STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185152	A. BUILDING _____ B. WING _____	03/26/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMERWOODS NURSING & REHABILITATION CENTER	555 BOURNE AVENUE SOMERSET, KY 42501

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy it was determined the facility failed to notify the physician of a significant change of condition for one (1) of fourteen (14) sampled residents (Resident #1). On 03/08/15, at approximately 8:30 AM to 9:30 AM, Resident #1 (who was normally alert and oriented) complained of shortness of breath, pain, and symptoms of chest congestion. Facility staff notified the resident's physician (exact time unknown) and received orders for an antibiotic and a breathing treatment. However, at the noon meal the resident was unable to hold a cup or utensils; and between 2:00 PM to 3:00 PM the resident was pale, clammy, and staring off into space. Facility nursing assistants stated they notified the resident's nurse regarding the change in the resident's condition. However, review of the clinical record revealed no documented evidence the resident's physician was notified of the resident's change in condition. On 03/08/15, at approximately 4:15 PM, Resident #1's family found the resident with labored breathing and he/she was not responding as he/she normally did to the family. The family member notified the nurse assigned to care for the resident; however, there was no documented evidence the resident's physician was notified. The family member contacted the resident's physician's Advanced Practice Registered Nurse (APRN) to have the resident sent to the hospital. The APRN notified the facility nurse and an order was received to transfer Resident #1 to the hospital. When Emergency Medical Services (EMS) arrived at the facility at 4:53 PM, they assessed the resident to be responsive only to painful stimuli; to have an oxygen saturation of 72% (normal range 95-100%) on three (3) liters of oxygen; to have a fever and very wet lung sounds; and [MEDICAL CONDITION] (the upper chambers of the heart (atria) quiver) with a heart rate of 90-170 beats per minute. When the resident arrived at the hospital, the resident's temperature was 103 degrees Fahrenheit rectally (normal rectal temperature range 99.1-99.6 degrees Fahrenheit). Further review revealed the resident had shallow, rapid, and difficult respiration at a rate of 26 respirations per minute (normal range 12-20 breaths per minute); and the resident's oxygen saturation was 82% (normal range is 95-100%). Resident #1 was admitted to the hospital and required intubation (a tube placed in the trachea (windpipe) for mechanical breathing on a ventilator), and sustained a [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]). The resident passed away at 5:00 AM on 03/09/15 (refer to F282 and F309). The facility's failure to have an effective system in place to ensure each resident's physician was immediately notified of changes of condition was likely to cause serious injury, harm, impairment, or death of a resident. Immediate Jeopardy was determined to exist on 03/08/15 at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282); 42 CFR 483.25 Quality of Care (F309); and 42 CFR 483.75 Administration (F514). The facility was notified of the Immediate Jeopardy on 03/20/15. An acceptable Allegation of Compliance was received on 03/24/15, which alleged removal of the Immediate Jeopardy on 03/25/15. A partial extended survey was conducted on 03/25-26/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/25/15, which lowered the Scope and Severity to D at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), and 42 CFR 483.25 Quality of Care (F309); and the Scope and Severity was lowered to an E at 42 CFR 483.75 Administration (F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled Notification of Physician for Change In Resident's Condition, dated August 2012, revealed it was the policy of the facility to notify the physician when a significant change in a resident's condition occurred with documentation contained within the medical record. Review of Resident #1's closed medical record revealed the facility admitted Resident #1 on 01/27/15 with [DIAGNOSES REDACTED]. Review of the Comprehensive Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. Further review of the assessment revealed the facility assessed the resident to eat independently with setup help only. Review of the closed medical record for Resident #1 revealed computerized Nurse's Notes for the resident dated 03/08/15 at 10:14 AM (the exact time of the assessment is unknown; this is the time the assessment was documented). The facility assessed Resident #1 to be slightly pale, with shortness of air, and oxygen saturation levels that ranged from 87 to 92% (normal is 95-100%), with oxygen being administered at four (4) liters per minute. The resident was noted to have chest pain with congestion in the upper lobes and diminished lung sounds in the bases. The Nurse's Note stated the resident's physician was contacted. Review of the Situation, Background, Assessment, Request (SBAR) communication note dated 03/08/15, at 11:07 AM, revealed the resident's oxygen saturation was 92% on four (4) liters of oxygen, the resident had chest congestion, a weak cough, and was short of air. Further review of the SBAR revealed new physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. An interview conducted with Certified Nurse Aide (CNA) #2 on 03/19/15 at 4:10 PM, and on 03/20/15 at 1:25 PM, revealed on 03/08/15 at approximately 7:30 AM Resident #1 was in bed and complained of smothering. The CNA assisted the resident to a wheelchair and to the dining room for breakfast. Further interview with CNA #2 revealed Resident #1 stated he/she did not feel well, was observed to be pale, and only ate about 25% of breakfast. Additional interview with CNA #2 revealed she did not report the change in the resident's condition to the resident's nurse because Licensed Practical Nurse (LPN) #1 (the nurse assigned to the resident) was already aware Resident #1 was not feeling well. According to CNA #2, later that day between 2:00 PM and 3:00 PM, the resident was in bed and she assisted the resident with changing his/her clothing. The CNA stated she did not notice any difference or change in the resident from earlier in the day. On the next shift (which started at 3:00 PM), CNA #2 stated the resident's family came to the facility and the resident was not responding to the family member and had slurred speech. According to CNA #2, the family member went to the nurses' station and spoke to LPN #1 regarding her concerns because Resident #1 was usually not like this. Interview with CNA #1 conducted on 03/19/15 at 1:25 PM, and on 03/20/15 at 11:20 AM, revealed she was in the dining room at the noon meal on 03/08/15 at approximately 12:30 PM to 1:30 PM. CNA #1 stated Resident #1 was not his/her usual self at that time. The resident was not as alert and oriented, was not able to feed himself/herself, and was not able to hold a cup or utensils. In addition, CNA #1 stated LPN #1 attempted to administer the resident's medications and the resident spilled his/her juice twice. The CNA stated LPN #1 had to assist the resident with taking his/her medications. Further interview with CNA #1 revealed while she was assisting CNA #2 to reposition Resident #1, she noticed the resident's skin was pale and

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

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) clammy and the resident was staring off into space. According to CNA #1, she reported her concerns regarding Resident #1's change of condition to LPN #1; however, CNA #1 stated LPN #1 blew her off and ignored her concerns. An interview with Licensed Practical Nurse (LPN) #1 on 03/19/15 at 2:50 PM revealed she was assigned to care for Resident #1 on 03/08/15. According to LPN #1, Resident #1 did not eat anything for breakfast on 03/08/15 and the resident reported to her during the 8:00 AM medication pass that he/she was having trouble breathing and may be getting [MEDICAL CONDITION]. Additional interview revealed Resident #1 had problems holding his/her cup at breakfast. According to LPN #1, she assessed Resident #1, obtained the resident's vital signs during this time, and documented the results in the Nurse's Notes at 10:15 AM on 03/08/15. LPN #1 stated she contacted the physician for Resident #1 and obtained orders for an antibiotic and a nebulizer treatment. Further interview revealed LPN #1 assisted the resident to bed at some point after lunch (exact time unknown) and administered his/her 2:00 PM medications between 1:00 PM and 3:00 PM. LPN #1 stated she did not notice any additional concerns or changes in the resident's condition. Review of the medical record revealed no documented evidence that LPN #1 reassessed Resident #1 or notified the physician after 11:16 AM on 03/08/15. Further interview with LPN #1 revealed she did not recall the nursing assistants reporting to her that the resident's condition had worsened. According to LPN #1, she was at the nurses' station on 03/08/15 at approximately 4:20 PM to 4:30 PM, when Resident #1's family member approached her and asked what was going on with Resident #1. LPN #1 stated she reported to the family member that she had called the resident's physician earlier in the day and that the resident had received medications already. LPN #1 stated the family member did not agree with the physician's orders [REDACTED].#1 had pneumonia. Further interview with the LPN revealed she did not assess the resident or notify the resident's physician of the family member's concerns. The LPN stated she then received a call from an Advanced Practice Registered Nurse (APRN), who worked for Resident #1's Primary Care Physician. LPN #1 stated they discussed Resident #1, and then the APRN called her back and gave her orders for Resident #1 to be transferred to the hospital for evaluation and treatment. LPN #1 stated she got Resident #1's paperwork ready to transfer to the hospital; however, she did not assess the resident. LPN #1 stated she only saw the resident when the paramedics were transporting the resident on a stretcher from the facility. An interview conducted with Family Member (FM) #1 on 03/18/15 at 3:30 PM, revealed when she arrived at the facility on 03/08/15 at approximately 4:15 PM, she found Resident #1 with labored gurgling respirations that could be heard from the door; the resident was lethargic and mumbling. According to FM #1, she went immediately to the nurses' station to see what was going on with Resident #1. The family member spoke with LPN #1 regarding her concerns. FM #1 stated she did not agree with the [DIAGNOSES REDACTED]. Further interview with FM #1 revealed she informed the APRN of the resident's condition and told her that she did not agree with the treatment. FM #1 stated that after speaking with the APRN, the APRN called the facility and gave orders for the resident to be transferred to the hospital. At the hospital, Resident #1 was diagnosed with [REDACTED]. Resident #1 passed away at the hospital at 5:00 AM on 03/09/15, the next day. Interview with the Director of Nursing (DON) on 03/20/15 at 5:15 PM, revealed staff was required to report when a resident had a change in condition to a nurse. The nurse was required to assess the resident as soon as possible, notify the physician, and document their findings using the Situation Background Assessment Request (SBAR) format. According to the DON, if staff determined an emergency existed, they could contact the physician and send the resident to the hospital. The DON stated she was informed Resident #1 was transferred to the hospital on [DATE]. However, she was not aware that CNAs had reported changes of condition to LPN #1, who had not notified the resident's physician. She further stated she was not aware the LPN did not call the physician with the family member's concerns. The DON stated she was also not aware LPN #1 did not assess Resident #1 after the family member reported her concerns with Resident #1's condition on 03/08/15. Interview on 03/20/15 at 6:00 PM, with the Administrator revealed he was not aware LPN #1 had not assessed Resident #1 after concerns were reported to her by the resident's family on 03/08/15. According to the Administrator, if a change in a resident's condition was reported to the nurse, the nurse was required to contact the resident's physician. Further interview with the Administrator revealed LPN #1 should have assessed Resident #1 when the family reported concerns, and acted on the findings of the assessment. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/08/15, Resident #1 was sent to the hospital and treated in the emergency room for pneumonia,[MEDICAL CONDITION], and ST segment elevation [MEDICAL CONDITION] infarction (STEMI) ([MEDICAL CONDITION]). The resident had a stent placed. Resident #1 passed away at the hospital on [DATE]. 2) On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor conducted evaluations of all current residents to determine if there were any medical needs requiring physician notification which had not been addressed. Two (2) issues were identified. (A)--A [MEDICAL TREATMENT] patient (identified by the facility as Resident A) refused [MEDICAL TREATMENT] and later had weeping from the lower extremities. A nursing intervention was implemented, the resident's physician was notified of the change, physician orders [REDACTED]. The Unit Manager validated implementation of the new orders and continued monitoring of the resident. (B)--Resident B (identified by the facility as Resident B), who has a [DIAGNOSES REDACTED]. The Physician was made aware and ordered diagnostic testing, the resident's responsible party was notified of the resident's condition, and the procedure was ordered. The Unit Manager validated the implementation of the new orders and monitoring of the patient. On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor reviewed all current residents' plans of care to determine that all interventions were being followed. Minor revisions were made to the care plans as needed. One care plan was significantly changed related to a patient's condition of [MEDICAL CONDITION] (interventions were in place). No change to the plans of care required notification to a Physician. 3) The INTERACT program is an evidence based Plan, Do, Check, Act process developed through funding from the Centers for Medicare and Medicaid Services (CMS) to prevent unnecessary acute care transfers and includes a binder of care paths, which are algorithms used for directing nurses through evaluating residents, providing care, and notifying the physician for certain common symptoms. It includes the SBAR (Situation, Background, Analysis, and Request) tool for nurses to complete and effectively communicate a resident's condition or change of condition with the Physician. On 03/20/15, the RN (Registered Nurse) Nurse Consultant re-educated the Staff Facilitator regarding conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluations, as well as physician notification; and, for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor and began re-education of Nurses, Medication Technicians, and Certified Nurse Aides on conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluation, as well as physician notification; and for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/21/15-03/22/15, Unit Managers, MDS Nurses, QI Nurses, Weekend House Supervisor, and Staff Facilitator continued with re-education with all Nurses, Medication Technicians, and Certified Nurse Aides related to conducting an evaluation based on resident condition to include the INTERACT program, follow-up evaluations, as well as physician notification for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15, the RN Facility Consultant re-educated the Staff Facilitator regarding the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. On 3/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor on the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Beginning 03/21/15 and ongoing, all licensed staff was re-educated by the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, or Staff Facilitator regarding the requirement to follow the plan of care and if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Posttests were developed on 03/23/15 for Licensed Nurses, Medication Technicians, and Certified Nurse Aides to demonstrate retained knowledge of the re-education. Approximately 90 percent of the licensed nurses and approximately 75 percent of the

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F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) Medication Aides and Certified Nurse Aides have completed the in-service education and posttest. These staff indicated understanding and stated all questions were answered at the end of the education sessions. No Licensed Nurse, Medication Technician, or CNA will work after 03/23/15 without having completed this re-education. No Licensed Nurse, Medication Aide, or CNA will provide patient care after 03/24/15 without having completed both the re-education and posttest. Beginning 03/21/15 and ongoing, all CNAs were re-educated with following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No CNAs will work after 03/23/15 without having received this re-education. All newly employed direct care staff will receive this education prior to working on a unit. Direct care staff on leave of absence or vacation will complete this re-education prior to working. 4) Beginning 03/23/15, the Director of Nursing, QI Nurses, Unit Managers, Staff Facilitator, Weekend House Supervisor, or RN Facility Consultant will conduct walking rounds to review with facility licensed nurse staff residents' conditions daily. These rounds will also include an investigation to determine if licensed staff are notifying the physician of significant changes in condition and completing ongoing evaluation as needed. This process will also include observation and discussion with Licensed Nurses and Certified Nurse Aides to determine if plans of care, including revisions, are being followed. The rounds will also consist of discussion with CNAs to determine if they have noted any changes in the residents throughout their shift and review of the STOP and WATCH (the tool included in the INTERACT program for CNAs to alert changes in resident condition in the electronic medical record). This will continue daily until abatement of Immediate Jeopardy then four (4) times per week for four (4) weeks thereafter. Beginning 03/23/15, the Director of Nursing, QI Nurses, Staff Facilitator, Unit Managers, Weekend House Supervisor, or RN Facility Consultant will review all Nurse's Notes daily to determine if any significant change in condition has occurred without physician notification or any significant change in condition has occurred without evaluation. This will occur daily until abatement of the Immediate Jeopardy and then four (4) times per week for four (4) weeks. The Clinical Interdisciplinary Team (IDT) which includes the Director of Nursing, Unit Managers, QI Nurses, Staff Facilitator, MDS Nurses, Weekend House Supervisor, RN Facility Consultant, or Treatment Nurse, will continue to follow the established process of reviewing the Nurse's Notes, Shift Reports, and physician's orders [REDACTED]. The Weekend House Supervisor reviews the documents Saturday and Sunday and reports to the Director of Nursing and Administrator at least daily. The Weekend House Supervisor and MDS Nurses will revise care plans through the established process. 5) On 03/20/15, an ad hoc Quality Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Associate Medical Director who approved. In attendance was the Administrator, RN Facility Consultant, Unit Managers, QI Nurses, MDS Nurses, Social Services Director, Kitchen Manager, Staff Facilitator, Admissions Director, and Activity Director. No further recommendations were made. The Administrator, Director of Nursing, QI Nurses, or RN Facility consultant will review the audits daily until abatement of Immediate Jeopardy. Thereafter, the results of these audits will be reviewed with the Quality Improvement Committee weekly and anytime a concern is identified until substantial compliance has been achieved; then per the schedule established by the Executive QI Committee. Thereafter, Members of the QI Committee will consist of at a minimum, the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, and Staff Facilitator. The Executive QI Committee consists of the Administrator, Director of Nursing Services, Unit Managers, QI Nurses, RN MDS Coordinator, Staff Facilitator, Treatment Nurse, Social Services Director, Social Services Assistant, Director of Activities, Director of Admissions, Dietary Services Director, Maintenance Director, Director of Environment and Safety, and Medical Director. ***The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the closed record for Resident #1 revealed the resident was transferred to the hospital on [DATE]. 2) Observations of Residents #11, #12, #13, and #14 on 03/25/15-03/26/15 revealed no concerns with changes of condition or following the plan of care. Review of Resident #11's medical record (identified by the facility as Resident A) revealed the facility assessed the resident to have weeping [MEDICAL CONDITION] to the lower extremities on 03/21/15. The resident's physician was notified of the change in the resident's condition on 03/21/15 at 7:39 PM, and orders were received for Keflex (antibiotic) 500 mg for [MEDICAL CONDITION] to the lower extremities. Review of the plan of care revealed no concerns. Review of the medical record for Resident #12 (identified by the facility as Resident B) revealed the facility assessed the resident to have a change in condition on 03/22/15 at 9:06 PM. The resident had [MEDICAL CONDITION] to the lower extremities. The resident's physician was notified and orders received for a venous study. Review of the plan of care revealed no concerns. Review of the medical records for Residents #13 and #14 revealed the residents were assessed for a change of condition on 03/21/15 with no changes of condition identified. Review of the plans of care for these residents revealed no concerns. 3) Interview with the Staff Facilitator on 03/26/15 at 1:55 PM revealed the Staff Facilitator had been trained by the Nurse Consultant on the Interact Program related to follow-up evaluations/assessments of residents using the SBAR tool. The Nurse Consultant had also trained the Staff Facilitator on assessing changes of condition, physician notification, and following residents' plans of care. According to the Staff Facilitator, she then began training all nursing staff. Interviews with CNAs #3, #4, #5, #6, #7, and #8 on 03/26/15 at 10:52 AM, 11:11 AM, 11:34 AM, 11:50 AM, 2:05 PM, and 2:20 PM respectfully, revealed the CNAs had been trained regarding notifying the nurse of a change of condition, using the Stop and Watch program, the resident assessment for change of condition, and following the plan of care. Interviews on 03/26/15 with LPN #2 at 11:00 AM, LPN #3 at 10:55 AM, LPN #4 at 1:00 PM, RN #1 at 12:50 PM, the Treatment Nurse at 11:30 AM, the West Wing Unit Manager at 1:15 PM, and the Second Floor Unit Manager at 1:30 PM revealed they had been trained regarding changes of condition, assessing/monitoring residents after a change of condition, notification of the physician, using the SBAR form, and following the resident's care plan. Review of the INTERACT training documentation revealed the training was given on 03/20/15, the Staff Facilitator had been educated by the Nurse Consultant and the Staff Facilitator conducted training for nursing staff with no concerns identified. The documentation revealed the facility was monitoring staff that had been trained to ensure they were following the process. Review of posttests revealed staff had been given posttests and the results were reviewed by the facility. 4) Interviews on 03/26/15 with the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, the MDS Nurse at 2:15 PM, the QI Nurse at 2:25 PM, and the West Wing Unit Manager at 1:15 PM revealed walking rounds were being conducted twice daily. These rounds included review of Nurse's Notes for SBAR assessments; monitor residents for change in condition; staff to discuss residents' condition with nurses and CNAs; and ensure care plans were being followed. They were also monitoring to ensure physicians were notified if needed and to ensure that nurses conducted follow-up evaluations if needed. Review of the facility's documentation of walking rounds conducted from 03/22/15 through 03/26/15 revealed walking rounds were being completed and were ongoing on 03/26/15 with no concerns identified. 5) Interviews on 03/26/15 at 3:30 PM with the Administrator, the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, and the QI Nurse at 2:25 PM revealed the facility's Quality Assurance Committee was meeting daily to review daily audits for concerns with assessments, physician notification of change of condition, and following the residents' plans of care. Review of the Quality Assurance Committee minutes conducted on 03/21/15 through 03/26/15 revealed the facility had identified no concerns.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility's policy it was determined the facility failed to follow the plan of care and notify the resident's physician of an ineffective breathing pattern for one (1) of fourteen (14) sampled residents (Resident #1). Review of the Comprehensive Care Plan for Resident #1 revealed the facility identified a care need of potential for, or actual ineffective breathing pattern related to the resident's history of breathing problems. According to the plan of care, interventions included to notify the resident's physician of signs and symptoms of an ineffective breathing pattern. Resident #1 experienced a change in condition on 03/08/15 between 8:30 AM and 9:30 AM. He/she complained of shortness of breath, pain, and chest congestion. The facility assessed the resident to be slightly pale and short of air with oxygen

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) saturation levels that ranged from 87 to 92% (normal range 95-100%), with oxygen being administered at four (4) liters per minute. The resident's physician was contacted and orders were received [MEDICATION NAME](antibiotic) and [MEDICATION NAME] nebulizer treatment (breathing treatment). Staff interviews revealed the resident's condition did not improve. On 03/08/15 at 4:15 PM, the family visited Resident #1 and found the resident with labored breathing and he/she was lethargic; the nurse was notified of the resident's condition. However, the nurse failed to monitor the resident's respiratory status after being notified by the family that the resident was in respiratory distress, as per the plan of care required. The family contacted the Nurse Practitioner and orders were received to transfer the resident to the hospital. The nurse failed to assess the resident for worsening condition and notify the resident's physician of the resident's condition, per the plan of care. The resident was transferred to the local hospital. Resident #1 required intubation shortly after arrival to the hospital and later sustained a [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]). The resident was admitted to the hospital and passed away at 5:00 AM on 03/09/15 (reference F157 and F282). The facility's failure to ensure each resident's plan of care was implemented was likely to cause serious injury, harm, impairment, or death of a resident. Immediate Jeopardy was determined to exist on 03/08/15 at 42 CFR 483.10 Resident Rights (F157 - J), 42 CFR 483.20 Resident Assessment (F282 - J), and 42 CFR 483.25 Quality of Care (F309 - J), and 42 CFR 483.75 Administration (F514 - K). The facility was notified of the Immediate Jeopardy on 03/20/15. An acceptable Allegation of Compliance was received on 03/24/15, which alleged removal of the Immediate Jeopardy on 03/25/15. A partial extended survey was conducted on 03/25-26/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/25/15, which lowered the Scope and Severity to D at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), and 42 CFR 483.25 Quality of Care (F309); and 42 CFR 483.75 Administration (F514) was lowered to an E, while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Interview conducted with the Director of Nursing on 03/20/15 at 5:15 PM revealed the facility did not have a specific policy regarding following or implementing a resident's plan of care but utilized the Interact Care Path Algorithm Program for interventions of monitoring residents who had a change of condition. Review of the Interact Care Path Algorithm for Shortness of Breath dated 2011 revealed for symptoms of difficult or labored breathing that were out of proportion to the resident's level or activity, or a new complaint of shortness of breath, vital signs were to be obtained which should include the resident's oxygen saturation. If abnormal, new or worsening chest pain required notification of the Physician and monitoring the resident's vital signs every four to eight (4-8) hours. Staff was also to monitor the resident for a worsening condition. Record review revealed the facility admitted Resident #1 on 01/27/15 from the hospital with [DIAGNOSES REDACTED]. Review of the Comprehensive Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. The resident was assessed to be independent with eating and required setup help only. According to the assessment, the resident only had shortness of breath with exertion (walking, bathing, and transferring). According to the Care Area Assessment Summary (CAAS), the resident was alert, oriented to person, place, and time, and able to make needs and wants known to staff. Review of the Comprehensive Care Plan for Resident #1 dated 02/05/15, revealed the facility identified a care need of potential for or actual ineffective breathing pattern related to [DIAGNOSES REDACTED]. Interventions included monitoring for ineffective breathing pattern, shortness of breath, wheezing, crackles, cough, elevated temperature, activity intolerance, increased confusion, and pleuritic chest pain. According to the plan of care, interventions included to notify the resident's physician of signs and symptoms of an ineffective breathing pattern. Review of Resident #1's Nurse's Notes dated 03/08/15 at 10:14 AM, revealed at an earlier time (exact time unknown) the resident was assessed to be slightly pale and have shortness of air with oxygen saturation levels that ranged from 87 to 92%, with oxygen being administered at four (4) liters per minute (normal range 95-100%). The resident was assessed to have chest pain and chest congestion in the upper lobes and diminished lung sounds in the bases. The physician was contacted. Further review revealed new physician's orders [REDACTED]. Further review of the clinical record revealed a Nurse's Note dated 03/08/15 at 4:52 PM, which stated the resident's family was in the facility and reported to the nurse that the resident had labored respirations. The family member questioned the type of treatment the resident was receiving and called the Advanced Practice Registered Nurse (APRN). The APRN called the facility and requested to have the resident transferred to the emergency room . Further review of the clinical record revealed no documented evidence the nurse conducted a follow-up assessment of the resident's condition after 11:07 AM on 03/08/15. There was no documented evidence that the nurse monitored the resident's condition for improvement or decline or notified the physician after the family informed the nurse that Resident #1 was having difficulty breathing, as required per the resident's plan of care. Review of the Hospital Record for Resident #1 revealed upon arrival to the emergency roiagnom on [DATE] at 5:10 PM, the resident had shallow, rapid, and difficult respirations at a rate of 26 respirations per minute and his/her oxygen saturation was 82% (normal 95-100%); the resident's temperature was noted to be 103 degrees Fahrenheit, rectally. Further review of the record revealed the resident required intubation and sustained a [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]). Resident #1 was admitted to the hospital and passed away at 5:00 AM on 03/09/15. Interview conducted on 03/19/15 at 1:25 PM and on 03/20/15 at 11:20 AM, with Certified Nurse Aide (CNA) #1 revealed she was in the dining room at the noon meal on 03/08/15 at approximately 12:30 PM to 1:30 PM. According to the CNA, Resident #1 was not his/her usual self. The CNA said Resident #1 was not as alert and was slow to respond verbally. The CNA said physically the resident was unable to hold a cup or utensils and could not feed himself/herself. The resident was not able to hold his/her juice glass and spilled the juice. CNA #1 stated the resident was provided another cup of juice by Licensed Practical Nurse (LPN) #1 which the resident also spilled. Further interview with the CNA revealed during this time, the resident was administered medications by LPN #1. However, LPN #1 had to assist the resident to take his/her medications. According to CNA #1, she reported her concerns regarding Resident #1's change of condition to LPN #1; however, CNA #1 stated LPN #1 blew her off and ignored her concerns. Interview with LPN #1 on 03/19/15 at 2:50 PM revealed she was assigned to care for Resident #1 on 03/08/15. During the 8:00 AM medication pass, LPN #1 said Resident #1 reported having trouble breathing and told the nurse he/she may be getting [MEDICAL CONDITION]. Further interview with the LPN revealed Resident #1 had problems holding a cup at breakfast and did not eat anything for breakfast. According to LPN #1, she assessed Resident #1 and obtained vital signs during this time. LPN #1 stated she contacted the On-Call Physician for Resident #1 and informed the physician of Resident #1's condition. The physician gave orders for an antibiotic and a nebulizer treatment. Further interview revealed LPN #1 assisted the resident to bed at some point in the day after lunch (exact time unknown) and administered 2:00 PM medications to the resident between 1:00 PM and 3:00 PM. The LPN stated she did not notice any additional concerns or changes in the resident's condition when she administered the 2:00 PM medication. At approximately 4:20 PM on 03/08/15, the LPN said she was approached by a family member of Resident #1 and the family member asked about the condition of Resident #1 and reported to her that they thought the resident had pneumonia. According to LPN #1, she reported to the family member what she told the physician earlier in the day and that the resident received medications earlier in the day. The LPN said the family member did not agree with the resident's assessment and treatment and thought Resident #1 had pneumonia. Further interview with the LPN revealed she did not assess the resident's condition after the family member talked with her nor did she obtain vital signs on Resident #1, which she should have been doing, per the care plan. According to LPN #1, she only saw the resident when the paramedics were transporting the resident on a stretcher from the facility. According to LPN #1, care plan interventions of monitoring the resident were done when making rounds to pass medications, and to ensure the plan of care was being followed. LPN #1 stated she was not aware of any changes with Resident #1 and the resident was not in any distress when she put the resident to bed after lunch and when she administered the 2:00 PM medications. An interview conducted with Family Member (FM) #1 on 03/18/15 at 3:30 PM, revealed the FM arrived at the facility on 03/08/15 at approximately 4:15 PM and found Resident #1 having labored gurgling respirations, and the resident was lethargic and mumbling. According to FM #1, she went immediately to the nurses' station to check on the condition of Resident #1. The family member spoke with LPN #1 and was informed by the LPN that Resident #1 had an upper respiratory infection and had [MEDICATION NAME](antibiotic medication). FM #1 stated she contacted the APRN who worked with the resident's physician and informed the APRN of the resident's condition. According to FM #1, facility nursing staff did not

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) assess Resident #1's condition while the family member was at the facility. FM #1 stated that Resident #1 was transported to the hospital via ambulance and was diagnosed with [REDACTED]. Interview with the Director of Nursing (DON) was conducted on 03/20/15 at 5:15 PM. The DON stated when a resident's care plan intervention included monitoring of symptoms the Situation, Background, Assessment, Request (SBAR) format was utilized to note an initial change of condition. The facility's acute charting (documentation of the resident's condition once per shift) was then utilized to document the monitoring of the resident. Further interview revealed when a resident experienced a change in condition, the nurse was required to assess the resident as soon as possible, notify the physician, and document findings. According to the DON, LPN #1 did not follow the resident's plan of care and assess Resident #1 after CNA #1 and FM #1 reported changes in the resident's condition on 03/08/15. According to the DON, she had been informed Resident #1 was transferred on 03/08/15, but she was not aware Resident #1 was not assessed by the nurse after the family reported concerns with Resident #1's condition on 03/08/15. Interview conducted with the Administrator on 03/20/15 at 6:00 PM, revealed he was not aware LPN #1 had not assessed Resident #1 after concerns were reported by the resident's family on 03/08/15. According to the Administrator, if a resident had a change of condition and was care planned with interventions for monitoring of the condition, the nurse was required to assess the resident, contact the physician, and document findings/notification in the medical record. Further interview with the Administrator revealed LPN #1 should have assessed/monitored Resident #1 when the family reported their concerns with the resident on 03/08/15. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/08/15, Resident #1 was sent to the hospital and treated in the emergency room for pneumonia,[MEDICAL CONDITION], and ST segment elevation [MEDICAL CONDITION] infarction (STEMI) ([MEDICAL CONDITION]). The resident had a stent placed. Resident #1 passed away at the hospital on [DATE]. 2) On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor conducted evaluations of all current residents to determine if there were any medical needs requiring physician notification which had not been addressed. Two (2) issues were identified. (A)--A [MEDICAL TREATMENT] patient (identified by the facility as Resident A) refused [MEDICAL TREATMENT] and later had weeping from the lower extremities. A nursing intervention was implemented, the resident's physician was notified of the change, physician orders [REDACTED]. The Unit Manager validated implementation of the new orders and continued monitoring of the resident. (B)--Resident B (identified by the facility as Resident B), who has a [DIAGNOSES REDACTED]. The Physician was made aware and ordered diagnostic testing, the resident's responsible party was notified of the resident's condition, and the procedure was ordered. The Unit Manager validated the implementation of the new orders and monitoring of the patient. On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor reviewed all current residents' plans of care to determine that all interventions were being followed. Minor revisions were made to the care plans as needed. One care plan was significantly changed related to a patient's condition of [MEDICAL CONDITION] (interventions were in place). No change to the plans of care required notification to a Physician. 3) The INTERACT program is an evidence based Plan, Do, Check, Act process developed through funding from the Centers for Medicare and Medicaid Services (CMS) to prevent unnecessary acute care transfers and includes a binder of care paths, which are algorithms used for directing nurses through evaluating residents, providing care, and notifying the physician for certain common symptoms. It includes the SBAR (Situation, Background, Analysis, and Request) tool for nurses to complete and effectively communicate a resident's condition or change of condition with the Physician. On 03/20/15, the RN (Registered Nurse) Nurse Consultant re-educated the Staff Facilitator regarding conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluations, as well as physician notification; and, for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor and began re-education of Nurses, Medication Technicians, and Certified Nurse Aides on conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluation, as well as physician notification; and for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/21/15-03/22/15, Unit Managers, MDS Nurses, QI Nurses, Weekend House Supervisor, and Staff Facilitator continued with re-education with all Nurses, Medication Technicians, and Certified Nurse Aides related to conducting an evaluation based on resident condition to include the INTERACT program, follow-up evaluations, as well as physician notification for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15, the RN Facility Consultant re-educated the Staff Facilitator regarding the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. On 3/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor on the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Beginning 03/21/15 and ongoing, all licensed staff was re-educated by the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, or Staff Facilitator regarding the requirement to follow the plan of care and if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Posttests were developed on 03/23/15 for Licensed Nurses, Medication Technicians, and Certified Nurse Aides to demonstrate retained knowledge of the re-education. Approximately 90 percent of the licensed nurses and approximately 75 percent of the Medication Aides and Certified Nurse Aides have completed the in-service education and posttest. These staff indicated understanding and stated all questions were answered at the end of the education sessions. No Licensed Nurse, Medication Technician, or CNA will work after 03/23/15 without having completed this re-education. No Licensed Nurse, Medication Aide, or CNA will provide patient care after 03/24/15 without having completed both the re-education and posttest. Beginning 03/21/15 and ongoing, all CNAs were re-educated with following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No CNAs will work after 03/23/15 without having received this re-education. All newly employed direct care staff will receive this education prior to working on a unit. Direct care staff on leave of absence or vacation will complete this re-education prior to working. 4) Beginning 03/23/15, the Director of Nursing, QI Nurses, Unit Managers, Staff Facilitator, Weekend House Supervisor, or RN Facility Consultant will conduct walking rounds to review with facility licensed nurse staff residents' conditions daily. These rounds will also include an investigation to determine if licensed staff are notifying the physician of significant changes in condition and completing ongoing evaluation as needed. This process will also include observation and discussion with Licensed Nurses and Certified Nurse Aides to determine if plans of care, including revisions, are being followed. The rounds will also consist of discussion with CNAs to determine if they have noted any changes in the residents throughout their shift and review of the STOP and WATCH (the tool included in the INTERACT program for CNAs to alert changes in resident condition in the electronic medical record). This will continue daily until abatement of Immediate Jeopardy then four (4) times per week for four (4) weeks thereafter. Beginning 03/23/15, the Director of Nursing, QI Nurses, Staff Facilitator, Unit Managers, Weekend House Supervisor, or RN Facility Consultant will review all Nurse's Notes daily to determine if any significant change in condition has occurred without physician notification or any significant change in condition has occurred without evaluation. This will occur daily until abatement of the Immediate Jeopardy and then four (4) times per week for four (4) weeks. The Clinical Interdisciplinary Team (IDT) which includes the Director of Nursing, Unit Managers, QI Nurses, Staff Facilitator, MDS Nurses, Weekend House Supervisor, RN Facility Consultant, or Treatment Nurse, will continue to follow the established process of reviewing the Nurse's Notes, Shift Reports, and physician's orders [REDACTED]. The Weekend House Supervisor reviews the documents Saturday and Sunday and reports to the Director of Nursing and Administrator at least

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) daily. The Weekend House Supervisor and MDS Nurses will revise care plans through the established process. 5) On 03/20/15, an ad hoc Quality Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Associate Medical Director who approved. In attendance was the Administrator, RN Facility Consultant, Unit Managers, QI Nurses, MDS Nurses, Social Services Director, Kitchen Manager, Staff Facilitator, Admissions Director, and Activity Director. No further recommendations were made. The Administrator, Director of Nursing, QI Nurses, or RN Facility consultant will review the audits daily until abatement of Immediate Jeopardy. Thereafter, the results of these audits will be reviewed with the Quality Improvement Committee weekly and anytime a concern is identified until substantial compliance has been achieved; then per the schedule established by the Executive QI Committee. Thereafter, Members of the QI Committee will consist of at a minimum, the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, and Staff Facilitator. The Executive QI Committee consists of the Administrator, Director of Nursing Services, Unit Managers, QI Nurses, RN MDS Coordinator, Staff Facilitator, Treatment Nurse, Social Services Director, Social Services Assistant, Director of Activities, Director of Admissions, Dietary Services Director, Maintenance Director, Director of Environment and Safety, and Medical Director. ***The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the closed record for Resident #1 revealed the resident was transferred to the hospital on [DATE]. 2) Observations of Residents #11, #12, #13, and #14 on 03/25/15-03/26/15 revealed no concerns with changes of condition or following the plan of care. Review of Resident #11's medical record (identified by the facility as Resident A) revealed the facility assessed the resident to have weeping [MEDICAL CONDITION] to the lower extremities on 03/21/15. The resident's physician was notified of the change in the resident's condition on 03/21/15 at 7:39 PM, and orders were received for Keflex (antibiotic) 500 mg for [MEDICAL CONDITION] to the lower extremities. Review of the plan of care revealed no concerns. Review of the medical record for Resident #12 (identified by the facility as Resident B) revealed the facility assessed the resident to have a change in condition on 03/22/15 at 9:06 PM. The resident had [MEDICAL CONDITION] to the lower extremities. The resident's physician was notified and orders received for a venous study. Review of the plan of care revealed no concerns. Review of the medical records for Residents #13 and #14 revealed the residents were assessed for a change of condition on 03/21/15 with no changes of condition identified. Review of the plans of care for these residents revealed no concerns. 3) Interview with the Staff Facilitator on 03/26/15 at 1:55 PM revealed the Staff Facilitator had been trained by the Nurse Consultant on the Interact Program related to follow-up evaluations/assessments of residents using the SBAR tool. The Nurse Consultant had also trained the Staff Facilitator on assessing changes of condition, physician notification, and following residents' plans of care. According to the Staff Facilitator, she then began training all nursing staff. Interviews with CNAs #3, #4, #5, #6, #7, and #8 on 03/26/15 at 10:52 AM, 11:11 AM, 11:34 AM, 11:50 AM, 2:05 PM, and 2:20 PM respectfully, revealed the CNAs had been trained regarding notifying the nurse of a change of condition, using the Stop and Watch program, the resident assessment for change of condition, and following the plan of care. Interviews on 03/26/15 with LPN #2 at 11:00 AM, LPN #3 at 10:55 AM, LPN #4 at 1:00 PM, RN #1 at 12:50 PM, the Treatment Nurse at 11:30 AM, the West Wing Unit Manager at 1:15 PM, and the Second Floor Unit Manager at 1:30 PM revealed they had been trained regarding changes of condition, assessing/monitoring residents after a change of condition, notification of the physician, using the SBAR form, and following the resident's care plan. Review of the INTERACT training documentation revealed the training was given on 03/20/15, the Staff Facilitator had been educated by the Nurse Consultant and the Staff Facilitator conducted training for nursing staff with no concerns identified. The documentation revealed the facility was monitoring staff that had been trained to ensure they were following the process. Review of posttests revealed staff had been given posttests and the results were reviewed by the facility. 4) Interviews on 03/26/15 with the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, the MDS Nurse at 2:15 PM, the QI Nurse at 2:25 PM, and the West Wing Unit Manager at 1:15 PM revealed walking rounds were being conducted twice daily. These rounds included review of Nurse's Notes for SBAR assessments; monitor residents for change in condition; staff to discuss residents' condition with nurses and CNAs; and ensure care plans were being followed. They were also monitoring to ensure physicians were notified if needed and to ensure that nurses conducted follow-up evaluations if needed. Review of the facility's documentation of walking rounds conducted from 03/22/15 through 03/26/15 revealed walking rounds were being completed and were ongoing on 03/26/15 with no concerns identified. 5) Interviews on 03/26/15 at 3:30 PM with the Administrator, the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, and the QI Nurse at 2:25 PM revealed the facility's Quality Assurance Committee was meeting daily to review daily audits for concerns with assessments, physician notification of change of condition, and following the residents' plans of care. Review of the Quality Assurance Committee minutes conducted on 03/21/15 through 03/26/15 revealed the facility had identified no concerns.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, hospital records, Emergency Medical Services Run Sheet, and a review of the facility's policies it was determined the facility failed to ensure one (1) of fourteen (14) sampled residents (Resident #1) received necessary care and services and was monitored and reassessed by nursing staff after the resident experienced a change in condition. On 03/08/15 between 8:30 AM and 9:30 AM, Resident #1 complained of shortness of breath, pain, and chest congestion. The resident was assessed to be slightly pale and short of air with oxygen saturation that ranged from 87 to 92% (normal range is 95 - 100%), with oxygen being administered at four (4) liters per minute. The resident's physician was contacted and orders were received [MEDICATION NAME](antibiotic) and [MEDICATION NAME] nebulizer treatment (breathing treatment). Staff interviews revealed the resident did not eat or drink as usual for lunch and was observed by staff between 2:00 PM and 3:00 PM to be pale, clammy, and staring off (not focusing). The nurse was notified of the resident's further change in condition at lunch and the change that was noted around 2:00 PM to 3:00 PM; however, the nurse did not reassess the resident at that time. On 03/08/15 at 4:15 PM, the family visited Resident #1 and found the resident with labored breathing and he/she was lethargic. The nurse was notified of the resident's condition by the family; however, the nurse did not assess the resident at that time. The family contacted the Advanced Practice Registered Nurse (APRN) and orders were received to transfer the resident to the hospital. After the nurse was notified by the APRN of the resident's condition, she still failed to assess the resident. The resident was transferred to the local hospital and required intubation (a tube placed in the mouth and throat for breathing) shortly after arrival to the hospital and later sustained a [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]). The resident was admitted to the hospital and passed away at 5:00 AM on 03/09/15 (reference F157 and F282). The facility's failure to ensure each resident was monitored/assessed and provided necessary care and services was likely to cause serious injury, harm, impairment, or death of a resident. Immediate Jeopardy was determined to exist on 03/08/15 at 42 CFR 483.10 Resident Rights (F157 - J), 42 CFR 483.20 Resident Assessment (F282 - J), 42 CFR 483.25 Quality of Care (F309 - J), and 42 CFR 483.75 Administration (F514 - K). The facility was notified of the Immediate Jeopardy on 03/20/15. An acceptable Allegation of Compliance was received on 03/24/15, which alleged removal of the Immediate Jeopardy on 03/25/15. A partial extended survey was conducted on 03/25-26/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/25/15, which lowered the Scope and Severity to D at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), and 42 CFR 483.25 Quality of Care (F309); and 42 CFR 483.75 Administration (F514) was lowered to an E while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's assessment policy titled Acute Episode, dated August 2012, revealed it was the policy of the facility to be alert to any change in a resident's condition and to respond in an appropriate manner to ensure satisfactory intervention treatment for [REDACTED]. Review of the facility's policy titled Nursing Assessment of Condition, which includes the Situation, Background, Assessment, Request (SBAR) format for communicating changes in residents to the physician, revealed if the nurse determined an emergency existed or a resident required immediate transfer to the hospital the physician was to be called, or 911 as

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) appropriate. Staff was not required to wait to fill out forms or enter data in the computer. The policy stated documentation could be done after the event. Review of Resident #1's medical record revealed the facility admitted the resident from the hospital with a history of Pneumonia on 01/27/15. The resident's [DIAGNOSES REDACTED]. Review of the Comprehensive Admission Minimum Data Set (MDS) assessment for Resident #1 dated 02/03/15, revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. Further review of the assessment revealed Resident #1 was assessed to be independent with eating and needed setup help only. According to the assessment, the resident only had shortness of breath with exertion (walking, bathing, and transferring). Review of the Care Area Assessment Summary (CAAS) notes dated 02/03/15, revealed Resident #1 was alert, oriented to person, place, and time, and able to make needs and wants known to staff. The CAAS stated the resident was in the facility for rehabilitation. Review of the Comprehensive Care Plan developed for Resident #1 dated 02/05/15, with a focus of potential for or actual ineffective breathing pattern related to [DIAGNOSES REDACTED]. Further review of the care plan revealed staff was to notify the physician of signs/symptoms of insufficient breathing patterns or as indicated for an elevated temperature. Review of the Nurse's Notes for Resident #1 dated 03/08/15 at 10:14 AM, revealed at an earlier time (exact time unknown) Resident #1 was assessed to be slightly pale with shortness of air and oxygen saturation levels that ranged from 87 to 92% (normal range 95 - 100%), with oxygen being administered at four (4) liters per minute. The resident was noted to have chest pain with congestion in the upper lobes and diminished lung sounds in the bases. According to the Note, the physician was contacted. Review of the Nurse's Notes revealed a Situation, Background, Assessment, Request (SBAR) communication note dated 03/08/15 at 11:07 AM, revealed the resident's oxygen saturation was 92% on 4 liters of oxygen and the resident had chest congestion, a weak cough, and was short of air. The physician was notified and new orders were received [MEDICATION NAME] mg (milligrams) two (2) times per day; and an [MEDICATION NAME] Nebulizer treatment every four (4) hours as needed for chest congestion and shortness of air. Review of a Nurse's Note dated 03/08/15, at 11:16 AM, revealed the physician had been notified and orders for medications were received earlier in the shift. Review of the Medication Administration Record [REDACTED]. However, the next Nurse's Note was at 4:52 PM on 03/08/15, which noted that the resident's family was in the facility and had disagreed with the type of treatment that was ordered for the resident. The family called the Advanced Practice Registered Nurse (APRN) about their concerns. The APRN called the facility and gave orders for Resident #1 be transferred to the emergency room . Further review of the clinical record revealed no documented evidence the facility assessed Resident #1 for further change of condition or that the resident's condition was monitored after 11:07 AM on 03/08/15. Review of the Emergency Medical Service (EMS) Run Sheet for Resident #1 dated 03/08/15, revealed EMS was dispatched to the facility at 4:46 PM and arrived at the facility at 4:53 PM. According to the Run Sheet, EMS assessed the resident to be responsive to painful stimuli only and to have an oxygen saturation of 72% on three (3) liters of oxygen. Further review of the EMS Note revealed the resident had a fever and very wet lung sounds, and was in [MEDICAL CONDITION] (an irregular rapid heart rate) with a heart rate of 90-170 beats per minute. The resident was transported to the hospital and arrived at the hospital on [DATE] at 5:07 PM. Review of the Hospital emergency room Records for Resident #1 revealed upon arrival to the emergency roiagnom on [DATE] at 5:10 PM, the resident's temperature was 103 degrees Fahrenheit, rectally. The resident was assessed to have shallow, rapid, and difficult respirations at a rate of 26 respirations per minute with an oxygen saturation of 82%. Review of the arterial blood gas measurements (true measurements of oxygen and carbon [MEDICATION NAME] in the blood) obtained for Resident #1 at 5:30 PM revealed the resident had low oxygen levels of 81% (normal range 95-98%) and a high carbon [MEDICATION NAME] level of 68.2 (normal range 35-45), which was critical on 100% oxygen being delivered via face mask. Continued review of the hospital record revealed Resident #1 required intubation and sustained a [MEDICAL CONDITION] infarction. The resident was admitted to the hospital and passed away at 5:00 AM on 03/09/15. Interview with Certified Nurse Aide (CNA) #1 on 03/19/15 at 1:25 PM; and, on 03/20/15 at 11:20 AM, revealed she was in the dining room assisting residents on 03/08/15 at approximately 12:30 PM to 1:30 PM. According to the CNA, Resident #1 was not his/her usual self. The resident was not as alert and oriented because the resident had slurred delayed speech. The CNA said the resident was not able to hold a cup or utensils and was unable to feed himself/herself. The resident was not able to hold a juice glass, and had to be assisted to take the medications by LPN #1. Additional interview with CNA #1 revealed during this time LPN #1 administered medications to the resident. CNA #1 stated she observed Resident #1 to be pale, clammy, and staring off into space on 03/08/15 between 2:00 PM and 3:00 PM. According to CNA #1, she reported her concerns with the resident's change of condition to LPN #1, stating the resident was not normally like this. However, the CNA said the Nurse blew her off and ignored her concerns. Interview conducted with CNA #2 on 03/19/15 at 4:10 PM, and on 03/20/15 at 1:25 PM, revealed on 03/08/15 between 2:00 PM and 3:00 PM, Resident #1 was in bed dressed in street clothing. The CNA said she assisted the resident to change as the resident was still not feeling well. According to CNA #2, during second shift on 03/08/15 the resident's family came to the facility. CNA #2 stated the resident did not respond to the family member and his/her speech was slurred. The CNA said the family member went to the nurse's desk and spoke to LPN #1 regarding her concerns with Resident #1's condition, stating the resident had a change in condition. An interview on 03/18/15 at 3:30 PM, conducted with Family Member (FM) #1 revealed FM #1 arrived at the facility on 03/08/15 at approximately 4:15 PM. FM #1 stated when she arrived she found Resident #1 with labored gurgling respirations that could be heard from the door. According to FM #1, the resident was lethargic, mumbling, and was not responding to her as he/she usually did. Further interview revealed FM #1 went immediately to the nurses' station to ask the nurse about Resident #1. The family member spoke with LPN #1 regarding her concerns with the resident having labored breathing and not acting as he/she usually did. According to FM #1, she was informed by LPN #1 that the resident had an Upper Respiratory Infection and had [MEDICATION NAME](antibiotic medication) and a breathing treatment. FM #1 stated she did not agree with the course of treatment and contacted the APRN who worked with the resident's physician and knew the resident's history. FM #1 informed the APRN of the resident's condition and the APRN contacted the facility to have the resident sent to the hospital. According to FM #1, neither LPN #1 nor any other nurse checked on, or assessed Resident #1 while she was at the facility. FM#1 stated Resident #1 was transported to the hospital by ambulance. The resident was diagnosed with [REDACTED]. Interview with Licensed Practical Nurse (LPN) #1 on 03/19/15 at 2:50 PM, revealed she was assigned to care for Resident #1 on 03/08/15. According to LPN #1, Resident #1 did not eat anything for breakfast on 03/08/15, which was unusual for the resident. The resident reported to her during the 8:00 AM medication pass, that she was having trouble breathing and that he/she may be getting [MEDICAL CONDITION]. LPN #1 stated Resident #1 had problems holding a cup during breakfast, which was unusual for the resident. According to LPN #1, the resident was assessed and his/her vital signs were obtained on 03/08/15 between 7:00 AM and 9:00 AM. LPN #1 stated she contacted Resident #1's physician sometime after breakfast and obtained orders for an antibiotic and an as needed nebulizer treatment. Further interview revealed LPN #1 assisted the resident to bed after lunch (exact time unknown) with the use of a lift. The LPN stated she administered Resident #1's 2:00 PM medications between 1:00 PM and 3:00 PM and did not notice any additional concerns or changes for the resident. Further interview with LPN #1 revealed she rechecked Resident #1's oxygen saturation later in the day at an unknown time and the results had improved but she did not document the results in the record. LPN #1 stated she had not been notified of any concerns with Resident #1's condition by CNA #1. According to LPN #1, she was at the nurses' station on 03/08/15 at approximately 4:20 PM when she was approached by a family member of Resident #1 and asked what was going on with the resident. The LPN stated she reported to the family member what she had told the physician earlier in the day and that the resident had received medications. LPN #1 stated the family member did not agree with the physician's orders [REDACTED].#1 had pneumonia. LPN #1 said she stated to the family member that Resident #1 very well could have pneumonia. LPN#1 stated she later (time unknown) received a call from an APRN who worked for Resident #1's Primary Care Physician. The LPN stated the resident's condition and the physician's orders [REDACTED]. LPN #1 stated the APRN called her back and gave her orders for Resident #1 to be transferred to the hospital for evaluation and treatment. LPN #1 stated that she did not assess Resident #1 after the family had notified her of concerns with the resident's condition because she was getting paperwork ready to transfer the resident to the hospital. The LPN stated she only saw the resident when the paramedics were transporting the resident on a stretcher from the facility. According to LPN #1, residents were charted on during each shift and monitored during medication administration, meals, and during walking rounds conducted at shift change. An interview conducted with the APRN on 03/20/15, revealed the APRN received a call from Resident #1's family on 03/08/15 at

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) 4:30 PM, regarding concerns with Resident #1 being short of breath and not responding to the family member. The APRN stated she called the facility to inquire about the resident. According to the APRN, she was informed that the resident was started [MEDICATION NAME] had received a nebulizer treatment. The APRN stated she felt this treatment was not adequate for Resident #1 due to the resident's recent history of pneumonia and the resident's multiple complex medical issues. The APRN discussed this with the family member, called the facility back, and gave orders to transfer the resident to the hospital. Interview with the Director of Nursing (DON) on 03/20/15 at 5:15 PM, revealed if a resident had a change of condition or a concern was reported to the nurse, the nurse was required to assess the resident using the Situation, Background, Assessment, Request (SBAR) format (the facility's method to gather information before calling the physician if a change of condition occurs). If the assessment indicated the physician needed to be notified, then staff was required to notify the physician using the care path algorithm (a protocol used to identify abnormal findings and guide physician notification). Further interview revealed the nurse was required to document the concern and the findings in the medical record. The DON stated she had been informed Resident #1 was transferred to the hospital on [DATE]. However, she was not aware that Resident #1 was not assessed by the nurse after the family reported their concerns and she was also not aware that the nurse did not even visualize the resident after concerns were reported to her until the resident was being transported from the facility by EMS. Interview with the Administrator conducted on 03/20/15 at 6:00 PM, revealed he was not aware LPN #1 had not assessed Resident #1 after she had been informed by the resident's family of their concerns on 03/08/15. According to the Administrator, if a resident had a change of condition or concerns were reported, the nurse was required to assess the resident and notify the resident's physician and family if indicated. Further interview with the Administrator revealed LPN #1 should have assessed/monitored Resident #1 when the family reported concerns with the resident on 03/08/15. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/08/15, Resident #1 was sent to the hospital and treated in the emergency room for pneumonia,[MEDICAL CONDITION], and ST segment elevation [MEDICAL CONDITION] infarction (STEMI) ([MEDICAL CONDITION]). The resident had a stent placed. Resident #1 passed away at the hospital on [DATE]. 2) On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor conducted evaluations of all current residents to determine if there were any medical needs requiring physician notification which had not been addressed. Two (2) issues were identified. (A)--A [MEDICAL TREATMENT] patient (identified by the facility as Resident A) refused [MEDICAL TREATMENT] and later had weeping from the lower extremities. A nursing intervention was implemented, the resident's physician was notified of the change, physician orders [REDACTED]. The Unit Manager validated implementation of the new orders and continued monitoring of the resident. (B)--Resident B (identified by the facility as Resident B), who has a [DIAGNOSES REDACTED]. The Physician was made aware and ordered diagnostic testing, the resident's responsible party was notified of the resident's condition, and the procedure was ordered. The Unit Manager validated the implementation of the new orders and monitoring of the patient. On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor reviewed all current residents' plans of care to determine that all interventions were being followed. Minor revisions were made to the care plans as needed. One care plan was significantly changed related to a patient's condition of [MEDICAL CONDITION] (interventions were in place). No change to the plans of care required notification to a Physician. 3) The INTERACT program is an evidence based Plan, Do, Check, Act process developed through funding from the Centers for Medicare and Medicaid Services (CMS) to prevent unnecessary acute care transfers and includes a binder of care paths, which are algorithms used for directing nurses through evaluating residents, providing care, and notifying the physician for certain common symptoms. It includes the SBAR (Situation, Background, Analysis, and Request) tool for nurses to complete and effectively communicate a resident's condition or change of condition with the Physician. On 03/20/15, the RN (Registered Nurse) Nurse Consultant re-educated the Staff Facilitator regarding conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluations, as well as physician notification; and, for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor and began re-education of Nurses, Medication Technicians, and Certified Nurse Aides on conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluation, as well as physician notification; and for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/21/15-03/22/15, Unit Managers, MDS Nurses, QI Nurses, Weekend House Supervisor, and Staff Facilitator continued with re-education with all Nurses, Medication Technicians, and Certified Nurse Aides related to conducting an evaluation based on resident condition to include the INTERACT program, follow-up evaluations, as well as physician notification for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15, the RN Facility Consultant re-educated the Staff Facilitator regarding the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. On 3/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor on the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Beginning 03/21/15 and ongoing, all licensed staff was re-educated by the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, or Staff Facilitator regarding the requirement to follow the plan of care and if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Posttests were developed on 03/23/15 for Licensed Nurses, Medication Technicians, and Certified Nurse Aides to demonstrate retained knowledge of the re-education. Approximately 90 percent of the licensed nurses and approximately 75 percent of the Medication Aides and Certified Nurse Aides have completed the in-service education and posttest. These staff indicated understanding and stated all questions were answered at the end of the education sessions. No Licensed Nurse, Medication Technician, or CNA will work after 03/23/15 without having completed this re-education. No Licensed Nurse, Medication Aide, or CNA will provide patient care after 03/24/15 without having completed both the re-education and posttest. Beginning 03/21/15 and ongoing, all CNAs were re-educated with following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No CNAs will work after 03/23/15 without having received this re-education. All newly employed direct care staff will receive this education prior to working on a unit. Direct care staff on leave of absence or vacation will complete this re-education prior to working. 4) Beginning 03/23/15, the Director of Nursing, QI Nurses, Unit Managers, Staff Facilitator, Weekend House Supervisor, or RN Facility Consultant will conduct walking rounds to review with facility licensed nurse staff residents' conditions daily. These rounds will also include an investigation to determine if licensed staff are notifying the physician of significant changes in condition and completing ongoing evaluation as needed. This process will also include observation and discussion with Licensed Nurses and Certified Nurse Aides to determine if plans of care, including revisions, are being followed. The rounds will also consist of discussion with CNAs to determine if they have noted any changes in the residents throughout their shift and review of the STOP and WATCH (the tool included in the INTERACT program for CNAs to alert changes in resident condition in the electronic medical record). This will continue daily until abatement of Immediate Jeopardy then four (4) times per week for four (4) weeks thereafter. Beginning 03/23/15, the Director of Nursing, QI Nurses, Staff Facilitator, Unit Managers, Weekend House Supervisor, or RN Facility Consultant will review all Nurse's Notes daily to determine if any significant change in condition has occurred without physician notification or any significant change in condition has occurred without evaluation. This will occur daily until abatement of the Immediate Jeopardy and then four (4) times per week for four (4) weeks. The Clinical Interdisciplinary Team (IDT) which includes the Director of Nursing, Unit Managers, QI Nurses, Staff

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 8) Facilitator, MDS Nurses, Weekend House Supervisor, RN Facility Consultant, or Treatment Nurse, will continue to follow the established process of reviewing the Nurse's Notes, Shift Reports, and physician's orders [REDACTED]. The Weekend House Supervisor reviews the documents Saturday and Sunday and reports to the Director of Nursing and Administrator at least daily. The Weekend House Supervisor and MDS Nurses will revise care plans through the established process. 5) On 03/20/15, an ad hoc Quality Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Associate Medical Director who approved. In attendance was the Administrator, RN Facility Consultant, Unit Managers, QI Nurses, MDS Nurses, Social Services Director, Kitchen Manager, Staff Facilitator, Admissions Director, and Activity Director. No further recommendations were made. The Administrator, Director of Nursing, QI Nurses, or RN Facility consultant will review the audits daily until abatement of Immediate Jeopardy. Thereafter, the results of these audits will be reviewed with the Quality Improvement Committee weekly and anytime a concern is identified until substantial compliance has been achieved; then per the schedule established by the Executive QI Committee. Thereafter, Members of the QI Committee will consist of at a minimum, the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, and Staff Facilitator. The Executive QI Committee consists of the Administrator, Director of Nursing Services, Unit Managers, QI Nurses, RN MDS Coordinator, Staff Facilitator, Treatment Nurse, Social Services Director, Social Services Assistant, Director of Activities, Director of Admissions, Dietary Services Director, Maintenance Director, Director of Environment and Safety, and Medical Director. ***The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the closed record for Resident #1 revealed the resident was transferred to the hospital on [DATE]. 2) Observations of Residents #11, #12, #13, and #14 on 03/25/15-03/26/15 revealed no concerns with changes of condition or following the plan of care. Review of Resident #11's medical record (identified by the facility as Resident A) revealed the facility assessed the resident to have weeping [MEDICAL CONDITION] to the lower extremities on 03/21/15. The resident's physician was notified of the change in the resident's condition on 03/21/15 at 7:39 PM, and orders were received for Keflex (antibiotic) 500 mg for [MEDICAL CONDITION] to the lower extremities. Review of the plan of care revealed no concerns. Review of the medical record for Resident #12 (identified by the facility as Resident B) revealed the facility assessed the resident to have a change in condition on 03/22/15 at 9:06 PM. The resident had [MEDICAL CONDITION] to the lower extremities. The resident's physician was notified and orders received for a venous study. Review of the plan of care revealed no concerns. Review of the medical records for Residents #13 and #14 revealed the residents were assessed for a change of condition on 03/21/15 with no changes of condition identified. Review of the plans of care for these residents revealed no concerns. 3) Interview with the Staff Facilitator on 03/26/15 at 1:55 PM revealed the Staff Facilitator had been trained by the Nurse Consultant on the Interact Program related to follow-up evaluations/assessments of residents using the SBAR tool. The Nurse Consultant had also trained the Staff Facilitator on assessing changes of condition, physician notification, and following residents' plans of care. According to the Staff Facilitator, she then began training all nursing staff. Interviews with CNAs #3, #4, #5, #6, #7, and #8 on 03/26/15 at 10:52 AM, 11:11 AM, 11:34 AM, 11:50 AM, 2:05 PM, and 2:20 PM respectfully, revealed the CNAs had been trained regarding notifying the nurse of a change of condition, using the Stop and Watch program, the resident assessment for change of condition, and following the plan of care. Interviews on 03/26/15 with LPN #2 at 11:00 AM, LPN #3 at 10:55 AM, LPN #4 at 1:00 PM, RN #1 at 12:50 PM, the Treatment Nurse at 11:30 AM, the West Wing Unit Manager at 1:15 PM, and the Second Floor Unit Manager at 1:30 PM revealed they had been trained regarding changes of condition, assessing/monitoring residents after a change of condition, notification of the physician, using the SBAR form, and following the resident's care plan. Review of the INTERACT training documentation revealed the training was given on 03/20/15, the Staff Facilitator had been educated by the Nurse Consultant and the Staff Facilitator conducted training for nursing staff with no concerns identified. The documentation revealed the facility was monitoring staff that had been trained to ensure they were following the process. Review of posttests revealed staff had been given posttests and the results were reviewed by the facility. 4) Interviews on 03/26/15 with the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, the MDS Nurse at 2:15 PM, the QI Nurse at 2:25 PM, and the West Wing Unit Manager at 1:15 PM revealed walking rounds were being conducted twice daily. These rounds included review of Nurse's Notes for SBAR assessments; monitor residents for change in condition; staff to discuss residents' condition with nurses and CNAs; and ensure care plans were being followed. They were also monitoring to ensure physicians were notified if needed and to ensure that nurses conducted follow-up evaluations if needed. Review of the facility's documentation of walking rounds conducted from 03/22/15 through 03/26/15 revealed walking rounds were being completed and were ongoing on 03/26/15 with no concerns identified. 5) Interviews on 03/26/15 at 3:30 PM with the Administrator, the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, and the QI Nurse at 2:25 PM revealed the facility's Quality Assurance Committee was meeting daily to review daily audits for concerns with assessments, physician notification of change of condition, and following the residents' plans of care. Review of the Quality Assurance Committee minutes conducted on 03/21/15 through 03/26/15 revealed the facility had identified no concerns.
F 0514 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies it was determined the facility failed to maintain complete clinical records for ten (10) of fourteen (14) sampled residents (Residents #1, #2, #3, #7, #8, #9, #10, #11, #12, and #13). On 03/08/15 between 8:30 AM and 9:30 AM, Resident #1 complained of shortness of breath, pain, and chest congestion. The facility assessed the resident to be slightly pale and short of air with oxygen saturation that ranged from 87 to 92% (normal range is 95 - 100%). The resident's physician was contacted and orders were received [MEDICATION NAME](antibiotic) and [MEDICATION NAME] nebulizer treatment (breathing treatment); however, the nurse failed to document the time of the telephone order. Staff interviews revealed Resident #1 did not eat or drink as usual for lunch and was observed by staff between 2:00 PM and 3:00 PM to be pale, clammy, and staring off (not focusing). The nurse was notified of the resident's further change in condition at lunch and, another change in condition that was noted around 2:00 PM to 3:00 PM; however, there was no documented evidence regarding the assessment/monitoring of the resident's condition. On 03/08/15 at 4:15 PM, the family visited Resident #1 and found the resident with labored breathing and lethargic. The nurse was notified of the resident's condition by the family; however, the nurse did not assess Resident #1 and document the findings of the assessment or the resident's condition. After the family contacted the Advanced Practice Registered Nurse (APRN), Resident #1 was transferred to the local hospital and required intubation (a tube placed in the mouth and throat for breathing). Resident #1 later sustained a [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]). The resident was admitted to the hospital and passed away at 5:00 AM on 03/09/15. In addition, the facility failed to maintain complete clinical records for Residents #2, #3, #7, #8, #9, #10, #11, #12, and #13 related to documentation of the receipt time of telephone physician orders. Facility nursing staff failed to consistently document the time verbal telephone Physician order [REDACTED]. The facility's failure to ensure each resident had an accurate clinical record was likely to cause serious injury, harm, impairment, or death of a resident. Immediate Jeopardy was determined to exist on 03/08/15 at 42 CFR 483.10 Resident Rights (F157 -J), 42 CFR 483.20 Resident Assessment (F282 - J), 42 CFR 483.25 Quality of Care (F309 -J), and 42 CFR 483.75 Administration (F514 - K). The facility was notified of the Immediate Jeopardy on 03/20/15. An acceptable Allegation of Compliance was received on 03/24/15, which alleged removal of the Immediate Jeopardy on 03/25/15. A partial extended survey was conducted on 03/25-26/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/25/15, which lowered the Scope and Severity to D at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), and 42 CFR 483.25 Quality of Care (F309); and 42 CFR 483.75 Administration (F514) was lowered

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) to an E while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled Receipt of physician's orders [REDACTED]. Review of the Order Form (BN2002) revealed a section for documentation of the time and date the order was received by the nurse. Review of the facility's policy titled Interact Care Path dated 11/21/12, revealed it was the licensed nurse's responsibility to document review of the resident, reporting of the resident's condition, implementation of care per orders, outcomes of treatment, and the resident's condition. 1. Interview with Licensed Practical Nurse (LPN) #1 on 03/19/15 at 2:50 PM, revealed she was assigned to care for Resident #1 on 03/08/15. According to LPN #1, the resident reported to her during the 8:00 AM medication pass, that he/she was having trouble breathing and that he/she may be getting [MEDICAL CONDITION]. LPN #1 stated Resident #1 had problems holding a cup during breakfast, which was unusual for the resident. According to LPN #1, the resident was assessed and his/her vital signs were obtained on 03/08/15 between 7:00 AM and 9:00 AM; however, the vital signs were not documented until 10:10 AM. LPN #1 stated she contacted Resident #1's Physician sometime after breakfast and obtained orders for an antibiotic and an as needed nebulizer treatment. Further interview revealed LPN #1 assisted the resident to bed after lunch (exact time unknown) with the use of a lift. The LPN stated she administered Resident #1's 2:00 PM medications between 1:00 PM and 3:00 PM and did not notice any additional concerns or changes for the resident, but she did not document the resident's oxygen saturation. Further interview with LPN #1 revealed she rechecked Resident #1's oxygen saturation later in the day at an unknown time and the results had improved; however, LPN #1 stated she did not document the results in the resident's record. Further interview with LPN #1 revealed on 03/08/15 at approximately 4:20 PM, she was approached by a family member of Resident #1 and asked what was going on with the resident. The LPN stated she reported to the family member what she had told the physician earlier in the day and that the resident had received medications. LPN #1 stated the family member did not agree with the physician's orders [REDACTED].#1 had pneumonia. LPN #1 stated she told the family member that Resident #1 very well could have pneumonia. LPN #1 stated she later (time unknown) received a call from an APRN who worked for Resident #1's Primary Care Physician. The LPN told the APRN the resident's condition and the physician's orders [REDACTED]. LPN #1 stated the APRN called her back and gave her orders for Resident #1 to be transferred to the hospital for evaluation and treatment. LPN #1 stated that she did not assess Resident #1 after the family had notified her of their concerns with the resident's condition because she was getting paperwork ready to transfer the resident to the hospital. The LPN stated she only saw the resident when the paramedics were transporting the resident on a stretcher from the facility. According to LPN #1, residents were charted on during each shift and monitored during medication administration, meals, and during walking rounds conducted at shift change. However, according to the facility's policy, it was LPN #1's responsibility, as a licensed nurse, to document her review of the resident, document the report of the resident's condition and outcomes of the resident's treatment. Review of Nurse's Notes entered at 11:16 AM revealed the Physician was notified earlier, (the time was not documented) and orders were received [MEDICATION NAME] mg (an antibiotic) twice daily and an [MEDICATION NAME] Nebulizer (medication for breathing) treatment every four (4) hours as needed. According to the Note, the medications were given, but the time was not documented in the Note. Further review of the record revealed a Note entered on 03/08/15 at 4:52 PM, which stated Resident #1's daughter was at the facility, and disagreed with the type of treatment for [REDACTED]. The Nurse Practitioner called LPN #1 to discuss the resident's situation. The Nurse's Note further stated the daughter wanted the resident sent to the hospital and orders were received to send the resident to the hospital. Review of the clinical record revealed no documented evidence of assessment findings, follow up of treatment, or the resident's condition from 11:16 AM on 03/08/15 through the time the resident left the facility, which should have been completed, according to facility policy. Further review of the clinical record revealed Physician Telephone Orders were received for Resident #1 on 02/12/15, 03/01/15, 03/03/15, 03/04/15, and 03/08/15. However, the times the physician's orders [REDACTED]. 2. Review of the medical record for Resident #2 revealed physician telephone orders were received on 03/10/15, 3/11/15, and 03/19/15. However, further review revealed the time the order was received was not included on the Telephone Order Form. 3. Review of the medical record for Resident #3 revealed physician telephone orders were received on 03/05/15, 03/06/15, 03/11/15, 03/12/15, and 03/16/15. Further review of the record revealed the time the physician orders [REDACTED]. 4. Review of the medical record for Resident #7 revealed physician telephone orders were received on 03/03/15, 03/10/15, and 03/23/15. However, further review of the medical record revealed the time the order was received was not included on the Telephone Order Form. 5. Review of the medical record for Resident #8 revealed a physician telephone order was received on 03/24/15. Further review of the medical record revealed the time the order was received was not included on the Telephone Order Form. 6. Review of the medical record for Resident #9 revealed physician telephone orders were received on 03/04/15 and 03/10/15. Further review of the medical record revealed the time the physician orders [REDACTED]. 7. Review of the medical record for Resident #10 revealed physician telephone orders were received on 03/06/15, 03/11/15, 03/12/15, 03/17/15, and 03/24/15. However, further review of the medical record revealed the time the order was received was not included on the Telephone Order Form. 8. Review of the medical record for Resident #11 revealed physician telephone orders were received on 03/06/15, 03/07/15, 03/08/15, 03/09/15, 03/11/15, 03/23/15, and 03/24/15. Further review of the medical record revealed the time the physician orders [REDACTED]. 9. Review of the medical record for Resident #12 revealed physician telephone orders were received on 03/01/15, 03/09/15, and 03/11/15. However, further review of the medical record revealed the time the order was received was not included on the Telephone Order Form. 10. Review of the medical record for Resident #13 revealed physician telephone orders were received on 03/05/15, 03/06/15, 03/07/15, 03/19/15, and 03/24/15. Further review of the medical record revealed the time the physician orders [REDACTED]. Interview conducted with Licensed Practical Nurse (LPN) #2 on 03/26/15 at 11:00 AM, revealed all physician's telephone orders should include the time the order was received/written. However, the LPN stated she often forgot to document the time when the order was received on the physician's orders [REDACTED]. Interview with the Treatment Nurse on 03/26/15 at 11:30 AM, revealed the nurse was to document the time the physician's orders [REDACTED]. Interview conducted with Registered Nurse (RN) #1 on 03/26/15 at 12:50 PM, revealed the physician's orders [REDACTED]. RN #1 stated she would often forget to include the time on the physician's orders [REDACTED]. Interview conducted with the West Wing Unit Manager on 03/26/15 at 1:15 PM, revealed the Unit Manager had been conducting daily audits of the residents' records but had not identified a problem with physician telephone orders with the times not being documented. Interview with the Director of Nursing (DON) on 03/26/15 at 2:45 PM, revealed the facility did not have a specific policy to address timing of physician's orders [REDACTED]. The DON stated that this section should be filled in each time a nurse received and documented a telephone physician's orders [REDACTED]. [REDACTED]. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/13/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/08/15, Resident #1 was sent to the hospital and treated in the emergency room for pneumonia,[MEDICAL CONDITION], and ST segment elevation [MEDICAL CONDITION] infarction (STEMI) ([MEDICAL CONDITION]). The resident had a stent placed. Resident #1 passed away at the hospital on [DATE]. 2) On 03/21/15-03/22/15 the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor conducted evaluations of all current residents to determine if there were any medical needs requiring physician notification which had not been addressed. Two issues were identified. A --A [MEDICAL TREATMENT] patient (identified by the facility as Resident A) refused [MEDICAL TREATMENT] and later had weeping from the lower extremities. A nursing intervention was implemented, the resident's physician was notified of the change, physician orders [REDACTED]. The Unit Manager validated implementation of the new orders and continued monitoring of the resident. B--Resident B (identified by the facility as Resident B), who had a [DIAGNOSES REDACTED]. The Physician was made aware and

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	185152	A. BUILDING _____ B. WING _____	03/26/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMERWOODS NURSING & REHABILITATION CENTER	555 BOURNE AVENUE SOMERSET, KY 42501

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

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) ordered diagnostic testing, the resident's responsible party was notified of the resident's condition, and the procedure was ordered. The Unit Manager validated the implementation of the new orders and monitoring of the patient. On 03/21/15-03/22/15, the Director of Nursing, Unit Managers, MDS Nurses, Quality Improvement (QI) Nurses, Staff Facilitator, and Weekend House Supervisor reviewed all current residents' plans of care to determine that all interventions were being followed. Minor revisions were made to the care plans as needed. One care plan was significantly changed related to a patient's condition of [MEDICAL CONDITION] (interventions were in place). No change to the plans of care required notification to a Physician. 3) The INTERACT program is an evidence based Plan, Do, Check, Act process developed through funding from the Centers for Medicare and Medicaid Services (CMS) to prevent unnecessary acute care transfers and includes a binder of care paths, which are algorithms used for directing nurses through evaluating residents, providing care, and notifying the physician for certain common symptoms. It includes the SBAR (Situation, Background, Analysis, and Request) tool for nurses to complete and effectively communicate a resident's condition or change of condition with the Physician. On 03/20/15, the RN (Registered Nurse) Nurse Consultant re-educated the Staff Facilitator regarding conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluations, as well as physician notification; and for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor and began re-education of Nurses, Medication Technicians, and Certified Nurse Aides on conducting an evaluation based on the resident's condition to include the INTERACT program, follow-up evaluation, as well as physician notification; and for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/21/15-03/22/15, Unit Managers, MDS Nurses, QI Nurses, Weekend House Supervisor, and Staff Facilitator continued with re-education with all Nurses, Medication Technicians, and Certified Nurse Aides related to conducting an evaluation based on resident condition to include the INTERACT program, follow-up evaluations, as well as physician notification for a significant change in condition, referring to the INTERACT program, but not to supersede nursing judgment. On 03/20/15, the RN Facility Consultant re-educated the Staff Facilitator regarding the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. On 3/20/15-03/21/15, the Staff Facilitator re-educated the Director of Nursing, Unit Managers, MDS Nurses, QI Nurses, and Weekend House Supervisor on the requirement to follow the plan of care; education further included if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Beginning 03/21/15 and ongoing, all licensed staff was re-educated by the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, or Staff Facilitator regarding the requirement to follow the plan of care and if the plan of care could not be followed and an alternative was not within their scope of practice the physician must be notified. Approximately 90 percent of the licensed nurses and approximately 75 percent of the Medication Aides and Certified Nurse Aides have completed the in-service education and posttest. These staff indicated understanding and stated all questions were answered at the end of the education sessions. Posttests were developed on 03/23/15 for Licensed Nurses, Medication Technicians, and Certified Nurse Aides to demonstrate retained knowledge of the re-education. This re-education included adding the resident to the acute charting, passing information on to the next shift of nurses, documentation of resident evaluations, the outcome, and if a change is noted. 0n 03/21/15-03/22/15, Unit Managers, MDS Nurses, QI Nurses, Weekend House Supervisor and Staff Facilitator continued with re-education with all Nurses, Medication Technicians, Certified Nurse Aides related to conducting an evaluation based on resident condition to include the INTERACT program, follow up evaluation as well as physician notification for a significant change in condition referring to the INTERACT program but not to supersede nursing judgment. This re-education included documentation of resident evaluations, the outcome, and if a change is noted in resident condition. Post Tests were developed on 03/23/15 for Licensed Nurses, Medication Technicians, and Certified Nurse Aides. No Licensed Nurse, Medication Technician, or CNA will work after 03/23/15 without having completed this re-education. No Licensed Nurse, Medication Aide, or CNA will provide patient care after 03/24/15 without having completed both the re-education and posttest. Beginning 03/21/15 and ongoing, all CNAs were re-educated with following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No CNAs will work after 03/23/15 without having received this re-education. All newly employed direct care staff will receive this education prior to working on a unit. Direct care staff on leave of absence or vacation will complete this re-education prior to working. 4) Beginning 03/23/15, the Director of Nursing, QI Nurses, Unit Managers, Staff Facilitator, Weekend House Supervisor, or RN Facility Consultant will conduct walking rounds to review with facility licensed nurse staff residents' conditions daily. These rounds will also include an investigation to determine if licensed staff are notifying the physician of significant changes in condition and completing ongoing evaluation as needed. This process will also include observation and discussion with Licensed Nurses and Certified Nurse Aides to determine if plans of care, including revisions, are being followed. The rounds will also consist of discussion with CNAs to determine if they have noted any changes in the residents throughout their shift and review of the STOP and WATCH (the tool included in the INTERACT program for CNAs to alert changes in resident condition in the electronic medical record). This will continue daily until abatement of Immediate Jeopardy then four (4) times per week for four (4) weeks thereafter. Beginning 03/23/15, the Director of Nursing, QI Nurses, Staff Facilitator, Unit Managers, Weekend House Supervisor, or RN Facility Consultant will review all Nurse's Notes daily to determine if any significant change in condition has occurred without physician notification or any significant change in condition has occurred without evaluation. This will occur daily until abatement of the Immediate Jeopardy and then four (4) times per week for four (4) weeks. The Clinical Interdisciplinary Team (IDT) which includes the Director of Nursing, Unit Managers, QI Nurses, Staff Facilitator, MDS Nurses, Weekend House Supervisor, RN Facility Consultant, or Treatment Nurse, will continue to follow the established process of reviewing the Nurse's Notes, Shift Reports, and physician's orders [REDACTED]. The Weekend House Supervisor reviews the documents Saturday and Sunday and reports to the Director of Nursing and Administrator at least daily. The Weekend House Supervisor and MDS Nurses will revise care plans through the established process. 5) On 03/20/15, an ad hoc Quality Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Associate Medical Director who approved. In attendance was the Administrator, RN Facility Consultant, Unit Managers, QI Nurses, MDS Nurses, Social Services Director, Kitchen Manager, Staff Facilitator, Admissions Director, and Activity Director. No further recommendations were made. The Administrator, Director of Nursing, QI Nurses, or RN Facility consultant will review the audits daily until abatement of Immediate Jeopardy. Thereafter, the results of these audits will be reviewed with the Quality Improvement Committee weekly and anytime a concern is identified until substantial compliance has been achieved; then per the schedule established by the Executive QI Committee. Thereafter, Members of the QI Committee will consist of at a minimum, the Director of Nursing, Unit Managers, QI Nurses, MDS Nurses, and Staff Facilitator. The Executive QI Committee consists of the Administrator, Director of Nursing Services, Unit Managers, QI Nurses, RN MDS Coordinator, Staff Facilitator, Treatment Nurse, Social Services Director, Social Services Assistant, Director of Activities, Director of Admissions, Dietary Services Director, Maintenance Director, Director of Environment and Safety, and Medical Director ***The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the closed record for Resident #1 revealed the resident was transferred to the hospital on [DATE]. 2) Observations conducted of Residents #11, #12, #13, and #14 on 03/25/15-03/26/15 revealed no concerns with changes of condition or following the plan of care. Review of Resident #11's medical record (identified by the facility as Resident A) revealed the facility assessed the resident to have weeping [MEDICAL CONDITION] to the lower extremities on 03/21/15. The resident's physician was notified of the change in the resident's condition on 03/21/15 at 7:39 PM, and orders were received for Keflex (antibiotic) 500 mg for [MEDICAL CONDITION] to the lower extremities. Review of the plan of care revealed no concerns. Review of the medical record for Resident #12 (identified by the facility as Resident B) revealed the facility assessed the

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	185152	A. BUILDING _____ B. WING _____	**03/26/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) resident to have a change in condition on 03/22/15 at 9:06 PM. The resident had [MEDICAL CONDITION] to the lower extremities. The resident's physician was notified and orders received for a venous study. Review of the plan of care revealed no concerns. Review of medical records for Residents #13 and #14 revealed the residents were assessed for a change of condition on 03/21/15 with no changes of condition identified. Review of the plans of care for these residents revealed no concerns. 3) Interview with the Staff Facilitator on 03/26/15 at 1:55 PM revealed the Staff Facilitator had been trained by the Nurse Consultant on the Interact Program related to follow-up evaluations/assessments of residents using the SBAR tool. The Nurse Consultant had also trained the Staff Facilitator on assessing changes of condition, physician notification, and following residents' plans of care. According to the Staff Facilitator, she then began training all nursing staff. Interviews with CNAs #3, #4, #5, #6, #7, and #8 on 03/26/15 at 10:52 AM, 11:11 AM, 11:34 AM, 11:50 AM, 2:05 PM, and 2:20 PM respectfully, revealed the CNAs had been trained regarding notifying the nurse of a change of condition, using the Stop and Watch program, the resident assessment for change of condition, and following the plan of care. Interviews on 03/26/15 with LPN #2 at 11:00 AM, LPN #3 at 10:55 AM, LPN #4 at 1:00 PM, RN #1 at 12:50 PM, the Treatment Nurse at 11:30 AM, the West Wing Unit Manager at 1:15 PM, and the Second Floor Unit Manager at 1:30 PM revealed they had been trained regarding changes of condition, assessing/monitoring residents after a change of condition, notification of the physician, using the SBAR form, and following the resident's care plan. Review of the INTERACT training documentation revealed the training was given on 03/20/15, the Staff Facilitator had been educated by the Nurse Consultant and the Staff Facilitator conducted training for nursing staff with no concerns identified. The documentation revealed the facility was monitoring staff that had been trained to ensure they were following the process. Review of posttests revealed staff had been given posttests and the results were reviewed by the facility. 4) Interviews on 03/26/15 with the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, the MDS Nurse at 2:15 PM, the QI Nurse at 2:25 PM, and the West Wing Unit Manager at 1:15 PM revealed walking rounds were being conducted twice daily. These rounds included review of Nurse's Notes for SBAR assessments; monitor residents for change in condition; staff to discuss residents' condition with nurses and CNAs; and ensure care plans were being followed. They were also monitoring to ensure physicians were notified if needed and to ensure that nurses conducted follow-up evaluations if needed. Review of the facility's documentation of walking rounds conducted from 03/22/15 through 03/26/15 revealed walking rounds were being completed and were ongoing on 03/26/15 with no concerns identified. 5) Interviews on 03/26/15 at 3:30 PM with the Administrator, the Nurse Consultant at 3:15 PM, the DON at 2:45 PM, and the QI Nurse at 2:25 PM revealed the facility's Quality Assurance Committee was meeting daily to review daily audits for concerns with assessments, physician notification of change of condition, and following the residents' plans of care. Review of the Quality Assurance Committee minutes conducted on 03/21/15 through 03/26/15 revealed the facility had identified no concerns. Interviews conducted on 04/15/15 (post survey interviews) with SRNA #2 at 11:00 AM, SRNA #7 at 12:10 PM, SRNA #1 at 12:50 PM and SRNA #9 at 1:30 PM, revealed the SRNAs had been trained to ensure accurate documentation of the Stop and Watch assessments to report changes of condition. Post survey interviews on 04/15/15 with LPN #5 at 1:20 PM and LPN #6 at 1:45 PM, Revealed the LPN had been trained and were knowledgeable of the facility's Interact policy and had been trained to accurately document assessments and physician's orders [REDACTED]. Post survey interview with the West Wing Unit Manager on 04/15/15 at 12:45 PM, revealed the Unit Manager had been making rounds to review charting on residents for accuracy and to ensure changes of condition and assessments were accurately documented in the residents' medical records. Interview on 04/15/15 (post survey interview), with the DON at 2:40 PM and the Administrator at 2:50 PM revealed the Management Team had been meeting twice daily to review audits completed to ensure changes of condition, assessments, and physician notifications were documented accurately. Further interview revealed the facility Quality Assurance committee had been meeting weekly to review/monitor the effectiveness of training and ongoing interventions. Record reviews conducted for Residents #15, #16, and #17 which included physician's orders [REDACTED]. Review of in-service education initiated on 03/20/15 revealed staff was trained on the facility's Interact Program to ensure complete and accurate documentation of physician's orders [REDACTED].