15/13, prior to exit on 08/22/13. 42 CFR 483.13 (F225 and F228) were lowered in scope and severity to a "D" while the facility continues to implement and monitor quality</p>	F 000			



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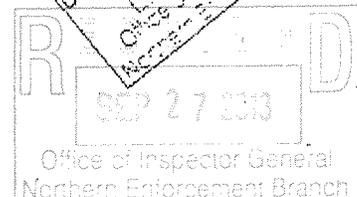
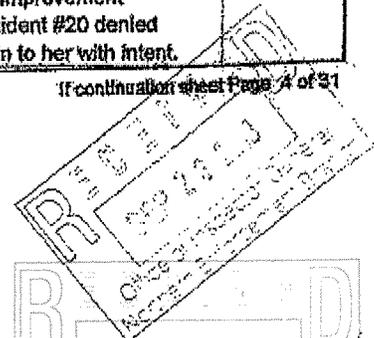
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F 000	Continued From page 2 assurance measures.	F 000			
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee; which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.	F 225			



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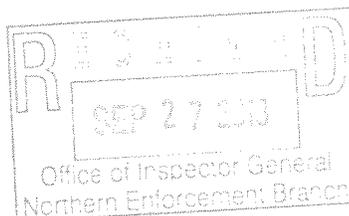
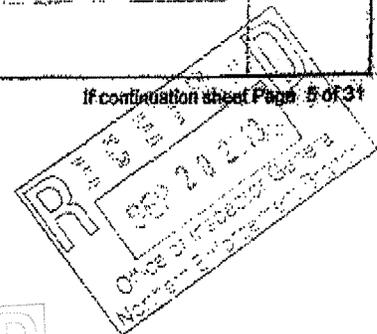
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F 225	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation and Abuse policy, it was determined the facility failed to have an effective system in place to ensure all allegations of abuse were reported to the appropriate agencies, that all residents were protected from further potential abuse and that an investigation was initiated timely for one (1) of thirty-one (31) sampled residents (Resident #20).</p> <p>During the annual survey, Resident #20 reported an allegation of abuse to the State Survey Agency on 08/13/13 at 3:00 PM. Per the interview, on 08/10/13 Resident #20 reported to Licensed Practical Nurse (LPN) #6 that State Registered Nurse Aide (SRNA) #6 had jerked his/her leg and hurt the resident. The resident stated he/she was scared of SRNA #6 and had requested to LPN #6 the SRNA not care for the resident anymore. However, per the resident's interview and record review, SRNA #6 continued to care for Resident #20 on 08/10/13; providing care to the resident during the day and evening shift, and also worked a double shift on 08/11/13 on another unit. Resident #20 also reported to the SSA that on 08/12/13 Social Worker #3 told the resident that LPN #6 was aware of the incident and "would take care of it". Interview with LPN #6 revealed he did not report the allegation of abuse by Resident #20 on 08/10/13 as he denied Resident #20 told him about the abuse. In addition, interview with LPN #2 revealed Resident #20 had also reported the allegation to her the morning of 08/12/13 and she had informed Social Worker #3</p>	F 225	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #20 was found not to have a negative outcome in relation to the allegation made on 8/13/13. An investigation of the allegation was initiated immediately on 8/13/13 by the Administrator and Director of Nursing. Also on 8/13/13, the Director of Nursing self-reported the allegation to Adult Protective Services and Office of Inspector General. The Social Worker named in the allegation was suspended by the Administrator on 8/13/13. The S.R.N.A. named in the allegation was suspended by the Director of Nursing on 8/13/13. A complete head-to-toe assessment was completed on Resident #20 by the Director of Nursing on 8/13/13 with no areas of concern noted. A pain assessment was completed for Resident #20 by the Director of Nursing on 8/13/13. Resident #20's attending physician was notified by the Director of Nursing on 8/13/13 with no new orders noted, as well as the responsible party being made aware of the allegation on 8/13/13 by the Director of Nursing. The facility Medical Director was notified on 8/13/13 by the Nurse Manager (Registered Nurse) with no new orders received. An interview with Resident #20 was conducted on 8/13/13 by the Director of Nursing and Regional Continuous Quality Improvement Director, where Resident #20 denied anyone inflicting pain to her with intent.</p>	



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F 225	<p>Continued From page 4</p> <p>that the allegation could be abuse. Interview with Social Worker #3 revealed she was made aware of the allegation on 08/12/13; however, she did not take the necessary steps to protect all residents in the facility, report and investigate the incident, because she thought Resident #20 was "simple-minded" and complained a lot. There was no documented evidence an investigation was initiated for Resident #20's allegation of abuse until 08/13/13 at 8:45 PM, after surveyor intervention.</p> <p>The facility's failure to have an effective system in place to ensure residents were protected from abuse, that allegations of abuse were reported timely and an investigation was initiated has caused or is likely to cause serious injury, harm, impairment or death to a resident. During the annual survey, the State Survey Agency (SSA) notified the facility of Resident #20's abuse allegation on 08/13/13. The facility immediately initiated an investigation and initiated corrective actions based on their findings. After further investigation, the SSA determined Immediate Jeopardy and Substandard Quality of Care (SQC) was identified on 08/15/13 and determined to exist on 08/10/13 at 42 CFR 483.13 Resident Behavior & Facility Practice (F225) at a scope and severity of a "J". The facility was notified on 08/15/13 of the Immediate Jeopardy.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 08/20/13 alleging the removal of Immediate Jeopardy on 08/15/13. The facility initiated corrective action on 08/19/13 upon being informed of an allegation of unreported abuse. The Immediate Jeopardy was determined to be removed as alleged on 08/15/13, prior to exit on 08/22/13. The scope and severity of F225</p>	F 225	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice? Prior six months documented/filed concerns/complaints were reviewed by the Continuous Quality Improvement Director (Registered Nurse) on 8/13/13 to ensure that there were no additional concerns that warranted reporting to Adult Protective Services or the Office of Inspector General. No additional concerns were identified that had not been previously addressed.</p> <p>A total of 47 skin assessments were completed on 8/14/13 by the Director of Nursing, Assistant Director of Nursing, Wound Care Nurse, and assigned staff nurses for all residents who were high risk and/or non-interviewable (BIMS score of less than 8) with no issues noted. A total of 45 resident interviews were completed on 8/14/13 on all residents deemed interviewable (BIMS score 8 and above) by the Admissions/Social Service Coordinator and the Continuous Quality Improvement Director in regards to whether they felt safe, were being provided good care, and have their concerns addressed timely. During these interviews, residents were also encouraged to voice any concerns now and ongoing with no concerns noted at this time. The entire resident population of 92 was assessed by either a skin assessment or by interview.</p>	



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F 225	<p>Continued From page 5</p> <p>was lowered to a "D" while the facility continues to implement and monitor quality assurance measures.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Policy for Prevention and Detection of Abuse and Neglect, revised 08/13/12, revealed the facility would report all alleged violations to the appropriate agencies and would then initiate an investigation and take corrective action as required. The facility would investigate alleged violations of abuse and neglect to determine if abuse or neglect had occurred, the extent of abuse/neglect, any causative factors, and appropriate interventions to prevent further injury. A resident assessment to determine whether injury occurred from the alleged abuse would be conducted and the results of the investigation would be documented in the medical record. If a report of suspected abuse or neglect was reported the staff was to complete the "Abuse Checklist" and take the following corrective action: Immediately take measures to protect the resident; assess the resident for mental or physical harm; contact the Administrator, DON, Supervisor or Charge Nurse on Duty and the Social Worker and inform him/her of the incident; Call the alleged incident into appropriate agencies; and alleged incidents would also be reported to the State Agency. The policy identified the facility would take measures to protect residents from further abuse and neglect and during the course of an investigation the alleged perpetrator would not be allowed to work. Upon conclusion of the investigation, the facility would make a determination as to whether there was sufficient evidence to substantiate the</p>	F 225	<p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?</p> <p>An emergency QA Interdisciplinary Team Meeting was conducted on 8/13/13 with a new Abuse policy being reviewed and approved. The Medical Director was notified regarding this policy by the Assistant Director of Nursing on 8/13/13. The Administrator educated the Director of Nursing on the Abuse Policy on 8/13/13. All facility staff and all agency staff currently in the facility on 8/13/13 were educated on the Abuse Policy by the Director of Nursing, Assistant Director of Nursing and Regional CQI Director. A "no one shall work" mandate was implemented by the Administrator on 8/13/13 to ensure that no additional staff would begin a shift without first being educated on the Abuse policy. The education emphasized Types/Definition of Abuse, Protection of the Resident, Reporting and Investigation. The education also reflected that failure to report "will result in disciplinary action up to and including termination." A post-test was administered to random employees working on 8/14/13 by the Administrator and the Staffing Development Coordinator to ensure that the training and verbal discussion were retained and comprehended. A total of 15 post-tests per week times 4 weeks continued to ensure comprehension of education.</p>		

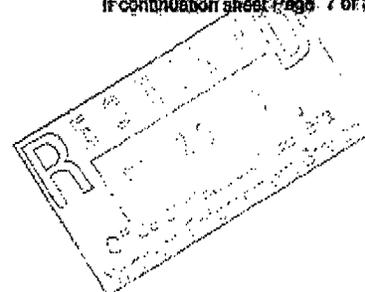
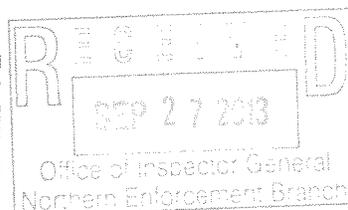
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F 225	<p>Continued From page 6 allegation of abuse.</p> <p>Interview with Resident #20, on 08/13/13 at 3:00 PM, revealed the resident was having trouble with the right leg. During a shower on 08/10/13 a SRNA moved the leg and picked it up and jerked it a little and it hurt. The resident stated he/she had reported this to LPN #6 on 08/10/13 when he/she yelled for the LPN while in the shower room. The resident further stated he/she told LPN #6 they did not want the aide to take care of him/her anymore because the resident was afraid of the aide and did not want the aide fooling with him/her. Per interview, LPN #6 told the resident to "leave it alone" and the resident stated he/she trusted LPN #6. However, the SRNA came back the rest of the day. The resident further stated he/she told Social Worker #3 of the incident on 08/12/13 and the Social Worker told the resident that LPN #6 had taken care of it. Per the resident, Social Worker #3 told the resident to "just forget about it".</p> <p>Review of Resident #20's record revealed the facility admitted the resident on 09/26/10 with diagnoses of Status Post Fracture of Hip, Venous Insufficiency and Chronic Obstructive Pulmonary Disease. Record review further revealed the facility assessed Resident #20 as having a cognition score of twelve (12) on the Minimum Data Set (MDS), dated 07/06/13, utilizing the Brief Interview for Mental Status (BIMS) indicating the resident was interviewable. The MDS further revealed the resident had no physical or behavioral symptoms or rejection of care and was assessed by the facility as having pain, but only occasionally. Review of the comprehensive plan of care, dated 07/06/13, for Resident #20 indicated he/she did have pain relieved by</p>	F-225	<p>How will the facility monitor performance to ensure solutions are sustained? The Administrator, Admissions/Social Services Coordinator or the Activity Director will conduct meetings with residents on a weekly basis for four weeks to determine that residents feel safe in the facility and that the residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns of this nature will be forwarded to the Administrator or Director of Nursing for immediate follow-up. The results of these meetings will be discussed weekly in the Interdisciplinary QA meeting that includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Activity Director, Social Services, Admissions, Dietary. The members of the weekly QA Interdisciplinary Committee and the GCI Committee will make recommendations regarding further monitoring and continued compliance.</p>	9-18-13	



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F 226	<p>Continued From page 7</p> <p>prescribed pain medications and topical analgesics.</p> <p>Interview with Social Worker #3, on 08/13/13 at 3:20 PM, revealed Resident #20 had told her on the morning of 08/12/13 (unsure of time) that SRNA #6 had jerked his/her right leg on 08/10/12, she was rough and had hurt him/her. Social Worker #3 indicated it was her understanding that the resident told LPN #6 about the aide hurting him/her on 08/10/12 and LPN #6 had talked with SRNA #6.</p> <p>Interview with LPN #6, on 08/14/13 at 11:33 AM, revealed Resident #20 had reported having pain in his/her leg to him, but Resident #20 had not reported abuse to him on 08/10/13. He stated he saw the resident during medication pass as SRNA #6 was taking the resident into the shower room and no complaint was alleged. He stated on 08/10/13 Resident #20 told him that he/she did not like SRNA #6, but he/she did not specify why. LPN #6 stated he did not hear an allegation of abuse from Resident #20 on 08/10/13.</p> <p>Further interview with Social Worker #3, on 08/13/13 at 3:20 PM, revealed LPN #2 called her on 08/12/13 (unsure of time) to report Resident #20 had alleged SRNA #6 had hurt her on 08/10/13. Per interview, Social Worker #3 acknowledged LPN #2 had reported an allegation of abuse to her on 08/12/13 (unsure of time); however, she stated she did not report the allegation and no investigation was initiated because Resident #20 was "simple-minded and complained a lot". However, review of the resident's comprehensive plan of care, dated 07/06/13, revealed there was no care plan for any concern with untoward behaviors or frequent</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3528 DUTCHMANS LANE LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 226	<p>Continued From page 8</p> <p>complaining. Review of a Behavior/Intervention Monthly Flow Record, dated August 2013, for Resident #20 revealed consistent zeroes for numbers of behavior episodes that had occurred from 08/01/13 through 08/15/13.</p> <p>Interview with LPN #2, on 08/14/13 at 10:34 AM, revealed on 08/12/13 during first shift, Resident #20 told her a big, fat girl grabbed his/her right leg and hurt it and the resident yelled out that it hurt and then the aide told him/her to shut up. She further stated the resident reported that it hurt really bad. LPN #2 stated she called Social Worker #3 on 08/12/13 and told her of the allegation stating to Social Worker #3 this could be an abuse situation. She stated she asked if she needed to report the allegation to the DON and the Social Worker told her she would handle it.</p> <p>Review of the Social Service Progress notes, dated 08/12/13, revealed Social Worker #3 charted LPN #2 called and stated that Resident #20 was saying that some SRNA had hurt him/her. The progress note indicated she told LPN #2 she would be there and talk with the resident. However, there was no documentation the resident had reported an incident to the Social Worker or that the Social Worker was aware of LPN #2's knowledge of the incident.</p> <p>Interview with SRNA #6, on 08/14/13 at 12:43 PM, revealed she had provided care for Resident #20 on 08/10/13 and had showered the resident that morning before breakfast. She further stated the resident complained of right leg pain when she rolled the resident to the edge of the bed to assist him/her with undressing for a shower and the resident would yell out sometimes when</p>	F 226		
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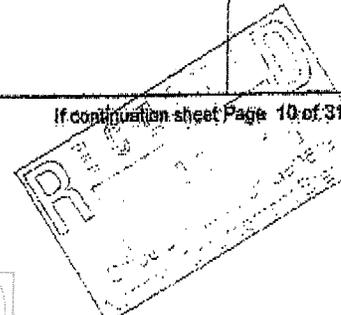
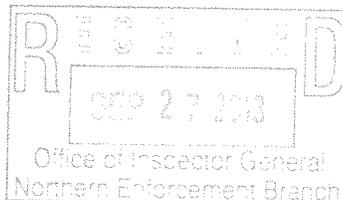
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 9</p> <p>he/she was rolled. SRNA #6 did state Resident #20 complained he/she had hurt him/her when he/she was pushed in the wheelchair over the hump into the shower room. She indicated she never grabbed or jerked the resident's leg and did not tell the resident to shut up.</p> <p>Review of the facility's investigation of the allegation of abuse revealed an abuse/neglect checklist was not completed until 08/13/13 at 8:45 PM by the Director of Nursing (DON) after surveyor intervention. Further review of the facility's investigation revealed SRNA #6 was not suspended from work until 08/13/13 (no time noted) per telephone by the DON. Social Worker #3 was notified of the suspension in person by the Administrator, on 08/13/13 at 5:00 PM.</p> <p>Interview with the DON and the Administrator, on 08/13/13 at 5:30 PM, revealed the Administrator was not made aware of the allegation of abuse by Resident #20 and no investigation had been initiated prior to surveyor intervention.</p> <p>Further interview with the DON, on 08/14/13 at 9:59 AM, revealed Social Worker #3 had reported to her that sometime on the morning of 08/12/13 an "issue" with Resident #20 had occurred over the weekend. Social Worker #3 stated the resident's leg was hurting and LPN #6 had taken care of it. She stated there was no allegation of abuse presented to her. The DON stated she had followed up and read the nursing notes revealing the resident had issues regarding pain and the nurse had assessed the resident's pain and given him/her medications ordered by the physician.</p> <p>Further interview with the Administrator, on</p>	F 225		



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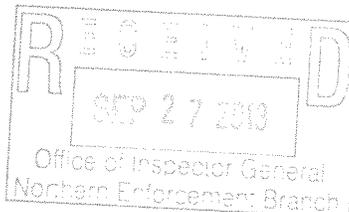
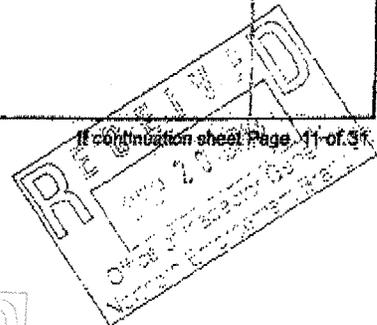
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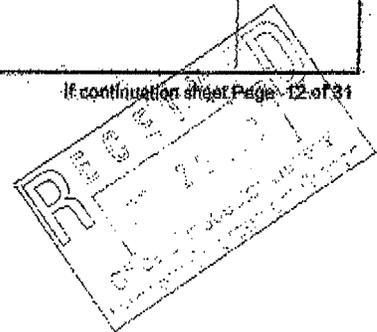
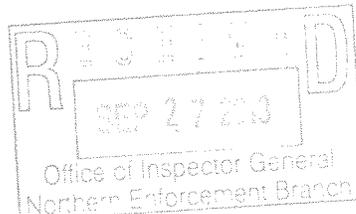
F 225	<p>Continued From page 10</p> <p>08/13/13 at 5:30 PM, revealed the Social Worker should have reported the incident immediately. The Administrator further revealed the facility did not report the allegation of abuse to the appropriate agencies, ensure the protection of all of the facility residents or initiate an investigation timely.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 08/20/13 alleging the Immediate Jeopardy was removed on 08/15/13. The facility took the following immediate steps to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. The facility suspended SRNA #6 on 08/13/13. 2. The Director of Nursing initiated an investigation into the allegation of abuse on 08/13/13. 3. The Director of Nursing reported the incident to the appropriate agencies on 08/13/13. 4. The Director of Nursing completed a head-to-toe physical assessment of Resident #20 on 08/13/13. 5. The Regional Continuous Quality Improvement (CQI) Director, RN reviewed the prior six months of facility concerns/complaints to ensure all were reported per policy. 6. The Director of Nursing, CQI Director, Assistant Director Nursing, Wound Care Nurse assessed the entire resident population of 92 residents either physically or by interview on 08/14/13. 	F 225		
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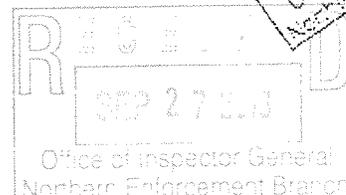
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F 225	<p>Continued From page 11:</p> <p>7. The facility held an emergency QA meeting on 08/13/13, attended by Corporate and Administrative staff.</p> <p>8. Diversicare abuse policy approved and implemented by the QA team on 08/13/13.</p> <p>9. The ADON notified the Medical Director on 08/13/13 of approval and implementation of the Diversicare Abuse Policy.</p> <p>10. The Administrative staff trained all facility staff in the building on the Diversicare Abuse Policy with a post test administered to the employees. A no-one-shall-work mandate was initiated by the Administrator on 08/13/13 until they were trained on the Diversicare Abuse Policy prior to working with a post test administered to employees on 08/14/13.</p> <p>11. The Administrator, Admission/Social Services Coordinator or the Activity Director will conduct meetings on a weekly basis with residents for four (4) weeks to determine if residents feel safe in the facility and that they are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family member or visitors. The first meeting will take place on 08/21/13.</p> <p>The State Agency validated the acceptable Allegation of Compliance AOC) as follows:</p> <p>1. Review of SRNA #6 employee file revealed a notice of suspension effective 08/13/13. Interview with SRNA #6, on 08/13/13 at 12:43 PM, confirmed the suspension and she stated she was not allowed to return pending results of the</p>	F 225		



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F 225	<p>Continued From page 12 investigation.</p> <p>2. Review of the facility's investigation, dated 08/13/13, revealed it was initiated by the Director of Nursing. Review of the Abuse/Neglect Investigation Checklist, revealed the facility initiated an investigation of the allegation of abuse regarding Resident #20 on 08/13/13.</p> <p>3. Review of the investigation report revealed the DON reported the allegation to the appropriate agencies at 9:40 PM on 08/13/13. The report was completed by the DON.</p> <p>4. Review of the investigation attachment revealed the DON conducted a head to toe assessment with no acute injury found on 08/13/13.</p> <p>5. Interview with the CQI Director, Staff #4, on 08/22/13 at 2:45 PM, revealed she had reviewed all concerns and complaints for the past six (6) months and no concerns had been identified.</p> <p>6. Review of a skin assessments on 08/22/13, revealed forty-seven (47) skin assessments were completed for residents who were identified as non-interviewable. Review of documented interviews were completed with forty-five (45) residents identified as interviewable to determine if they were being cared for appropriately and felt safe. The total of ninety-two (92) residents were assessed with no concerns identified. Interview with the DON and CQI Director, on 08/22/13 at 3:30 PM, revealed the skin assessments were completed by 08/14/13.</p> <p>7. Review of the minutes on 08/22/13 for the Emergency Quality Assurance Interdisciplinary</p>	F 225			



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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40208		
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F 225	<p>Continued From page 15</p> <p>Team Meeting, revealed the meeting was conducted on 08/13/13 and the team approved and implemented the new abuse policy.</p> <p>8. Review of the facility policy Resident Abuse with an effective date of 07/01/09, revealed it was the replacement policy for the new ownership of the facility. The abuse policy contained all components as required; screening, training, prevention, identification, investigations, protection, and reporting. The policy also included the procedure for prevention of misappropriation of resident property.</p> <p>9. Review of the QA minutes revealed the Medical Director was notified of the Immediate Jeopardy, the allegation and the change in the Abuse policy on 08/13/13.</p> <p>10. Review of the sign in sheets and completed post tests for the training on the abuse policy on 08/22/13, revealed one hundred and twenty-eight (128) staff had signed in for the abuse training and had completed the post test by 08/15/13. A "No One Shall Work" mandate was implemented by the Administrator on 08/13/13 for all staff to be educated on the Abuse Policy prior to returning to work. Interviews with fourteen (14) random staff revealed they had been trained on the new facility abuse policy to include; how to identify abuse, protection of the resident, how to report, when to report any and all suspicions/allegations of abuse.</p> <p>Interview with LPN #7, on 08/22/13 at 3:23 PM, revealed she had been retrained last week on the new abuse policy. LPN #7 identified the types of abuse and included the protection of the resident. She stated she would report any suspicion or an allegation of abuse to her supervisor. She</p>	F 225		

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F 226	<p>Continued From page 14</p> <p>stated they were told, failure to report would lead to disciplinary action. She stated she had taken a post test after the completion of the training.</p> <p>Interview with Registered Nurse (RN) #4, on 08/22/13 at 3:34 PM, revealed she had been trained on the new abuse policy and had completed a post test sometime last week.</p> <p>Interview with Staff Development Director #5, on 08/22/13 at 3:40 PM, revealed she was trained by the DON on the new abuse policy and then she did the training for the staff. She identified abuse policy and requirements to include the disciplinary process and stated she had completed a post test.</p> <p>Interview with MDS Nurse #6, on 08/22/13 at 3:41 PM, revealed she had been trained on the abuse policy and identified the process. She stated she had also completed a post test upon completion of the training.</p> <p>Interview with Housekeeping Staff #11, on 08/22/13 at 3:43 PM, revealed she was trained last week on abuse and neglect and had completed a post test. She stated they could lose their jobs for failing to report an allegation of abuse.</p> <p>Interview with Maintenance Staff #7, on 08/22/13 at 3:46 PM, revealed he had been trained on abuse and neglect last week and had completed a post test.</p> <p>Interview with Dietary Aide #12, on 08/22/13 at 3:49 PM, revealed he had been trained last week on the abuse/neglect policy and had completed a post test.</p>	F 226		

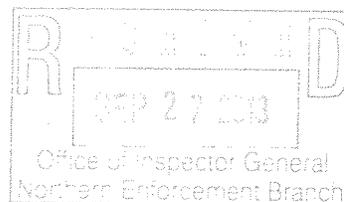
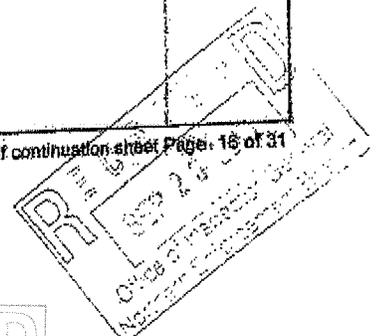
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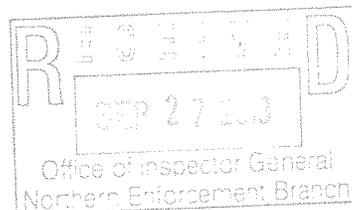
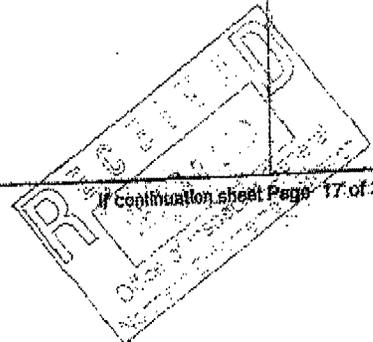
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 15 Interview with the Dietary Supervisor #13, on 08/22/13 at 3:53 PM, revealed he had been trained last week on abuse/neglect policy and had completed a post test. Interview with RN #5, on 08/22/13 at 3:59 PM, revealed she had been trained upon hire and last week for the abuse/neglect policy. She stated she was to report any allegation of abuse to the nursing supervisor on the weekends and during the week she was to report to the DON and/or the Administrator. She stated she had completed a post test after the training. Interview with SRNA #7, on 08/22/13 at 4:00 PM, revealed she had been trained last week on the abuse policy and had completed a post test. Interview with the Admissions Coordinator, SW #14, on 08/22/13 at 4:03 PM, revealed she had been trained last week on the abuse policy and had completed a post test. Interview with Activity Assistant #15, on 08/22/13 at 4:06 PM, revealed he had been trained last week on the abuse policy and completed a post test. Interview with SRNA #8, on 08/22/13 at 4:10 PM, revealed she had been trained last week on the abuse and neglect policy and had completed a post test. Interview with DON, on 08/22/13 at 4:15 PM, revealed she was trained on the new abuse policy by the administrator, last week. 11. Review of the minutes for the first scheduled	F 225		



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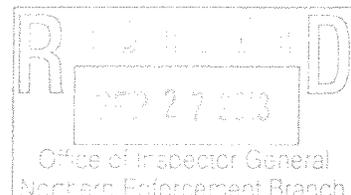
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F 225	Continued From page 16 meeting with the residents regarding concerns, dated 08/21/13 at 11:00 AM, confirmed the staff met with the residents to obtain any concerns the residents may have had. There were no concerns expressed by the residents. Interviews on 08/21/13 with Resident #22 at 3:10 PM, Resident #23 at 3:20 PM, Resident #24 at 3:28 PM revealed the meeting took place and the residents were encouraged to express any concerns.	F 225		
F 226 SS-J	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC. POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation and Abuse policy, it was determined the facility failed to have an effective system in place to ensure development and implementation of written policies and procedures which prohibited mistreatment, neglect and abuse of residents for one (1) of thirty-one (31) sampled residents (Resident #20). During the annual survey, Resident #20 reported an allegation of abuse to the State Survey Agency on 08/13/13 at 3:00 PM. Per the interview, on 08/10/13 Resident #20 reported to Licensed Practical Nurse (LPN) #6 that State Registered Nurse Aide (SRNA) #6 had jerked his/her leg and hurt the resident. The resident stated he/she was	F 226		



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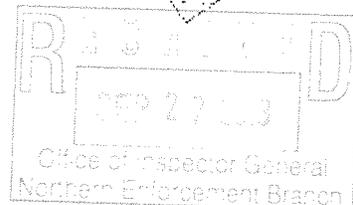
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F 226	<p>Continued From page 17</p> <p>scared of SRNA #6 and had requested to LPN #6 the SRNA not care for the resident anymore. However, per the resident's interview and record review, SRNA #6 continued to care for Resident #20 on 08/10/13; providing care to the resident during the day and evening shift, and also worked a double shift on 08/11/13 on another unit. Resident #20 also reported to the SSA that on 08/12/13 Social Worker #3 told the resident that LPN #6 was aware of the incident and "would take care of it". Interview with LPN #6 revealed he did not report the allegation of abuse by Resident #20 on 08/10/13 as he denied Resident #20 told him about the abuse. In addition, interview with LPN #2 revealed Resident #20 had also reported the allegation to her the morning of 08/12/13 and she had informed Social Worker #3 that the allegation could be abuse. Interview with Social Worker #3 revealed she was made aware of the allegation on 08/12/13; however, she did not take the necessary steps to protect all residents in the facility, report and investigate the incident, because she thought Resident #20 was "simple-minded" and complained a lot. In addition, Social Worker #3 stated she did not follow the facility's abuse policy and could not state why she did not report the allegation of abuse by Resident #20 as per the policy. There was no documented evidence an investigation was initiated for Resident #20's allegation of abuse until 08/13/13 at 8:45 PM, after surveyor intervention.</p> <p>The facility's failure to develop and implement policy and procedures related to abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. During the annual survey, the State Survey Agency (SSA) notified the facility of Resident #20's abuse</p>	F 226	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #20 was found not to have a negative outcome in relation to the allegation made on 8/13/13. An investigation of the allegation was initiated immediately on 8/13/13 by the Administrator and Director of Nursing. Also on 8/13/13, the Director of Nursing self-reported the allegation to Adult Protective Services and Office of Inspector General. The Social Worker named in the allegation was suspended by the Administrator on 8/13/13. The S.R.N.A. named in the allegation was suspended by the Director of Nursing on 8/13/13. A complete head-to-toe assessment was completed on Resident #20 by the Director of Nursing on 8/13/13 with no areas of concern noted. A pain assessment was completed for Resident #20 by the Director of Nursing on 8/13/13. Resident #20's attending physician was notified by the Director of Nursing on 8/13/13 with no new orders noted, as well as the responsible party being made aware of the allegation on 8/13/13 by the Director of Nursing. The facility Medical Director was notified on 8/13/13 by the Nurse Manager (Registered Nurse) with no new orders received. An interview with Resident #20 was conducted on 8/13/13 by the Director of Nursing and Regional Continuous Quality Improvement Director, where Resident #20 denied anyone inflicting pain to her with intent.</p>	



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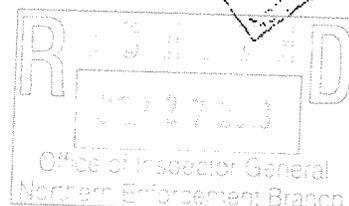
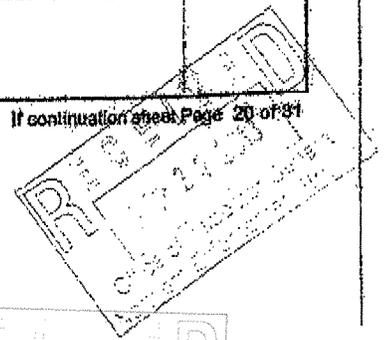
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185458	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40285	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	<p>Continued From page 19</p> <p>allegation on 08/13/13. The facility immediately initiated an investigation and initiated corrective actions based on their findings. After further investigation, the SSA determined immediate Jeopardy existed related to abuse and the facility was notified on 08/15/13 and determined to exist on 08/19/13.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 08/20/13 alleging the removal of immediate Jeopardy on 08/15/13. The facility initiated corrective action on 08/13/13 upon being informed of an allegation of unreported abuse. The immediate Jeopardy was determined to be removed as alleged on 08/15/13, prior to exit on 08/22/13. The scope and severity of F226 was lowered to a "D" while the facility continues to implement and monitor quality assurance measures.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Policy for Prevention and Detection of Abuse and Neglect, revised 09/13/12, revealed the facility would report all alleged violations to the appropriate agencies and would then initiate an investigation and take corrective action as required. The facility would investigate alleged violations of abuse and neglect to determine if abuse or neglect had occurred, the extent of abuse/neglect, any causative factors, and appropriate interventions to prevent further injury. A resident assessment to determine whether injury occurred from the alleged abuse would be conducted and the results of the investigation would be documented in the medical record. If a report of suspected abuse or neglect was reported the staff was to</p>	F 226	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice? Prior six months documented/filled concerns/complaints were reviewed by the Continuous Quality Improvement Director (Registered Nurse) on 8/13/13 to ensure that there were no additional concerns that warranted reporting to Adult Protective Services or the Office of Inspector General. No additional concerns were identified that had not been previously addressed. A total of 47 skin assessments were completed on 8/14/13 by the Director of Nursing, Assistant Director of Nursing, Wound Care Nurse, and assigned staff nurses for all residents who were high risk and/or non-interviewable (BIMS score of less than 8) with no issues noted. A total of 45 resident interviews were completed on 8/14/13 on all residents deemed interviewable (BIMS score 8 and above) by the Admissions/Social Service Coordinator and the Continuous Quality Improvement Director in regards to whether they felt safe, were being provided good care, and have their concerns addressed timely. During these interviews, residents were also encouraged to voice any concerns now and ongoing with no concerns noted at this time. The entire resident population of 92 was assessed by either a skin assessment or by interview.</p>	



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F 226	<p>Continued From page 19</p> <p>complete the "Abuse Checklist" and take the following corrective action: immediately take measures to protect the resident; assess the resident for mental or physical harm; contact the Administrator, DON, Supervisor or Charge Nurse on Duty and the Social Worker and inform him/her of the incident; Call the alleged incident to the appropriate agencies; and alleged incidents would also be reported to the State Agency. The policy identified the facility would take measures to protect residents from further abuse and neglect and during the course of an investigation the alleged perpetrator would not be allowed to work. Upon conclusion of the investigation, the facility would make a determination as to whether there was sufficient evidence to substantiate the allegation of abuse.</p> <p>Review of the facility's investigation, dated 08/13/13, of the allegation of abuse revealed an abuse/neglect investigation checklist was completed, on 08/13/13 at 8:45 PM, by the Director of Nursing (DON) after surveyor intervention. Further review of the facility investigation revealed SRNA #6 was notified of immediate suspension from work by the DON per telephone on 08/13/13 (no time noted) and Social Worker #3 was notified of immediate suspension in person by the Administrator, on 08/13/13 at 5:00 PM.</p> <p>Interview with Social Worker #3, on 08/13/13 at 3:20 PM, revealed Resident #20 reported SRNA #6 had jerked his/her right leg on 08/10/12 and was rough and hurt him/her. Social Worker #3 also stated LPN #2 called her on 08/12/13 (unsure of time) to report Resident #20 had alleged SRNA #6 had hurt him/her on 08/10/13. However, Social Worker #3 stated she did not</p>	F 226	<p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? An emergency QA Interdisciplinary Team Meeting was conducted on 8/13/13 with a new Abuse policy being reviewed and approved. The Medical Director was notified regarding this policy by the Assistant Director of Nursing on 8/13/13. The Administrator educated the Director of Nursing on the Abuse Policy on 8/12/13. All facility staff and all agency staff currently in the facility on 8/13/13 were educated on the Abuse Policy by the Director of Nursing, Assistant Director of Nursing and Regional OQI Director. A "no one shall work" mandates was implemented by the Administrator on 8/12/13 to ensure that no additional staff would begin a shift without first being educated on the Abuse policy. The education emphasized Types/Definition of Abuse, Protection of the Resident, Reporting and Investigation. The education also reflected that failure to report will result in disciplinary action up to and including termination. A post-test was administered to random employees working on 8/14/13 by the Administrator and the Staffing Development Coordinator to ensure that the training and verbal discussion were retained and comprehended. A total of 15 post-tests per week times 4 weeks continued to ensure comprehension of education.</p>	



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F 226	<p>Continued From page 20</p> <p>report the allegation and no investigation was initiated because Resident #20 was "simple-minded" and complained a lot. Per interview, Social Worker #3 revealed the facility's abuse policy was not followed in regards to the completion of the abuse/neglect investigation checklist, suspension of the alleged perpetrator to protect all residents, and appropriate reporting of the alleged abuse with initiation of an investigation into the allegation. Social Worker #3 could not specify the reason for not reporting the allegation of abuse by Resident #20 as directed by the policy.</p> <p>Interview with the DON and the Administrator, on 08/13/13 at 5:30 PM, revealed the Administrator was not made aware of the allegation of abuse by Resident #20 and no investigation had been initiated prior to surveyor intervention. The Administrator revealed the abuse policy in-effect at the time of the incident with Resident #20 was the previous administration's policy (Diversicare was the new owner/administration) and she felt the policy did not give clear guidance to the nursing staff. She stated the Social Worker should have reported the incident immediately and due to this an investigation was not initiated timely and residents were not protected.</p> <p>Further interview with the DON, on 08/14/13 at 9:59 AM, revealed if staff had received an allegation of abuse they should have reported it to her. The DON revealed she was responsible to initiate investigations for allegations of abuse which would include protection of all facility residents, reporting to appropriate agencies and initiation of an investigation.</p> <p>The facility provided an acceptable Allegation of</p>	F 226	<p>How will the facility monitor performance to ensure solutions are sustained? The Administrator, Admissions/Social Services Coordinator or the Activity Director will conduct meetings with residents on a weekly basis for four weeks to determine that residents feel safe in the facility and that the residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns of this nature will be forwarded to the Administrator or Director of Nursing for immediate follow-up. The results of these meetings will be discussed weekly in the Interdisciplinary QA meeting that includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Activity Director, Social Services, Admissions, Dietary. The members of the weekly QA Interdisciplinary Committee and the CQI Committee will make recommendations regarding further monitoring and continued compliance.</p>	

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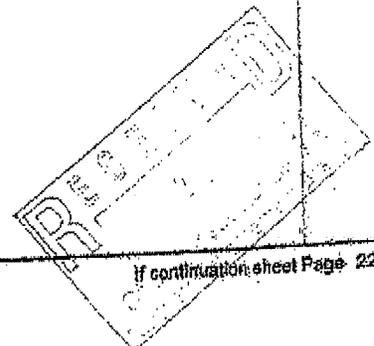
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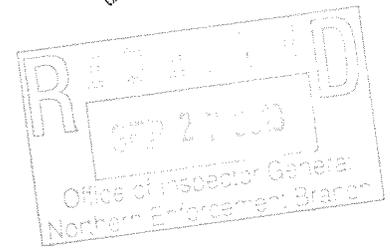
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3828 DUTCHMANS LANE LOUISVILLE, KY 40205	
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F 226	Continued From page 21 Compliance (AOC) on 08/20/13 alleging the Immediate Jeopardy was removed on 08/15/13. The facility took the following immediate steps to remove the Immediate Jeopardy: 1. The facility suspended SRNA #6 on 08/13/13. 2. The Director of Nursing initiated an investigation into the allegation of abuse on 08/13/13. 3. The Director of Nursing reported the incident to the appropriate agencies on 08/13/13. 4. The Director of Nursing completed a head-to-toe physical assessment of Resident #20 on 08/13/13. 5. The Regional Continuous Quality Improvement (CQI) Director, RN reviewed the prior six months of facility concerns/complaints to ensure all were reported per policy. 6. The Director of Nursing, CQI Director, Assistant Director Nursing, Wound Care Nurse assessed the entire resident population of 92 residents either physically or by interview on 08/14/13. 7. The facility held an emergency QA meeting on 08/13/13, attended by Corporate and Administrative staff. 8. Diversicare abuse policy approved and implemented by the QA team on 08/13/13. 9. The ADON notified the Medical Director on 08/13/13 of approval and implementation of the Diversicare Abuse Policy.	F 226		



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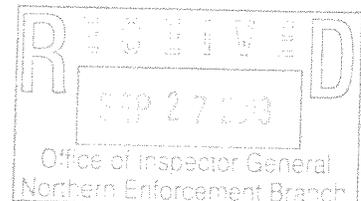
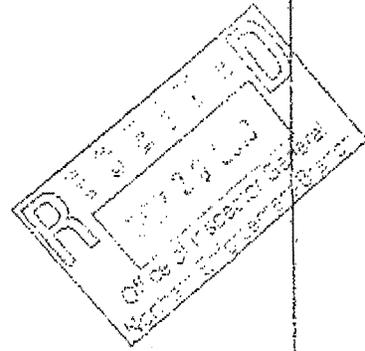
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F 226	<p>Continued From page 22</p> <p>10. The Administrative staff trained all facility staff in the building on the Diversicare Abuse Policy with a post test administered to the employees. A no-one-shall-work mandate was initiated by the Administrator on 08/13/13 until they were trained on the Diversicare Abuse Policy prior to working with a post test administered to employees on 08/14/13.</p> <p>11. The Administrator, Admission/Social Services Coordinator or the Activity Director will conduct meetings on a weekly basis with residents for four (4) weeks to determine if residents feel safe in the facility and that they are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family member or visitors. The first meeting will take place on 08/21/13.</p> <p>The State Agency validated the acceptable Allegation of Compliance (AOC) as follows:</p> <ol style="list-style-type: none"> 1. Review of SRNA #6 employee file revealed a notice of suspension effective 08/13/13. Interview with SRNA #6, on 08/13/13 at 12:43 PM, confirmed the suspension and she stated she was not allowed to return pending results of the investigation. 2. Review of the facility's investigation, dated 08/13/13, revealed it was initiated by the Director of Nursing. Review of the Abuse/Neglect Investigation Checklist, revealed the facility initiated an investigation of the allegation of abuse regarding Resident #20 on 08/13/13. 3. Review of the investigation report revealed the 	F 226		

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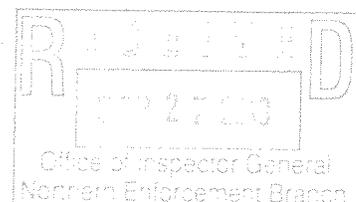
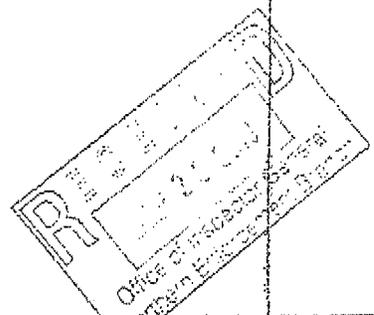
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F 226	<p>Continued From page 23</p> <p>DON reported the allegation to the appropriate agencies at 9:40 PM on 08/13/13. The report was completed by the DON.</p> <p>4. Review of the investigation attachment revealed the DON conducted a head to toe assessment with no acute injury found on 08/13/13.</p> <p>5. Interview with the CCI Director, Staff #4, on 08/22/13 at 2:45 PM, revealed she had reviewed all concerns and complaints for the past six (6) months and no concerns had been identified.</p> <p>6. Review of a skin assessments on 08/22/13, revealed forty-seven (47) skin assessments were completed for residents who were identified as non-interviewable. Review of documented interviews were completed with forty-five (45) residents identified as interviewable to determine if they were being cared for appropriately and felt safe. The total of ninety-two (92) residents were assessed with no concerns identified. Interview with the DON and CCI Director, on 08/22/13 at 3:30 PM, revealed the skin assessments were completed by 08/14/13.</p> <p>7. Review of the minutes on 08/22/13 for the Emergency Quality Assurance Interdisciplinary Team Meeting, revealed the meeting was conducted on 08/13/13 and the team approved and implemented the new abuse policy.</p> <p>8. Review of the facility policy Resident Abuse with an effective date of 07/01/09, revealed it was the replacement policy for the new ownership of the facility. The abuse policy contained all components as required; screening, training, prevention, identification, investigations.</p>	F 226		



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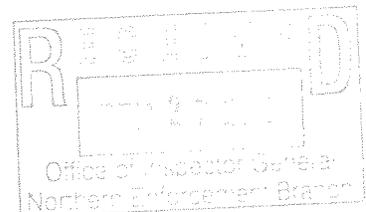
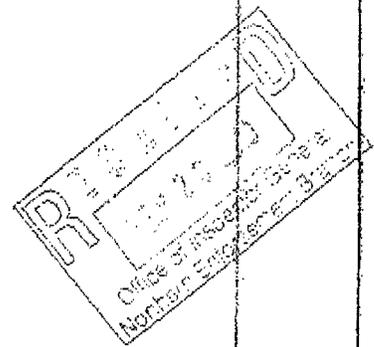
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3529 DUTCHMANS LANE LOUISVILLE, KY 40205		
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F 226	<p>Continued From page 24 protection, and reporting. The policy also included the procedure for prevention of misappropriation of resident property.</p> <p>9. Review of the QA minutes revealed the Medical Director was notified of the Immediate Jeopardy, the allegation and the change in the Abuse policy on 08/13/13.</p> <p>10. Review of the sign in sheets and completed post tests for the training on the abuse policy on 08/22/13, revealed one hundred and twenty-eight (128) staff had signed in for the abuse training and had completed the post test by 08/15/13. A "No One Shall Work" mandate was implemented by the Administrator on 08/13/13 for all staff to be educated on the Abuse Policy prior to returning to work. Interviews with fourteen (14) random staff revealed they had been trained on the new facility abuse policy to include; how to identify abuse, protection of the resident, how to report, when to report any and all suspicions/allegations of abuse.</p> <p>Interview with LPN #7, on 08/22/13 at 3:23 PM, revealed she had been retrained last week on the new abuse policy. LPN #7 identified the types of abuse and included the protection of the resident. She stated she would report any suspicion of or an allegation of abuse to her supervisor. She stated they were told, failure to report would lead to disciplinary action. She stated she had taken a post test after the completion of the training.</p> <p>Interview with Registered Nurse (RN) #4, on 08/22/13 at 3:34 PM, revealed she had been trained on the new abuse policy and had completed a post test sometime last week.</p> <p>Interview with Staff Development Director #5, on</p>	F 226			



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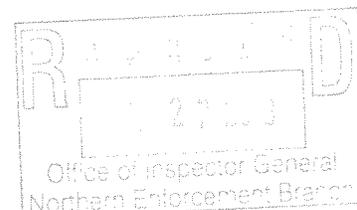
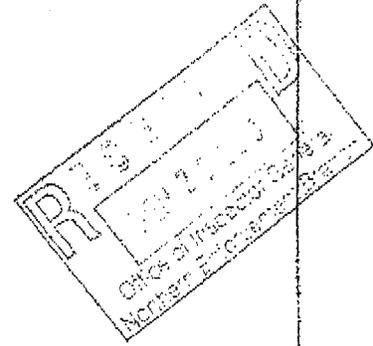
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F 226	<p>Continued From page 25</p> <p>08/22/13 at 3:40 PM, revealed she was trained by the DON on the new abuse policy and then she did the training for the staff. She identified abuse policy and requirements to include the disciplinary process and stated she had completed a post test.</p> <p>Interview with MDS Nurse #6, on 08/22/13 at 3:41 PM, revealed she had been trained on the abuse policy and identified the process. She stated she had also completed a post test upon completion of the training.</p> <p>Interview with Housekeeping Staff #11, on 08/22/13 at 3:43 PM, revealed she was trained last week on abuse and neglect and had completed a post test. She stated they could lose their jobs for failing to report an allegation of abuse.</p> <p>Interview with Maintenance Staff #7, on 08/22/13 at 3:45 PM, revealed he had been trained on abuse and neglect last week and had completed a post test.</p> <p>Interview with Dietary Aide #12, on 08/22/13 at 3:49 PM, revealed he had been trained last week on the abuse/neglect policy and had completed a post test.</p> <p>Interview with the Dietary Supervisor #13, on 08/22/13 at 3:53 PM, revealed he had been trained last week on abuse/neglect policy and had completed a post test.</p> <p>Interview with RN #5, on 08/22/13 at 3:59 PM, revealed she had been trained upon hire and last week for the abuse/neglect policy. She stated she was to report any allegation of abuse to the</p>	F 226		



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F 226	<p>Continued From page 26.</p> <p>nursing supervisor on the weekends and during the week she was to report to the DON and/or the Administrator. She stated she had completed a post test after the training.</p> <p>Interview with SRNA #7, on 08/22/13 at 4:00 PM, revealed she had been trained last week on the abuse policy and had completed a post test.</p> <p>Interview with the Admissions Coordinator, SW #14, on 08/22/13 at 4:03 PM, revealed she had been trained last week on the abuse policy and had completed a post test.</p> <p>Interview with Activity Assistant #16, on 08/22/13 at 4:06 PM, revealed he had been trained last week on the abuse policy and completed a post test.</p> <p>Interview with SRNA #8, on 08/22/13 at 4:10 PM, revealed she had been trained last week on the abuse and neglect policy and had completed a post test.</p> <p>Interview with DON, on 08/22/13 at 4:15 PM, revealed she was trained on the new abuse policy by the administrator, last week.</p> <p>11. Review of the minutes for the first scheduled meeting with the residents regarding concerns, dated 08/21/13 at 11:00 AM, confirmed the staff met with the residents to obtain any concerns the residents may have had. There were no concerns expressed by the residents. Interviews on 08/21/13 with Resident #22 at 3:10 PM, Resident #23 at 3:20 PM, Resident #24 at 3:28 PM revealed the meeting took place and the residents were encouraged to express any concerns.</p>	F 226		



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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3528 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441			

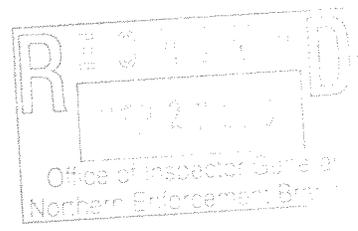
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(04) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18S465	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER TWINEROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3528 DUTCHMANS LANE LOUISVILLE, KY 40205	
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETION DATE
F 441	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and facility policy review, it was determined the facility failed to provide dedicated equipment to a single resident in contact isolation for one (1) of thirty-one (31) sampled residents and three (3) unsampled residents, Unsampled Resident C. Registered Nurse (RN) #3 removed her personal stethoscope from Unsampled Resident C's room, who was in contact isolation, after having checked the resident's gastrostomy (G-) feeding tube placement.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control policy, revised 05/11/12, revealed the Center for Disease Control (CDC) Guidelines were utilized. Universal precautions would be followed at all times by all employees. In addition, precautions, such as contact and droplet isolation would be followed when needed as recommended per CDC guidelines.</p> <p>Review of the facility's Infection Control in-service, Contact Isolation section, undated, revealed staff was to dedicate the use of non-critical resident care equipment to a single resident to avoid sharing between residents.</p> <p>Review of the facility's Cleaning and Disinfecting Equipment, undated, revealed the stethoscopes were to be cleaned between each use. The ear pieces, tubing, diaphragm and the bell were all to be wiped off with a soft cloth moistened in water or a mild soap. Glorox Germicidal Wipes were identified for use to disinfect stethoscopes when it had come in contact with an infectious disease.</p>	F 441	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Unsampled Resident 3 was not found to have been affected by the deficient practice. Non-critical resident care equipment was placed in Unsampled Resident 3 room for dedicated use for this specific resident on 8/14/13 by facility Central Supply. RN#3 educated by the Assistant Director of Nursing on 8/14/13 regarding equipment usage for residents in isolation.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? There are currently no additional residents on any type of isolation precaution. Going forward, any resident identified with the need for isolation precautions shall have designated non-critical care equipment as part of the facility's isolation procedure.</p>	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F-441	<p>Continued From page 29</p> <p>Observation during the medication pass with Registered Nurse (RN) #3, for Unsampled Resident C, on 08/14/13 at 8:18 AM, revealed the resident was in contact isolation. RN #3 removed her personal stethoscope from hanging around her neck and the stethoscope bell from her uniform pocket. She checked for G-tube placement. Upon completion of the task, she returned the stethoscope around her neck and placed the stethoscope bell in her right uniform pocket without cleaning the used equipment.</p> <p>Review of the clinical record for Unsampled Resident C revealed the facility admitted the resident on 08/09/13 with diagnoses of Methicillin-Resistant Staphylococcus Aureus (MRSA), Bacteremia, Pneumonia, Cardiovascular Accident (CVA/Stroke) and Congestive Heart Failure (CHF). A physician's order, dated 08/09/13, ordered contact isolation. The physician documented the diagnosis and indication for the contact isolation as MRSA.</p> <p>Interview with RN #3, on 08/14/13 at 11:52 AM, revealed Unsampled Resident C had been in contact isolation since 08/09/13 for MRSA in the blood. She did not have a stethoscope in the resident's room. Usually they do leave the stethoscope in the resident's room for personal use when a resident had been placed in isolation. She stated the stethoscope was used to check G-Tube placement prior to each medication administration and she kept the stethoscope bell in her uniform pocket so it did not get in the way with the resident's care. She reported she kept her keys, ink pens and other items in her pocket along with the stethoscope bell. She stated the keys were to the medication cart. She reported</p>	F-441	<p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? The nursing staff shall be educated on the facility policy regarding isolation precautions and subsequent infection control measures to be taken for residents being identified with the need for isolation precautions by the Staff Development Coordinator, by the date of 9/20/13. This education shall include use of resident specific non-critical care equipment for those residents in isolation, as well as standard cleaning/disinfecting protocol of equipment for general use.</p> <p>How will the facility monitor performance to ensure solutions are sustained? Random infection control procedure audits shall be completed by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator that would include any resident in isolation, plus additional selected residents from the general population. This audit will consist of standard precautions, cleaning and disinfecting of equipment and use of resident specific non-critical care equipment for those residents in isolation. There will be 5 audits completed weekly times 4 weeks. Any identified issue will have immediate staff 1:1 education provided by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator. The results of these audits shall be taken to the facility</p>	9-21-13	

Investigation Sheet Page 30 of 31
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 30. the stethoscope should have been cleaned prior to the stethoscope being place in her pocket otherwise, the keys would touch the bell of the stethoscope and germs could be carried back to the medication cart. Interview with the Director of Nurses (DON), on 08/16/13 at 1:50 PM, revealed residents in isolation should have equipment left in the room with them. She stated items such as stethoscopes are provided by the facility to be left in the rooms of residents placed in isolation. She also reported items brought out of an isolation room would be a concern for cross contamination.	F 441	monthly QA meetings for 2 months to determine if further interventions are warranted. In addition, the above referenced staff education in (3) will be provided semi-annually to all licensed nursing staff. Infection control is a topic that is covered monthly in the facility QA meetings, and will include any resident with isolation precautions, to ensure the precautionary measures are in place.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/05/2013
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An onsite revisit survey was initiated and concluded on 11/05/13 to determine if the facility had achieved compliance with deficiencies identified during the standard/extended survey completed on 08/22/13 and the facility was determined to be in compliance. A Life Safety Code desk review was completed and found the facility in compliance with federal Life Safety Code requirements.	{F 000}			

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

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.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A: BUILDING 01 - TWINBROOK NURSING HOME B: WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMAN'S LANE LOUISVILLE, KY 40205	
(X4) IO REFERENCE TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 000	INITIAL COMMENTS: CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1960, 1962, 1970, 1991, 1998 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story with a partial basement, Type III Protected SMOKE COMPARTMENTS: Twelve (12) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 1998. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system, upgraded in 1998. GENERATOR: Type 11, 125 KW rating, fuel source is diesel. A standard Life Safety Code survey was conducted on 08/13/12. Twinbrook Nursing Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

[Signature]

(X5) DATE

9/19/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING:		(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(S4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(S5) COMPLETION DATE	
K 000	Continued From page 1. Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a).	K 000			
K 029 SS-E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred and seven (107) certified beds and the census was ninety-two (92) on the day of the survey. The findings include: 1. Observation, on 08/13/13 at 10:25 AM, with	K 029			

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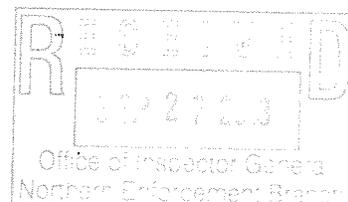
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING:	(X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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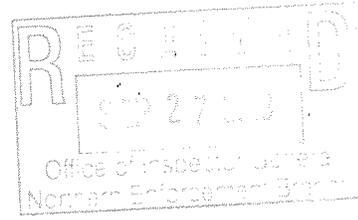
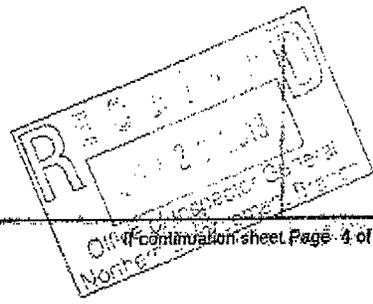
K 029	<p>Continued From page 2</p> <p>the Maintenance Supervisor revealed the door to the Cart Storage Room located near the E-F Nurse Station did not have a self-closing device installed on the door.</p> <p>Interview, on 08/13/13 at 10:25 AM, with the Maintenance Supervisor revealed he was not aware of the requirement for the Cart Storage Room door to be equipped with a self-closing device.</p> <p>2. Observation, on 08/13/13 at 10:57 AM, with the Maintenance Supervisor revealed the door to the Janitor Closet located in the G Wing did not have a self-closing device installed on the door.</p> <p>Interview, on 08/13/13 at 10:57 AM, with the Maintenance Supervisor revealed he was not aware of the requirement for the Janitor Closet door to be equipped with a self-closing device.</p> <p>3. Observation, on 08/13/13 at 2:07 PM, with the Maintenance Supervisor revealed the door to the Medical Records Room located in the C-D Wing did not have a self-closing device installed on the door.</p> <p>Interview, on 08/13/13 at 2:07 PM, with the Maintenance Supervisor revealed he was not aware of the requirement for the Medical Records Room door to be equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the deficient practice? All residents are considered to have a potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The self-closing devices were ordered on 8/14/13 and were installed on 8/20/13 to the identified areas: door to Cart Storage room near E-F nursing station, door to janitor closet on G-wing, and door to Medical Records room on C-D wing. The maintenance supervisor shall now randomly monitor doors for self-closing devices and that they are working properly on daily rounds of the facility.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained? The results of the implemented plan of correction and follow up monitoring on daily rounds by the Maintenance Supervisor shall be reviewed at the facility monthly QA meeting for 2 months to ensure there are no additional issues or concern in</p>	8-23-13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING OR TWINBROOK NURSING HOME B. WING	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3626 DUTCHMANS LANE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 029	<p>Continued From page 3</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²) including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>illumination of means of egress, including exit discharge, is arranged so that failure of any single</p>	K 029	<p>regards to the measures implemented. In addition, maintenance concerns are reviewed monthly in the facility QA meeting and this would allow for review of any identified preventative maintenance issue that would include a problem with the self-closing devices. If identified, additional actions would be taken and followed up on for correction.</p>
K 045 SS-P		K 045	



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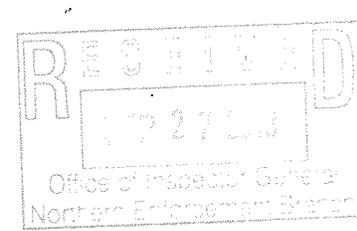
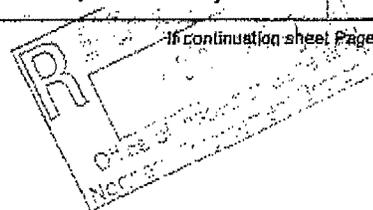
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFY PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING	(X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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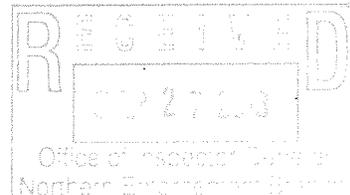
K-045	<p>Continued From page 4.</p> <p>lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.6.) 19,2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments, all residents, staff and visitors. The facility has one-hundred and seven (107) certified beds and the census was ninety-two (92) on the day of the survey. The facility failed to provide the required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observations, on 07/13/13 between 9:23 AM and 2:35 PM, with the Maintenance Supervisor revealed the two (2) exits from the A Wing Extension, the exit from the Laundry Room Corridor, the E Wing, the G Wing South, the G Wing North and the B Wing, did not have exterior egress lighting to provide the required illumination for each exit discharge. The exits were equipped with a light fixture with only one bulb.</p> <p>Interviews, on 07/13/13 between 9:23 AM and 2:35 PM, with the Maintenance Supervisor revealed he was not aware of the requirement for exterior light fixtures required for egress to have two (2) bulbs.</p>	K-045	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are considered to have a potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Two-bulb fixtures were ordered on 8/28/13 to replace the existing one-bulb fixtures for egress illumination, with installation completed on 9/6/13 for the identified exits: (2) exits from A Wing Extension, exit from Laundry Room Corridor, E Wing, G Wing South, G Wing North and B Wing. Going forward, should a replacement be needed, the maintenance supervisor will install two-bulb fixtures.</p> <p>How will the facility monitor its performance to ensure that solutions are sustained? The deficient practice shall be reviewed in the facility monthly QA for 2 months to ensure there are no additional issues or concerns as relates to the measures implemented. In addition, maintenance concerns are reviewed monthly in the facility QA</p>	9-9-13
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188466	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - TWINBROOK NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 045	Continued From page 5 Reference NFPA-101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is	K 045	meeting and this would allow for review of any identified preventative maintenance issue that would include a problem with the 2-bulb egress illumination. If identified, additional actions would be taken and followed up on for correction.		



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3528 DUTCHMANS LANE LOUISVILLE, KY 40205	
OS/ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X4) COMPLETION DATE
K 045	Continued From page 6 activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 076 SS-D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMAN'S LANE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 076	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, approximately thirty-five (35) residents, staff and visitors. The facility has one-hundred and seven (107) certified beds and the census was ninety-two (92) on the day of the survey. The facility failed to ensure oxygen cylinders were stored a minimum of five (5) feet away from any combustible items stored within the room.</p> <p>The findings include:</p> <p>Observation, on 08/13/13 at 2:02 PM, with the Maintenance Supervisor revealed the Oxygen Storage Room located near the C-D Nurses Station, had oxygen cylinders stored within five (5) feet of boxed medical supplies on open shelves.</p> <p>Interview, on 08/13/13 at 2:02 PM, with the Maintenance Supervisor revealed he was unaware oxygen cylinders could not be stored within five (5) feet of combustible items and acknowledged the potential of a hazardous situation.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2</p>	K 076	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are considered to have a potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Medical supplies were removed from the Oxygen Storage Room and moved to another location on 8/14/13. Going forward, only oxygen cylinders shall be stored in the Oxygen Storage Room. This shall be monitored on routine rounds completed by the Maintenance Supervisor and/or Central Supply personnel.</p> <p>How will the facility monitor its performance to ensure that solutions are sustained? The results of the implemented plan of correction and follow up monitoring on daily rounds by the Maintenance Supervisor shall be reviewed at the facility monthly QA meeting for 2 months to ensure there are no additional issues or concern in regards to the measures implemented. In addition, maintenance</p> <p>8-23/13</p>

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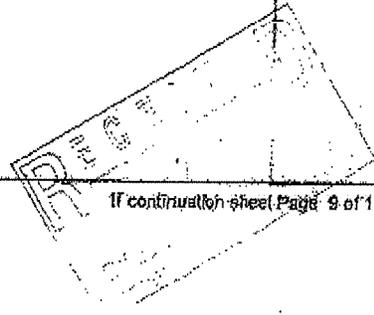
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

K 076 Continued From page 8
Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³):
(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.
(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.
(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:
(1) A minimum distance of 6.1 m (20 ft).
(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems
(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.
(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.
(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.
(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.
(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.
(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.
(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside

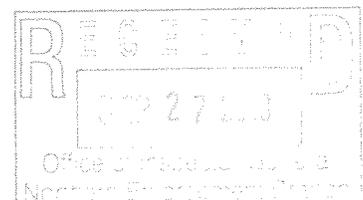
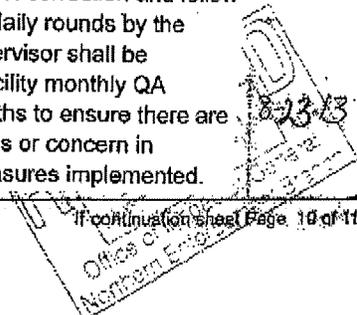
K 076 concerns are reviewed monthly in the facility QA meeting and this would allow for review of any identified preventative maintenance issue that would include a problem with the oxygen storage room. If identified, additional actions would be taken and followed up on for correction.



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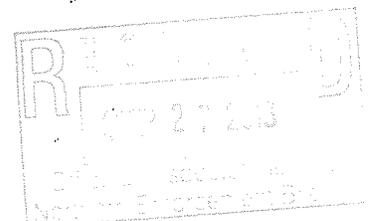
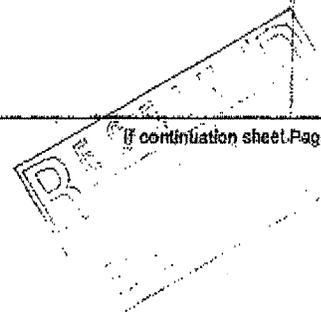
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING #1 - TWINBROOK NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED: 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 9 storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 147 SS=D	NFPA 70 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9:1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments on the Ground Floor, approximately twenty-five (25) residents, staff, and visitors. The facility has one-hundred and seven (107) certified beds and the census was ninety-two (92) on the day of the survey. The findings include: Observation, on 08/13/13 at 1:38 PM, with the Maintenance Supervisor revealed a refrigerator and a microwave oven were plugged into a power strip located in the C-D Wing Staff Break Room. Interview, on 08/13/13 at 1:38 PM, with the Maintenance Supervisor revealed he was aware of the requirements for the usage of power strips; however, he was not aware of the refrigerator and microwave oven plugged into a power strip located in the C-D Wing Staff Break Room.	K 147	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are considered to have a potential to be affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The use of the power strip in the C-D wing staff break room was corrected upon immediate identification. This shall be monitored on routine rounds completed by the Maintenance Supervisor for continued compliance. How will the facility monitor its performance to ensure that solutions are sustained? The results of the implemented plan of correction and follow up monitoring on daily rounds by the Maintenance Supervisor shall be reviewed at the facility monthly QA meeting for 2 months to ensure there are no additional issues or concern in regards to the measures implemented.	



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 10 Reference: NFPA 99 (1999 edition). 3-3.2.1.2.D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adaptors.	K 147	In addition, maintenance concerns are reviewed monthly in the facility QA meeting and this would allow for review of any identified preventative maintenance issue that would include a problem with power strip usage. If identified, additional actions would be taken and followed up on for correction.	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED R 09/27/2013
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/07/13 as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.