STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366023	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN TOWERS	5343 HAMILTON AVENUE CINCINNATI, OH 45224

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of personnel records, staff interview, and review of facility policy, the facility failed to ensure all staff were checked against the Nurse Aide Registry prior to employment to ensure the employee did not have a finding entered into the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of [REDACTED]. This had the potential to affect all 93 residents residing in the facility. Findings include: Review of personnel records revealed no evidence of employees being checked against the State Nurse Aide Registry prior to employment for the following employees: the Licensed Practical Nurse Admissions Manager (LPN AM) #155 hired on 04/25/19; Registered Nurse (RN) #166 hired on 08/16/04; Registered Nurse (RN) #177 hired on 06/10/19; and Registered Nurse (RN) #188 hired on 05/28/19. During interview on 03/03/20 at 3:00 P.M., Human Resource Manager (HRM) #70 verified the above-mentioned employees were not checked on the State Nurse Aide Registry. She stated she was not aware everyone in the facility was to be checked on the State Nurse Aide Registry. She stated she thought the LPN's and RN's were in good standing because of the check for the license with the nursing board. HRM #70 revealed the facility contracts all maintenance, housekeeping and dietary employees. Interview on 03/03/20 at 3:45 P.M. with the Administrator reviewed the hiring process documentation and confirmed the facility had not completed the State Nurse Aide Registry on the above-mentioned employees. The Administrator advised she was aware of the required State Nurse Aide Registry and thought the Human Resource department was completing the required background checks. Review of the facility policy titled Abuse, Neglect, Exploitation, and Mistreatment of [REDACTED].
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff and resident interviews, the facility failed to ensure elastic compression stockings were in place, weights were obtained daily for [MEDICAL CONDITION]. This affected one (Resident #11) of two residents reviewed for [MEDICAL CONDITION]. The census was 82. Findings include: Medical record review revealed Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of annual minimum data set ((MDS) dated [DATE] revealed intact cognitive skills for daily decision making and extensive assistance was required with dressing and personal hygiene. Review of physician order [REDACTED].M. and off at 6:00 P.M., return to elastic compression stocking once [MEDICAL CONDITION] (swelling) subsides. Review of care plan dated 01/18/20 revealed Resident #11 required staff assistance with activities of daily living care including applying the ACE wraps. Review of care plan dated 02/28/19 revealed Resident #11 had chronic lower leg [MEDICAL CONDITION] with use of a diuretic and required daily weights. Review of Resident #11's weight tracking system report for February 2020 to 03/03/20 revealed a weight was not obtained nine days, on 02/05/20, 02/08/20, 02/09/20, 02/12/20, 02/14/20, 02/18/20, 02/22/20, 03/01/20, and 03/02/20. Observation on 03/02/20 at 3:41 P.M. revealed Resident #11 was up in wheelchair with only non-skid socks in place to both feet, which were swollen. Interview with Resident #11, at the time of the observation, reported she wore elastic compression stocking on both lower legs to help prevent the swelling but the nurse never applied them earlier, for unknown reasons. Interview on 03/02/20 at 4:15 P.M. with Licensed Practical Nurse (LPN) #75, during observation of Resident #11, verified Resident #11 did not have ACE wraps or elastic compression stockings in place as ordered for [MEDICAL CONDITION]. LPN #75 confirmed she was the residents assigned nurse but reported the night shift nurse was responsible for application of the stockings prior to leaving in the morning and was unsure of the reason this was not completed. LPN #75 reported Resident #11 had a chronic problem with [MEDICAL CONDITION]. Interview on 03/05/20 at 3:52 P.M. with the Director of Nursing (DON) confirmed Resident #11 did not have daily weights obtained as ordered.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, menu review and recipe review, the facility failed to serve lunch according to the recipe and menu. This affected all 82 residents. Findings include: Observation of Rehab Unit dining room on 03/02/20 at 12:25 P.M. revealed residents received soft beef tacos with shredded lettuce and chopped tomatoes. No other toppings were offered during the service. Observation of Health Care Four dining room on 03/02/20 at 12:25 P.M. revealed residents were served taco meat on soft tortilla with shredded cheese. No other toppings offered or available. Observation of Health Care Three dining room on 03/02/20 at 1:19 P.M. revealed residents were served soft tacos with meat only. No toppings were available. Review of Monday's lunch menu revealed the main entree was listed as Soft Beef Taco. Review of recipe entitled beef taco, soft revealed the following ingredients listed onions, yellow, fresh, minced, tomatoes, fresh, chopped, olives, black, pitted, sliced, and sauce, salsa, picante, mild. The recipe stated to place shredded lettuce, chopped tomato, and black olives on taco or on the side, and salsa in a souffle dish for service. Interview on 03/03/20 at 03:11 P.M. Dining Director #300 reviewed taco menu item and verified it does not have a descriptor on the menu of included items, but he would expect additional items to the taco meat. Dining Director #300 verified he did saw two resident with just taco meat, but they were on limited diet. He did not recall seeing any residents with condiments, shredded lettuce, chopped tomato, black olives, or salsa on their plates, which were listed in the beef taco, soft recipe.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of Blood Glucose Monitoring System Reference Manual, the facility failed to ensure blood glucose monitoring equipment was properly disinfected between use of residents. This affected one (Resident #9) resident of nine observed for medication administration. The facility identified four (Residents #9, #33, #43, and #79) whom had blood glucose monitoring on the third floor of the health center. The facility census was 82. Findings include: Observation on 03/04/20 at 4:32 P.M. revealed Licensed Practical Nurse (LPN) #82 obtained a blood glucose monitoring device from the medication cart, cleaned the device with an alcohol pad, and obtained blood for glucose monitoring from Resident #9. LPN #82 then wiped the device with an alcohol pad and returned the device to the medication cart. Interview with LPN #82 at the time of the observation reported there were two medication carts on the third floor with two glucose monitoring meters on each medication cart which were shared amongst all residents who required blood glucose monitoring. The meters were cleaned between usage with alcohol pads. Review of Blood Glucose Monitoring System Reference Manual revealed to minimize the risk of transmitting blood borne pathogens, the cleaning and disinfection procedure should be performed as

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) recommended in the instructions. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood borne pathogens. A environmental protection agency (EPA) registered disinfectant effective against human immunodeficiency virus ,[MEDICAL CONDITION]., [MEDICAL CONDITION] and [MEDICAL CONDITION] virus is recommended. Two disposable wipes were needed for each cleaning and disinfecting procedure; one wipe for cleaning and a second wipe for disinfecting. To clean the meter, wipe the entire surface of the meter three times horizontally and three times vertically using one towelette to clean blood and other body fluids. After cleaning, disinfect by wiping the entire surface of the meter three times horizontally and three times vertically to remove blood-borne pathogens. Allow the exterior to remain wet for the appropriate contact time and then wipe the meter using using a dry cloth.