DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:3/1/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015
	185152		
NAME OF PROVIDER OF SU	PPLIER	STREET A	DDRESS, CITY, STATE, ZIP
SOMERWOODS NURSING	& REHABILITATION CENTER		NE AVENUE ET, KY 42501
For information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state	te survey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM		T BE PRECEDED BY FULL REGULATORY
F 0157		e resident's doctor and a family member of	f the resident
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET Based on interview, record review	m, etc.) that affect the resident. S HAVE BEEN EDITED TO PROTECT CO, and review of the facility's policy it was determined from the condition for each (1) of fourteen (14) separate (14	ermined the facility failed to notify the
Residents Affected - Few	at approximately 8:30 AM to 9:30 pain, and symptoms of chest cong orders for an antibiotic and a brea utensils; and between 2:00 PM to assistants stated they notified the the clinical record revealed no do	of condition for one (1) of fourteen (14) samp) AM, Resident #1 (who was normally alert a gestion. Facility staff notified the resident's ph thing treatment. However, at the noon meal th 3:00 PM the resident was pale, clammy, and resident's nurse regarding the change in the re- cumented evidence the resident's physician w	nd oriented) complained of shortness of breath, sysician (exact time unknown) and received he resident was unable to hold a cup or staring off into space. Facility nursing esident's condition. However, review of
	responding as he/she normally did however, there was no documente physician's Advanced Practice Re facility nurse and an order was re-	gistered Nurse (APRN) to have the resident seeived to transfer Resident #1 to the hospital.	he nurse assigned to care for the resident; ied. The family member contacted the resident's ent to the hospital. The APRN notified the
	to painful stimuli; to have an oxy fever and very wet lung sounds; a of 90-170 beats per minute. Who Fahrenheit rectally (normal rectal had shallow, rapid, and difficult r	gen saturation of 72% (normal range 95-100%)	unbers of the heart (atria) quiver) with a heart rate ent's temperature was 103 degrees heit). Further review revealed the resident ate (normal range 12-20 breaths per
	Resident #1 was admitted to the he	ospital and required intubation (a tube placed	in the trachea (windpipe) for mechanical on ([MEDICAL CONDITION]). The resident passed
	changes of condition was likely to determined to exist on 03/08/15 a 483.25 Quality of Care (F309); ar on 03/20/15. An acceptable Allegation of Comp 03/25/15. A partial extended surv was removed on 03/25/15, which Resident Assessment (F282), and	ective system in place to ensure each resident o cause serious injury, harm, impairment, or d t 42 CFR 483.10 Resident Rights (F157), 42 0 td 42 CFR 483.75 Administration (F514). The pliance was received on 03/24/15, which alleg ey was conducted on 03/25-26/15. The State to lowered the Scope and Severity to D at 42 CI	leath of a resident. Immediate Jeopardy was CFR 483.20 Resident Assessment (F282); 42 CFR e facility was notified of the Immediate Jeopardy sed removal of the Immediate Jeopardy on Survey Agency determined the Immediate Jeopardy FR 483.10 Resident Rights (F157), 42 CFR 483.20 the Scope and Severity was lowered to an E at 42
	activities. The findings include: Review of the facility's policy title revealed it was the policy of the f occurred with documentation con Review of Resident #1's closed m REDACTED]. Review of the Con assessed the resident to be cogniti of the assessment revealed the fac Review of the closed medical recc 10:14 AM (the exact time of the a assessed Resident #1 to be slightl (normal is 95-100%), with oxyge- pain with congestion in the upper physician was contacted. Review of the Situation, Backgrou resident's oxygen saturation was short of air. Further review of the Review of the Medication Admini An interview conducted with Cert 03/08/15 at approximately 7:30 A wheelchair and to the dining roon	ad Notification of Physician for Change In Reacility to notify the physician when a significatined within the medical record. delical record revealed the facility admitted Reprehensive Admission Minimum Data Set (I vely intact with a Brief Interview for Mental ility assessed the resident to eat independently of the resident #1 revealed computerized Nussessment is unknown; this is the time the asset y pale, with shortness of air, and oxygen saturn being administered at four (4) liters per min lobes and diminished lung sounds in the base and, Assessment, Request (SBAR) communic 12% on four (4) liters of oxygen, the resident SBAR revealed new physician's orders [RED STATE Nurse Aide (CNA) #2 on 03/19/15 at 4:1 MR Resident #1 was in bed and complained of the Forekfast. Further interview with CNA #	sident's Condition, dated August 2012, ant change in a resident's condition esident #1 on 01/27/15 with [DIAGNOSES MDS) assessment dated [DATE], revealed the facility Status (BIMS) score of 14. Further review y with setup help only. rse's Notes for the resident dated 03/08/15 at sessment was documented). The facility ration levels that ranged from 87 to 92% ute. The resident was noted to have chest es. The Nurse's Note stated the resident's ation note dated 03/08/15, at 11:07 AM, revealed the had chest congestion, a weak cough, and was DACTED].

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 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

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11 Facility ID: 185152 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185152	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	ION	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OF SU SOMERWOODS NURSING	PPLIER & REHABILITATION CENTER		STREET ADDRESS, CITY, STA 555 BOURNE AVENUE SOMERSET, KY 42501	ATE, ZIP
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hon		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIE		Y FULL REGULATORY
F 0157 Level of harm - Immediate jeopardy Residents Affected - Few	OR LSC IDENTIFYING INFORI (continued from page 1) clammy and the resident was star change of condition to LPN #1; h An interview with Licensed Practi on 03/08/15. According to LPN # her during the 8:00 AM medicati Additional interview revealed Re Resident #1, obtained the residen AM on 03/08/15. LPN #1 stated s nebulizer treatment. Further inter unknown) and administered his/h additional concerns or changes in that LPN #1 reassessed Resident Further interview with LPN #1 re condition had worsened. Accordi PM, when Resident #1's family n reported to the family member th received medications already. LP pneumonia. Further interview wit the family member's concerns. TI who worked for Resident #1's Pr back and gave her orders for Resi got Resident #1's paperwork read only saw the resident when the p An interview conducted with Fam 03/08/15 at approximately 4:15 P door; the resident was lethargic a was going on with Resident #1. T with the [DIAGNOSES REDAC' told her that she did not agree wit facility and gave orders for the re with [REDACTED]. Resident #1 Interview with the Director of Nu had a change in condition to a nu physician, and document their fin	MATION) ing off into space. According to Cowever, CNA #1 stated LPN #1 bical Nurse (LPN) #1 on 03/19/15 a: 1, Resident #1 did not eat anythin on pass that he/she was having tro sident #1 had problems holding hi's vital signs during this time, and she contacted the physician for Review revealed LPN #1 assisted the re 2:00 PM medications between the resident's condition. Review of the resident's condition after vealed she did not recall the nursing to LPN #1, she was at the nursing to LPN #1, she was at the nursing to LPN #1 stated the family member did het LPN revealed she did not as the LPN stated she then received a mary Care Physician. LPN #1 stated ent #1 to be transferred to the hey to transfer to the hospital; howe tramsdics were transporting the re tily Member (FM) #1 on 03/18/15 M, she found Resident #1 with land mumbling. According to FM #he family member spoke with LP (FED). Further interview with FM he treatment. FM #1 stated that sident to be transferred to the hosp passed away at the hospital at 5:0	NA #1, she reported her concerns lew her off and ignored her conce to 2:50 PM revealed she was assig g for breakfast on 03/08/15 and thuble breathing and may be getting s/her cup at breakfast. According documented the results in the Nu sident #1 and obtained orders for resident to bed at some point afte 1:00 PM and 3:00 PM. LPN #1 sta of the medical record revealed no 11:16 AM on 03/08/15. gassistants reporting to her that tes' station on 03/08/15. gassistants reporting to her that tes' station on 03/08/15 at approxim what was going on with Resident sician earlier in the day and that td not agree with the physician's or sess the resident or notify the resicall from an Advanced Practice R ed they discussed Resident #1, an spital for evaluation and treatmen ver, she did not assess the resident sident on a stretcher from the faci at 3:30 PM, revealed when she are rored gurgling respirations that col, she went immediately to the nu N #1 regarding her concerns. FM #1 revealed she informed the APF after speaking with the APRN, thoital. At the hospital, Resident #1 to AM on 03/09/15, the next day. My, revealed staff was required to ess the resident as soon as possible und Assessment Request (SBAR)	regarding Resident #1's rest. ned to care for Resident #1 he resident reported to g [MEDICAL CONDITION]. to LPN #1, she assessed use's Notes at 10:15 an antibiotic and a er lunch (exact time ated she did not notice any documented evidence the resident's mately 4:20 PM to 4:30 #1. LPN #1 stated she the resident had dent's physician of egistered Nurse (APRN), dd then the APRN called her t. LPN #1 stated she tity. Trived at the facility on buld be heard from the rsse' station to see what #1 stated she did not agree RN of the resident's condition and he APRN called the was diagnosed report when a resident e, notify the or informat. According to the
	aware the LPÑ did not call the ph did not assess Resident #1 after that the ph did not assess Resident #1 after that the ph did not assess Resident #1 after that the ph did not assess the provided an accept actions to remove the Immediate 1) On 03/08/15, Resident #1 was and ST segment elevation [MED] placed. Resident #1 passed away at the he 2) On 03/21/15-03/22/15, the Dire Facilitator, and Weekend House S medical needs requiring physician (A)—A [MEDICAL TREATMEN had weeping from the lower extremitic change, physician orders [REDAt of the resident. (B)—Resident B (identified by the and ordered diagnostic testing, the reswas ordered. The Unit Manager v On 03/21/15-03/22/15, the Direct Facilitator, and Weekend House S were being followed. Minor revist to a patient's condition of [MEDInotification to a Physician. 3) The INTERACT program is an Medicare and Medicaid Services are algorithms used for directing certain common symptoms. It inc and effectively communicate a re On 03/20/15-03/21/15, the RN (Registered) based on the resident's condition notification; and, for a significant judgment. On 03/20/15-03/21/15, the Staff F Weekend House Supervisor and the nevaluation based on the resident of notification; and for a significant judgment. On 03/20/15-03/21/15, the Staff F Weekend House Supervisor and the resident condition to include the significant change in condition, ro On 03/20/15-03/21/15, the Staff F Weekend House Supervisor on the could not be followed and an alter Beginning 03/21/15 and ongoing, Nurses, or Staff Facilitator regard	the resident's family on 03/08/15. to the nurse, the nurse was require revealed LPN #1 should have assistent. able Allegation of Compliance (A Jeopardy: Sent to the hospital and treated in the ICAL CONDITION] infarction (Soppital on [DATE]. Supervisor conducted evaluations on notification which had not been T] patient (identified by the facilities. A nursing intervention was in CTED]. The Unit Manager validates. A nursing intervention was intentified by the facilities. A nursing intervention was intentified by the facilities. A nursing intervention was notification which had not been T] patient (identified by the facilities. A nursing intervention was intentified by the facilities. A nursing intervention was intentified by the facilities. A nursing intervention was notificated the implementation of the for of Nursing, Unit Managers, MI Supervisor reviewed all current recions were made to the care plans. CAL CONDITION] (intervention evidence based Plan, Do, Check, (CMS) to prevent unnecessary actinurses through evaluating residen ludes the SBAR (Situation, Backgistent's condition or change of colures of Nurse Consultant re-educated the Director of actilitator re-educated the Director of the INTERACT program, follow-unferring to	concerns, 'The DON stated she was not aware LPN #1 had not According to the Administrator, is to contact the resident's physicisesed Resident #1's condition had been been some of the seed Resident #1 when the family OC) on 03/24/15. The facility imphe emergency room for pneumonited the contact the resident's physicisesed Resident #1 when the family OC) on 03/24/15. The facility imphe emergency room for pneumonited for all current residents to determine addressed. Two (2) issues were identy as Resident A) refused [MEDIC plemented, the resident's physiciated implementation of the new orders and monitoring of the S Nurses, Quality Improvement (sidents' plans of care to determine as needed. One care plan was signs were in place). No change to the Act process developed through fut the care transfers and includes a bis, providing care, and notifying the ground, Analysis, and Request) to addition with the Physician. ted the Staff Facilitator regarding m, follow-up evaluations, as well as physician ted the INTERACT program, but not of Nursing, Unit Managers, MDS dication Technicians, and Certifice RACT program, follow-up evaluation, as well as physician must be dekend House Supervisor, and Staff Nurse Aides related to conducting evaluations, as well as physician m, but not to supersede nursing juitator regarding the requirement to owed and an alternative was not voof Nursing, Unit Managers, MDS of care; education further included of practice the physician must be by the Director of Nursing, Unit 9 plan of care and if the plan of care physician must be notified.	as also not aware LPN #1 m on 03/08/15. assessed Resident #1 after f a change in a an. Further y reported concerns, and olemented the following ia.[MEDICAL CONDITION], N]). The resident had a stent at (QI) Nurses, Staff the if there were any tentified. CAL TREATMENT] and later an was notified of the ders and continued monitoring the Physician was made aware d the procedure the patient. QI) Nurses, Staff that all interventions difficantly changed related to plans of care required anding from the Centers for inder of care paths, which the physician for ol for nurses to complete conducting an evaluation as physician to supersede nursing S Nurses, QI Nurses, and d Nurse Aides on conducting tion, as well as physician to supersede nursing aff Facilitator continued with ug an evaluation based an otification for a degment. of follow the plan of vithin their scope of Nurses, QI Nurses, and if the plan of care notified. Managers, QI Nurses, MDS e could not be

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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.

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. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM and 9:30 AM. Ha/she complained of changes in condition on 03/08/15 between 8:30 AM.

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

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCT	TON	(X3) DATE SURVEY
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		COMPLETED 03/26/2015
CORRECTION	NUMBER			00/20/2010
NAME OF PROVIDER OF SUP	185152		STREET ADDRESS, CITY, STA	TE 7ID
	REHABILITATION CENTER		555 BOURNE AVENUE	IIE, ZII
OSINER WOODS HERSING A	REMIDIEMINION	· 	SOMERSET, KY 42501	
	nome's plan to correct this deficience	• •		
	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	FULL REGULATORY
F 0282	(continued from page 3)			
Level of harm - Immediate jeopardy	minute. The resident's physician v		%), with oxygen being administere eeived [MEDICATION NAME](ar	
Level of harm - Immediate jeopardy Residents Affected - Few	(continued from page 3) saturation levels that ranged from minute. The resident's physician v NAME] nebulizer treatment (breathing treat 4:15 PM, the family visited Resurse was notified of the resident' after being notified by the family The family contacted the Nurse Prailed to assess the resident was to the hospital and later sustained the hospital and passed away at 5: The facility's failure to ensure each impairment, or death of a resident (F157 - 1), 42 CFR 483.20 Reside Administration (F514 - K). The fan acceptable Allegation of Comp (3/25/15. A partial extended surw was removed on 03/25/15, which Resident Assessment (F282), and to an E, while the facility monitor The findings include: Interview conducted with the Dire regarding following or implement interventions of monitoring reside Shortness of Breath dated 2011 re resident's level or activity, or a ne include the resident's oxygen satu and monitoring the resident's vital worsening condition. Record review revealed the facility the Comprehensive Admission M be cognitively intact with a Brief independent with eating and requibreath with exertion (walking, bat resident was alert, oriented to per Review of the Comprehensive Car potential for or actual ineffective or ineffective breathing pattern, sintolerance, increased confusion, the resident's physician of signs at Review of Resident #1's Nurse's N resident was aleast, oriented to per Review of the Comprehensive Car potential for or actual ineffective or ineffective breathing pattern, sintolerance, increased confusion, the resident's physician of signs at Review of the Signal and chest congestion in Further review revealed new phys Further review revealed new phys Further review of the clinical recovers of the signal and chest congestion in Further review of the clinical recovers of the Hospital Record for resident had shallow, rapid, and daturation was 82% (normal 95-16 resident had shallow, rapid, and daturation was 82% (normal 95-16 resident had shallow, rapid, and daturation was 82% (normal 95-	87 to 92% (normal range 95-100 vas contacted and orders were recatment). Staff interviews revealed sident #1 and found the resident was condition. However, the nurse f that the resident was in respirator actitioner and orders were receive by the property of the property of the transferred to the local hospital. I a [MEDICAL CONDITION] info 00 AM on 03/09/15 (reference F or resident's plan of care was imple. Immediate Jeopardy was determent Assessment (F282 - J), and 42 cicility was notified of the Immediatione was received on 03/25-26/15 lowered the Scope and Severity to 42 CFR 483.25 Quality of Care (see the effectiveness of systemic characteristic plants of the systemic characteristic plants of the property	It the resident's condition did not in with labored breathing and he/she wailed to monitor the resident's respy distress, as per the plan of care red to transfer the resident to the horesident's physician of the resident Resident #I required intubation sharction ([MEDICAL CONDITION 157 and F282). Emented was likely to cause seriou nined to exist on 03/08/15 at 42 CF CFR 483.25 Quality of Care (F30 ate Jeopardy on 03/20/15. Which alleged removal of the Inni. The State Survey Agency determ o D at 42 CFR 483.10 Resident Ri. F309); and 42 CFR 483.10 Resident Ri. F309); and 42 CFR 483.75 Admin tanges and quality assurance activities the Interact Care Path Algon. Review of the Interact Care Path Algon. Review of the Interact Care Path or labored breathing that were out h, vital signs were to be obtained varing chest pain required notificatiours. Staff was also to monitor the 15 from the hospital with [DIAGN ent dated [DATE], revealed the facility identificatiours. Staff was also to monitor the 15 from the hospital with [DIAGN ent dated [DATE], revealed the facility identificatiours. Staff was also to monitor the 15 from the hospital with [DIAGN ent dated [DATE], revealed the facility identifications. Fig. 15 from the hospital with [DIAGN ent dated [DATE], revealed the facility identifications. Fig. 16 from the hospital with [DIAGN ent dated [DATE], revealed the facility identifications seathing pattern. The path of the care Area Assessment Sun ake needs and wants known to stability identifications and the sasessment of the resident only good to the plan of care, interventions eathing pattern. The path of the path of care, interventions eathing pattern. The path of the path of care, interventions eathing pattern. The path of the path of care, interventions eathing pattern. The path of the path of care, interventions eathing pattern. The path of the path of care, interventions eathing pattern. The path of the path of care, interventions eathing pattern. The path of the path of the path of the path of the path	ntibiotic) and [MEDICATION nprove. On 03/08/15 was lethargic; the biratory status required. spital. The nurse ts condition, per overly after arrival will. The resident was admitted to sinjury, harm, FR 483.10 Resident Rights 9 - J), and 42 CFR 483.75 mediate Jeopardy on nined the Immediate Jeopardy gipts (F157), 42 CFR 483.20 instration (F514) was lowered tites. thave a specific policy rithm Program for h Algorithm for of proportion to the which should on of the Physician resident for a lossessed to be had shortness of mmary (CAAS), the aff. ed a care need of tions included monitoring e, activity sincluded to notify time unknown) the ranged from 87 to dent was assessed to have sician was contacted. the resident's family mber questioned the called the clinical record tion after 11:07 AM on approvement or decline or thing, as required DATE1 at 5:10 PM, the erroxygen of the conditions. Included the conditions included the clinical record tion after 11:07 AM on approvement or decline or thing, as required DATE1 at 5:10 PM, the erroxygen of the conditions. If the conditions included she was to the CNA, Resident #1 was 100.08/15. During the 8:00 ne/she may be getting ling a cup at breakfrast and did not during this time, the ehis/her medications. If #1; however, CNA #1 103/08/15. During the 8:00 ne/she may be getting ling a cup at breakfrast and did not during this time. N #1 assisted the medications to the or changes in the 3/08/15, the LPN said she not femiliar member what
	reported to her that they thought to she told the physician earlier in th family member did not agree with Further interview with the LPN renor did she obtain vital signs on R she only saw the resident when th LPN #1, care plan interventions of the plan of care was being follow not in any distress when she put the	he resident had pneumonia. Acco e day and that the resident receive the resident's assessment and tre- vealed she did not assess the resid- tesident #1, which she should have e paramedics were transporting the f monitoring the resident were do dd. LPN #1 stated she was not aw he resident to bed after lunch and	rding to LPN #1, she reported to the demedications earlier in the day. That atment and thought Resident #1 he dent's condition after the family me been doing, per the care plan. As the resident on a stretcher from the one when making rounds to pass mare of any changes with Resident when she administered the 2:00 Plant.	he family member what The LPN said the ad pneumonia. ember talked with her ccording to LPN #1, facility. According to edications, and to ensure #1 and the resident was M medications.
	An interview conducted with Fam	ny ivieniber (FIVI) #1 on 03/18/15	at 5.50 FW, revealed the FM arriv	red at the facility on

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

Facility ID: 185152

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NAME OF PROVIDER OF SUI		STREET ADDRESS, CITY, STA	ATE, ZIP	
SOMERWOODS NURSING &	MERWOODS NURSING & REHABILITATION CENTER 555 BOURNE AVENUE SOMERSET, KY 42501			
For information on the nursing l	home's plan to correct this deficient	cy, please contact the nursing home or the state survey agency.		
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED B'MATION)	Y FULL REGULATORY	
NAME OF PROVIDER OF SUI COMERWOODS NURSING &	PELIER REHABILITATION CENTER REHABILITATION CENTER REHABILITATION CENTER COMES plan to correct this deficient SUMMARY STATEMENT OF E OR LSC IDENTIFYING INFORN (continued from page 4) assess Resident #1's condition wh to the hospital via ambulance and Interview with the Director of Nur plan intervention included monito to note an initial change of condit shift) was then utilized to docume a change in condition, the nurse w document findings. According to #1 and FM #1 reported changes ir #1 was transferred on 03/08/15, b concerns with Resident #1's condi Interview conducted with the Adm Resident #1 after concerns were r resident had a change of condition required to assess the resident, co interview with the Administrator concerns with the resident on 03/08 **The facility provided an accepta actions to remove the Immediate. 1) On 03/08/15, Resident #1 was s and ST segment elevation [MEDI placed. Resident #1 passed away at the he 2) On 03/21/15-03/22/15, the Direct Facilitator, and Weekend House 8 medical needs requiring physician (A)A [MEDICAL TREATMEN' had weeping from the lower extremiti change, physician orders [REDAG of the resident. (B)Resident B (identified by the and ordered diagnostic testing, the res was ordered. The Unit Manager v On 03/21/15-03/22/15, the Direct Facilitator, and Weekend House 8 were being followed. Minor revis to a patient's condition of [MEDII notification; and Medicard Services are algorithms used for directing oretain common symptoms. It inc and effectively communicate a res on 03/20/15, the RN (Registered I) based on the resident's condition to notification; and, for a significant judgment. On 03/21/15-03/22/15, the Staff F Weekend House Supervisor and te an evaluation based on the residen notification; and for a significant judgment. On 03/21/15-03/22/15, unit Mana re-education with all Nurses, Med on resident condition to include the significant of the residen norification of the residen norification of the residen norification of the residen norification of the residen no	S55 BOURNE AVENUE SOMERSET, KY 42501 Ey, please contact the nursing home or the state survey agency. DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED B'MATION) ille the family member was at the facility. FM #1 stated that Reside was diagnosed with [REDACTED]. sing (DON) was conducted on 03/20/15 at 5:15 PM. The DON staving of symptoms the Situation, Background, Assessment, Requestion. The facility's acute charting (documentation of the resident's content the monitoring of the resident. Further interview revealed when was required to assess the resident as soon as possible, notify the ph the DON, LPN #1 did not follow the resident's plan of care and ass the resident's condition on 03/08/15. According to the DON, she lut she was not aware Resident #1 was not assessed by the nurse aftition on 03/08/15. The facility on 03/08/15. According to the Adn and was care planned with interventions for monitoring of the contact the physician, and document findings/notification in the medi instact the physician, and document findings/notification in the medi revealed LPN #1 should have assessed/monitored Resident #1 whe D8/15. able Allegation of Compliance (AOC) on 03/24/15. The facility impleopardy: sent to the hospital and treated in the emergency room for pneumon CAL CONDITION] infarction (STEMI) ([MEDICAL CONDITION pspital on [DATE]. ctor of Nursing, Unit Managers, MDS Nurses, Quality Improveme Supervisor conducted evaluations of all current residents to determit notification which had not been addressed. Two (2) issues were it of patient (identified by the facility as Resident A) refused [MEDIC es. A nursing intervention was implemented, the resident's physicic CTED]. The Unit Managers, MDS Nurses, Quality Improvement Supervisor reviewed all current residents' plans of care to determine in ostification which had not been addressed. Two (2) issues were it of patients as evaluating residents, providing care, and notifying t ludes the SBAR (Situation, Background, Analysis, and Request) to include the implementation of	ent #1 was transported ted when a resident's care t (SBAR) format was utilized ondition once per a resident experienced tyscian, and sess Resident #1 after CNA had been informed Resident ter the family reported If #1 had not assessed ministrator, if a midition, the nurse was ical record. Further en the family reported their plemented the following hia,[MEDICAL CONDITION] hill). The resident had a stent ent (QI) Nurses, Staff time if there were any dentified. CAL TREATMENT] and later an was notified of the ders and continued monitoring the Physician was made aware and the procedure he patient. (QI) Nurses, Staff that all interventions mificantly changed related to plans of care required unding from the Centers for pinder of care paths, which the physician for hol for nurses to complete the conducting an evaluation as physician to supersede nursing S Nurses, QI Nurses, and di Nurse Aides on conducting ation, as well as physician to supersede nursing aff Facilitator continued with ng an evaluation based un notification for a udgment. to follow the plan of within their scope of Nurses, QI Nurses, and di fit he plan of care e notified. Monagers, QI Nurses, MDS re could not be urse Aides to demonstrate cimately 75 percent of the Chese staff indicated teted this re-education. g completed both the they were unable to follow irrect care staff will ill complete this and House Supervisor, or RN conditions daily. cian of significant bservation and discussion	
	their shift and review of the STOI	cussion with CNAs to determine if they have noted any changes in P and WATCH (the tool included in the INTERACT program for C c medical record).		
	Beginning 03/23/15, the Director of Facility Consultant will review all without physician notification or daily until abatement of the Imme The Clinical Interdisciplinary Tear Facilitator, MDS Nurses, Weeken established process of reviewing to	c medical record). ment of Immediate Jeopardy then four (4) times per week for four of Nursing, QI Nurses, Staff Facilitator, Unit Managers, Weekend I I Nurse's Notes daily to determine if any significant change in condany significant change in condition has occurred without evaluation that Jeopardy and then four (4) times per week for four (4) weeks m (IDT) which includes the Director of Nursing, Unit Managers, Q and House Supervisor, RN Facility Consultant, or Treatment Nurse, the Nurse's Notes, Shift Reports, and physician's orders [REDACT] is Saturday and Sunday and reports to the Director of Nursing and A	House Supervisor, or RN lition has occurred n. This will occur s. JI Nurses, Staff will continue to follow the ED]. The Weekend House	

Facility ID: 185152

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING ____ 03/26/2015 185152 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 555 BOURNE AVENUE SOMERSET, KY 42501 SOMERWOODS NURSING & REHABILITATION CENTER For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 5) daily. The Weekend House Supervisor and MDS Nurses will revise care plans through the established process. F 0282 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 Straff Exciliator. The Executive QI Committee consists of the Administrator. Level of harm - Immediate jeopardy Residents Affected - Few the Executive QI Committee. Thereafter, Members of the QI Committee will consist of at a minimum, the Director of Nursing Unit Managers, QI 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 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 revealed no concerns. 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 Review of the Quality Assurance Committee minutes conducted on 03/21/15 through 03/26/15 revealed the facility had identified no concerns. Provide necessary care and services to maintain the highest well being of each resident **NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F 0309 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 Level of harm - Immediate Residents Affected - Few 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

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

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).

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

Facility ID: 185152

(X1) PROVIDER / SUPPLIER (X3) DATE SURVEY STATEMENT OF (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING ____ 03/26/2015 185152 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION F 0309 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 Level of harm - Immediate jeopardy Residents Affected - Few 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 O2/03/15, 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 (A 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 review of the Emergency Medical Service (EMS) Run Sneet for Restoent #1 dated 05/08/15, 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 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 was day succeeding the resident was not as a left and oriented because the resident was potential to the NA or the resident was not as a left and oriented because the resident was potential to the NA or 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 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 Resid 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 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 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 the resident (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 to the hospital. The LPN stated she only saw the 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

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185152 If continuation sheet

Previous Versions Obsolete		Page 7 of 12

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(SA) ID PRIFICE TO SECRETIFICATION OF DITICULINCY MUST REPRECIDED BY FULL REGULAT ORLS SECRETIFICATION OF DITICULAR TO SECRETIFICATION OF SECRETIF	For information on the nursing	home's plan to correct this deficien	·	
Level of harm - Immediate incention with Resident #1 being short of breath and not responding to the family member. The APR Resident Affected - Few Resident #1 due to the resident's recent history of presuments and the resident's multiple complex medical issues. The A discussed fith with the family member, called the facility best, and gave order to transfer the resident is the high great with the family member. The facility best, and gave order to transfer the resident is the high great of the control of the resident's recent history of presuments and the resident is multiple complex medical issues. The A discussed this with the family forms of the facility best, and gave order to transfer the resident is the high great of the family and the family and the present of the member of the concern was reported to the mirror where the terms was required to assess the resident study the present of the family and the present of the family order of the family by EMS. In the family by EMS. Administrator, if a resident had a change of condition or concerns were reported the name and the Administrator order of the family of the family of the family order of the family order of the family order of the family order of the family order of the family order of the family order of the family of the family order o	(X4) ID PREFIX TAG			Y FULL REGULATORY
medical needs requiring physician inoffication 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] that had been applied to the problem of the problem. The patient is a problem of the problem of the change, physician own notified of the change, physician own orders and continued it of the resident. (B)—Resident B (dentified by the facility as Resident B), who has a [DIAGNOSES REDACTED]. The Physician was made of the resident of the problem	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIOR LSC IDENTIFYING INFORMATION) (continued from page 7) 4:30 PM, regarding concerns with Resident #1 being short of breath and not responding to the she called the facility to inquire about the resident. According to the APRN, she was informed the resident Affected - Few (material and the seident and the seident and the resident and resident and the resident		MATION) In Resident #1 being short of breath and not responding to the family bout the resident. According to the APRN, she was informed that thad received a nebulizer treatment. The APRN stated she felt this trecent history of pneumonia and the resident's multiple complex member, called the facility back, and gave orders to transfer the residering (DON) on 03/20/15 at 5:15 PM, revealed if a resident had a cle, the nurse was required to assess the resident using the Situation, I mat (the facility's method to gather information before calling the pent indicated the physician needed to be notified, then staff was required to document the concern and the findings in the mident #1 was transferred to the hospital on [DATE]. However, she the nurse after the family reported their concerns and she was also resident after concerns were reported to her until the resident was beconducted on 03/20/15 at 6:00 PM, revealed he was not aware LPN formed by the resident's family of their concerns on 03/08/15. Acc change of condition or concerns were reported, the nurse was requiphysician and family if indicated. Further interview with the Admir ded Resident #1 when the family reported concerns with the resident able Allegation of Compliance (AOC) on 03/24/15. The facility im Jeopardy: sent to the hospital and treated in the emergency room for pneumon ICAL CONDITION] infarction (STEMI) ([MEDICAL CONDITION ospital on [DATE].	y member. The APRN stated he resident was reatment was not adequate for edical issues. The APRN ent to the hospital. hange of condition or a Background, ohysician if a change of uired to notify the visician notification), heedical record. The DON was not aware that not aware that the being transported from If I had not assessed ording to the ired to assess the histrator revealed LPN to no 3/08/15. plemented the following haia,[MEDICAL CONDITION] hair,[MEDICAL CONDITION] hair,[MEDICAL CONDITION] hair,[MEDICAL CONDITION] hair,[MEDICAL CONDITION] hair, [MEDICAL
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 throug their shift and review of the STOP and WATCH (the tool included in the INTERACT program for CNAs to alert change resident condition in the electronic medical record).		medical needs requiring physician (A)A [MEDICAL TREATMEN had weeping from the lower extremitic change, physician orders [REDA' of the resident. (B)Resident B (identified by the and ordered diagnostic testing, the reswas ordered. The Unit Manager von 03/21/15-03/22/15, the Direct Facilitator, and Weekend Houses were being followed. Minor revist to a patient's condition of [MEDI notification to a Physician. 3) The INTERACT program is an Medicare and Medicaid Services are algorithms used for directing certain common symptoms. It inc and effectively communicate a re On 03/20/15, the RN (Registered) based on the resident's condition notification; and, for a significant judgment. On 03/20/15-03/21/15, the Staff F Weekend House Supervisor and the an evaluation based on the resident in other included in a re-education with all Nurses, Meon resident condition to include the significant change in condition, ro On 03/20/15, the RN Facility Con Care; education further included in practice the physician must be no On 3/20/15-03/21/15, the Staff Face Weekend House Supervisor on the could not be followed and an alte Beginning 03/21/15 and ongoing, Nurses, or Staff Facilitator regard followed and an alternative was not postess were developed on 03/22 retained knowledge of the re-education Ades and Certified Nunderstanding and stated all ques No Licensed Nurse, Medication A re-education and posttest. Beginning 03/21/15 and ongoing, the plan of care they must report No CNAs will work after 03/23/1: receive this education prior to working. 4) Beginning 03/23/15, the Direct Facility Consultant will conduct These rounds will also include and the second surface to the second surface to the second surface to the second surface to the process of the re-education prior to working.	n notification which had not been addressed. Two (2) issues were ic T] patient (identified by the facility as Resident A) refused [MEDIGIES. A nursing intervention was implemented, the resident's physicia CTED]. The Unit Manager validated implementation of the new or facility as Resident B), who has a [DIAGNOSES REDACTED]. The Unit Manager validated implementation of the new orders and monitoring of the order of Nursing, Unit Managers, MDS Nurses, Quality Improvement Supervisor reviewed all current residents' plans of care to determine ions were made to the care plans as needed. One care plan was sign CAL CONDITION] (interventions were in place). No change to the evidence based Plan, Do, Check, Act process developed through fit (CMS) to prevent unnecessary acute care transfers and includes a bruses through evaluating residents, providing care, and notifying the cludes the SBAR (Situation, Background, Analysis, and Request) to sident's condition or change of condition with the Physician. Nurse) Nurse Consultant re-educated the Staff Facilitator regarding to include the INTERACT program, follow-up evaluations, as well a change in condition, referring to the INTERACT program, but not account of the intervention of Nurses, Medication Technicians, and Certified Signaphic and Certified Nurse	dentified. CAL TREATMENT] and later an was notified of the ders and continued monitoring the Physician was made aware and the procedure the patient. (QI) Nurses, Staff that all interventions initicantly changed related to plans of care required aunding from the Centers for binder of care paths, which the physician for boil for nurses to complete the ground to grow the path of the physician to supersede nursing to follow the plan of within their scope of the plan of care to the plan of
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, o 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		resident condition in the electroni This will continue daily until abate Beginning 03/23/15, the Director Facility Consultant will review all without physician notification or daily until abatement of the Imme	ic medical record). ement of Immediate Jeopardy then four (4) times per week for four of Nursing, QI Nurses, Staff Facilitator, Unit Managers, Weekend I of Nurse's Notes daily to determine if any significant change in conc any significant change in condition has occurred without evaluation ediate Jeopardy and then four (4) times per week for four (4) weeks	(4) weeks thereafter. House Supervisor, or RN lition has occurred n. This will occur

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 185152

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	03/26/2015	
CORRECTION	NUMBER 185152			
NAME OF PROVIDER OF SUI		STREET ADDRESS, CITY, STA	L ATE, ZIP	
SOMERWOODS NURSING &	& REHABILITATION CENTER 555 BOURNE AVENUE			
For information on the nursing l	nome's plan to correct this deficience	SOMERSET, KY 42501 cy, please contact the nursing home or the state survey agency.		
(X4) ID PREFIX TAG	•	EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY	Y FULL REGULATORY	
E 0200	OR LSC IDENTIFYING INFORM	MATION)		
F 0309 Level of harm - Immediate jeopardy Residents Affected - Few	established process of reviewing t Supervisor reviews the documents daily. The Weekend House Super	d House Supervisor, RN Facility Consultant, or Treatment Nurse, the Nurse's Notes, Shift Reports, and physician's orders [REDACTI s Saturday and Sunday and reports to the Director of Nursing and A visor and MDS Nurses will revise care plans through the establishe Improvement Committee was convened to review the facility's into	ED]. The Weekend House Administrator at least ed process.	
Residents Affected - Few	5) On 03/20/15, an ad hoc Quality Allegation of Compliance was de Administrator, RN Facility Consu Staff Facilitator, Admissions Dire The Administrator, Director of Nu Immediate Jeopardy. Thereafter, tand anytime a concern is identifie the Executive QI Committee. The Unit Managers, QI Nurses, MDS Director of Nursing Services, Uni Services Director, Social Services Maintenance Director, Director of ***The State Survey Agency valid: 1) Review of the closed record for 2) Observations of Residents #11, following the plan of care. Review of Resident #11's medical resident to have weeping [MEDIC the change in the resident's condit [MEDICAL CONDITION] to the Review of the medical records for 03/21/15 with no changes of cond 3) Interview with the Staff Facilitat Consultant on the Interact Prograt Consultant had also trained the St residents' plans of care. According Interviews with CNAs #3, #4, #5, respectfully, revealed the CNAs h Watch program, the resident assenterviews on 03/26/15 with LPN Nurse at 11:30 AM, the West Wir been trained regarding changes of the physician, using the SBAR for Review of the INTERACT training educated by the Nurse Consultant identified. The documentation rev following the process. Review of facility. 4) Interviews on 03/26/15 with the at 2:25 PM, and the West Wirg Urounds included review of Nurse's residents' condition with nurses a physicians were notified if needed Review of the facility's documenta were being completed and were of 5 Interviews on 03/26/15 at 3:30 Nurse at 2:25 PM revealed the fac with assessments, physician notific Review of the Quality Assurance (dentified no concerns.	Improvement Committee was convened to review the facility's inveloped and reviewed with the Associate Medical Director who applitant, Unit Managers, QI Nurses, MDS Nurses, Social Services Director, and Activity Director. No further recommendations were madrising, QI Nurses, or RN Facility consultant will review the audits of the results of these audits will be reviewed with the Quality Improved until substantial compliance has been achieved; then per the sche reafter, Members of the QI Committee will consist of at a minimum Nurses, and Staff Facilitator. The Executive QI Committee consists than Managers, QI Nurses, RN MDS Coordinator, Staff Facilitator, The Assistant, Director of Activities, Director of Admissions, Dietary. Environment and Safety, and Medical Director. Indeed the Immediate Jeopardy was removed as follows: Resident #1 revealed the resident was transferred to the hospital or #12, #13, and #14 on 03/25/15-03/26/15 revealed no concerns with record (identified by the facility as Resident A) revealed the facility as Resident A) revealed the facility as Resident #12 (identified by the facility as Resident B) revealed for Keflex (a lower extremities. Review of the plan of care revealed no concerns Resident #12 (identified by the facility as Resident B) revealed the facilition on 03/22/15 at 9:06 PM. The resident had [MEDICAL COND an was notified and orders received for a venous study. Review of Residents #13 and #14 revealed the residents were assessed for a c ition identified. Review of the plans of care for these residents revetor on 03/26/15 at 1:55 PM revealed the Staff Facilitator had been in related to follow-up evaluations/assessments of residents using it aff Facilitator on assessing changes of condition, physician notifica to the Staff Facilitator, she then began training all nursing staff, #6, #7, and #8 on 03/26/15 at 10:55 AM, LPN #4 at 1:00 PM, RN #1 and been trained regarding notifying the nurse of a change of condition, and following the plan of care. Publication of validation of the	estigation and concerns. An orroved. In attendance was the rector, Kitchen Manager, le. laily until abatement of ement Committee weekly dule established by n, the Director of Nursing, s of the Administrator, eatment Nurse, Social Services Director, In [DATE]. In changes of condition or y assessed the ent's physician was notified of antibiotic) 500 mg for s. s. facility assessed the ITTION] to the lower the plan of care hange of condition on eated no concerns. trained by the Nurse to SBAR tool. The Nurse tion, and following its AM, 2:05 PM, and 2:20 PM ion, using the Stop and at 12:50 PM, the Treatment to 1:30 PM revealed they had on, notification of staff Facilitator had been too concerns are they were re reviewed by the sea to 2:15 PM, the QI Nurse cated twice daily. These didition; staff to discuss so monitoring to ensure ed. revealed walking rounds on the plant of care.	
F 0514 Level of harm - Immediate	professional standards	ganized clinical records on each resident that meet S HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**		
jeopardy Residents Affected - Some	Based on interview, record review complete clinical records for ten (and #13). On 03/08/15 between 8. congestion. The facility assessed to 92% (normal range is 95 - 1	, and review of the facility's policies it was determined the facility 10) of fourteen (14) sampled residents (Residents #1, #2, #3, #7, #3, 30 AM and 9:30 AM, Resident #1 complained of shortness of brea the resident to be slightly pale and short of air with oxygen saturation (00%). The resident's physician was contacted and orders were recent to NAME] nebulizer treatment (breathing treatment); however	failed to maintain 3, #9, #10, #11, #12, tth, pain, and chest on that ranged from ived [MEDICATION	
	3:00 PM to be pale, clammy, and condition at lunch and, another ch documented evidence regarding the visited Resident #1 and found the condition by the family; however, resident's condition. After the family contacted the Adv	#1 did not eat or drink as usual for lunch and was observed by staf staring off (not focusing). The nurse was notified of the resident's fange in condition that was noted around 2:00 PM to 3:00 PM; how he assessment/monitoring of the resident's condition. On 03/08/15 a resident with labored breathing and lethargic. The nurse was notifithe the nurse did not assess Resident #1 and document the findings of vanced Practice Registered Nurse (APRN), Resident #1 was transferenced processes the statement of the start of the sta	outher change in ever, there was no at 4:15 PM, the family ed of the resident's the assessment or the tred to the local hospital	
	CONDITION] infarction ([MEDI 03/09/15. In addition, the facility failed to m	aced in the mouth and throat for breathing). Resident #1 later sustain CAL CONDITION]). The resident was admitted to the hospital and aintain complete clinical records for Residents #2, #3, #7, #8, #9, #	d passed away at 5:00 AM on 1:10, #11, #12, and	
	consistently document the time ve The facility's failure to ensure each impairment, or death of a resident	ne receipt time of telephone physician orders. Facility nursing staff tribal telephone Physician order [REDACTED]. In resident had an accurate clinical record was likely to cause serious. Immediate Jeopardy was determined to exist on 03/08/15 at 42 Cl was Assessment (F282) = 10, 42 CFB 483 25 Onglity of Care (F300 - 1).	s injury, harm, FR 483.10 Resident Rights	
(F157 -J), 42 CFR 483.20 Resident Assessment (F282 - J), 42 CFR 483.25 Quality of Care (F309 -J), and 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 03/25/15. A partial extended survey was conducted on 03/25-26/15. The State Survey Agency determined was removed on 03/25/15, which lowered the Scope and Severity to D at 42 CFR 483.10 Resident Rights (Resident Assessment (F282), and 42 CFR 483.25 Quality of Care (F309); and 42 CFR 483.75 Administrat		mediate Jeopardy on nined the Immediate Jeopardy ights (F157), 42 CFR 483.20		

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				OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	ON .	(X3) DATE SURVEY
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING		COMPLETED 03/26/2015
CORRECTION	185152			
NAME OF PROVIDER OF SU		S	TREET ADDRESS, CITY, STA	ATE, ZIP
SOMERWOODS NURSING	& REHABILITATION CENTER		55 BOURNE AVENUE	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home	OMERSET, KY 42501 or the state survey agency.	
(X4) ID PREFIX TAG	•	DEFICIENCIES (EACH DEFICIEN		FULL REGULATORY
F 0514	(continued from page 9)			
Level of harm - Immediate jeopardy	The findings include:	s the effectiveness of systemic chang	ges and quality assurance activit	ies.
Residents Affected - Some		ed Receipt of physician's orders [RE e time and date the order was received.]		r Form (BN2002) revealed
	Review of the facility's policy title	ed Interact Care Path dated 11/21/12 v of the resident, reporting of the res	, revealed it was the licensed nu	
	orders, outcomes of treatment, an	d the resident's condition.	• •	•
	#1 on 03/08/15. According to LP	cal Nurse (LPN) #1 on 03/19/15 at 2 N #1, the resident reported to her du	ring the 8:00 AM medication pa	ass, that he/she was
	holding	he/she may be getting [MEDICAL	_	•
		s unusual for the resident. According 8/15 between 7:00 AM and 9:00 AM		
	AM. LPN #1 stated she contacted	Resident #1's Physician sometime a Further interview revealed LPN #1	after breakfast and obtained orde	ers for an antibiotic and
	unknown) with the use of a lift. T	The LPN stated she administered Resonal concerns or changes for the resi	sident #1's 2:00 PM medications	between 1:00 PM and 3:00
	saturation. Further interview with	LPN #1 revealed she rechecked Re	sident #1's oxygen saturation lat	ter in the day at an
	record.	l improved; however, LPN #1 stated		
		vealed on 03/08/15 at approximately going on with the resident. The LPN		
		ay and that the resident had received lers [REDACTED].#1 had pneumon		
	#1 very well could have pneumor	nia. LPN #1 stated she later (time un ician. The LPN told the APRN the re	known) received a call from an	APRN who worked for
	LPN #1 stated the APRN called h	ner back and gave her orders for Res	ident #1 to be transferred to the	hospital for evaluation
	the resident's condition because s	t she did not assess Resident #1 after he was getting paperwork ready to to	ransfer the resident to the hospit	al. The LPN stated
	LPN #1, residents were charted of	ne paramedics were transporting the in during each shift and monitored do	uring medication administration	, meals, and during
	walking rounds conducted at shif licensed nurse, to document her r	t change. However, according to the eview of the resident, document the	facility's policy, it was LPN #1 report of the resident's condition	's responsibility, as a n and outcomes of the
	resident's treatment.	at 11:16 AM revealed the Physician		
		TON NAME] mg (an antibiotic) twi		
	breathing) treatment every four (4	4) hours as needed. According to the her review of the record revealed a N		
	Resident #1's daughter was at the	facility, and disagreed with the type	e of treatment for [REDACTED]]. The Nurse Practitioner
	the hospital and orders were rece	dent's situation. The Nurse's Note fur ived to send the resident to the hospi	ital. Review of the clinical recor	d revealed no
	through the time the resident left	ent findings, follow up of treatment, the facility, which should have been	completed, according to facility	y policy.
	03/01/15, 03/03/15, 03/04/15, and	ord revealed Physician Telephone Or d 03/08/15. However, the times the p	ohysician's orders [REDACTED	0].
	2. Review of the medical record for	or Resident #2 revealed physician te w revealed the time the order was re	lephone orders were received or	n 03/10/15, 3/11/15, and
	3. Review of the medical record for	or Resident #3 revealed physician te . Further review of the record reveal	lephone orders were received or	n 03/05/15, 03/06/15,
	4. Review of the medical record for	or Resident #7 revealed physician te	lephone orders were received or	n 03/03/15, 03/10/15, and
	Telephone Order Form.	w of the medical record revealed the		
	review of the medical record reve	or Resident #8 revealed a physician ealed the time the order was received	I was not included on the Teleph	none Order Form.
	Further review of the medical rec	or Resident #9 revealed physician te ord revealed the time the physician	orders [REDACTED].	
		or Resident #10 revealed physician t . However, further review of the me		
	was not included on the Telephor 8. Review of the medical record for	ne Order Form. or Resident #11 revealed physician t	elephone orders were received of	on 03/06/15, 03/07/15,
	03/08/15, 03/09/15, 03/11/15, 03/ orders [REDACTED].	/23/15, and 03/24/15. Further review	of the medical record revealed	the time the physician
	9. Review of the medical record for	or Resident #12 revealed physician t		
	the Telephone Order Form.			
	03/07/15, 03/19/15, and 03/24/15	for Resident #13 revealed physician . Further review of the medical reco	rd revealed the time the physicia	an orders [REDACTED].
	orders should include the time the	d Practical Nurse (LPN) #2 on 03/26 order was received/written. However	ver, the LPN stated she often for	
		on the physician's orders [REDAC's on 03/26/15 at 11:30 AM, revealed		e time the physician's
	orders [REDACTED]. Interview conducted with Registe	red Nurse (RN) #1 on 03/26/15 at 12	2:50 PM, revealed the physician	's orders [REDACTED], RN #1
	stated she would often forget to it	nclude the time on the physician's or st Wing Unit Manager on 03/26/15 a	ders [REDACTED].	
	daily audits of the residents' recor	rds but had not identified a problem		
		rsing (DON) on 03/26/15 at 2:45 PM		
	received and documented a telepl	ers [REDACTED]. The DON stated none physician's orders [REDACTE]	D]. [REDACTED].	
	**The facility provided an accept actions to remove the Immediate	able Allegation of Compliance (AOC Jeopardy:	C) on 03/13/15. The facility imp	lemented the following
	1) On 03/08/15, Resident #1 was	sent to the hospital and treated in the ICAL CONDITION] infarction (STI		
	placed.		, ([a, aont ma a biont
		ctor of Nursing, Unit Managers, MD		
	medical needs requiring physicia	Supervisor conducted evaluations of n notification which had not been ad	ldressed. Two issues were identi	ified.
	weeping from the lower extremit	 patient (identified by the facility a ies. A nursing intervention was impl 	emented, the resident's physicia	n was notified of the
		CTED]. The Unit Manager validated		
		acility as Resident B), who had a [D	IAGNOSES REDACTED]. The	Physician was made aware and

On 03/21/15-03/22/15, Unit Managers, MDS Nurses, QI Nurses, Weekend House Supervisor and Staff Facilitator continued wit 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.

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

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. Will consist of at a minimum, the Director of Nursing, Unit Managers, QI Nurses, RN MDS Coordinator, Staff Facilitator, Treatment

2) Observations conducted of Residents #11, #12, #13, and #14 on 03/23/13-03/20/13 leveated to 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 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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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:3/1/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OF SUP SOMERWOODS NURSING &	PPLIER & REHABILITATION CENTER	555 BOI	ADDRESS, CITY, STATE, ZIP RNE AVENUE SET, KY 42501
For information on the nursing h	nome's plan to correct this deficience	cy, please contact the nursing home or the	
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MI	ST BE PRECEDED BY FULL REGULATORY
F 0514 Level of harm - Immediate jeopardy	extremities. The resident's physicirevealed no concerns.	ian was notified and orders received for a v	•
Residents Affected - Some	Review of medical records for Res 03/21/15 with no changes of cond of the Staff Facilitie Consultant on the Interact Prograt Consultant had also trained the Staff Facilitie Consultant on the Interact Prograt Consultant had also trained the Stresidents' plans of care. According Interviews with CNAs #3, #4, #5, respectfully, revealed the CNAs head was been consultant had been trained regarding changes of the physician, using the SBAR for Review of the INTERACT training educated by the Nurse Consultant identified. The documentation revolution of facility. 4) Interviews on 03/26/15 with the at 2:25 PM, and the West Wing Urounds included review of Nurse's residents' condition with nurses and physicians were notified if needer Review of the facility's documentation for the facility's documents were being completed and were of 5) Interviews on 03/26/15 at 3:30 Nurse at 2:25 PM revealed the face with assessments, physician notification of the Quality Assurance of identified no concerns. Interview of the Quality Assurance of identified no concerns. Interview conducted on 04/15/15 SRNA #7 at 12:10 PM, SRNA #1 documentation of the Stop and W Post survey interviews with the Werounds to review charting on reside documented in the residents' medilaterview on 04/15/15 (post survey Management Team had been mee physician notifications were docubeen meeting weekly to review/m Record reviews conducted for Res Review of in-service education interview of in-service education interview education interview of in-service education interview of in-service education interview education interview of in-service education interview education interview education interview education interview education interview education interview of in-service education interview	m related to follow-up evaluations/assessmaff Facilitator on assessing changes of con gto the Staff Facilitator, she then began tra #6, #7, and #8 on 03/26/15 at 10:52 AM, 1 had been trained regarding notifying the nu sament for change of condition, and follow #2 at 11:00 AM, LPN #3 at 10:55 AM, LPn gUnit Manager at 1:15 PM, and the Seco foodition, assessing/monitoring residents rm, and following the resident's care plan. g documentation revealed the training was and the Staff Facilitator conducted training readed the facility was monitoring staff that posttests revealed staff had been given post and the Staff Facilitator conducted training readed the facility was monitoring staff that posttests revealed staff had been given post and the Staff Facilitator conducted training readed the facility was monitoring staff that posttests revealed staff had been given post and the Staff Facilitator conducted from one and CNAs; and ensure care plans were being and to ensure that nurses conducted from 03 ingoing on 03/26/15 with no concerns iden PM with the Administrator, the Nurse Condition of change of condition, and follow Committee minutes conducted on 03/21/15 (post survey interviews) with SRNA #2 at at 12:50 PM and SRNA #9 at 1:30 PM, re atch assessments to report changes of condition Swith LPN #5 at 1:20 PM and LPN #6 at teract policy and had been trained to accurate the staff of accuracy and to ensure changes of coal records. St Wing Unit Manager on 04/15/15 at 12:4 lents for accuracy and to ensure changes of coal records. y interview), with the DON at 2:40 PM and ting twice daily to review audits complete mented accurately. Further interview reversionitor the effectiveness of training and on idents #15, #16, and #17 which included price in the proper continuation of the continuation of the proper con	for these residents revealed no concerns. aff Facilitator had been trained by the Nurse ents of residents using the SBAR tool. The Nurse lition, physician notification, and following ning all nursing staff. 1:11 AM, 11:34 AM, 11:50 AM, 2:05 PM, and 2:20 PM are of a change of condition, using the Stop and nog the plan of care. 1:44 at 1:00 PM, RN #1 at 12:50 PM, the Treatment of Floor Unit Manager at 1:30 PM revealed they had after a change of condition, notification of given on 03/20/15, the Staff Facilitator had been a for nursing staff with no concerns had been trained to ensure they were tests and the results were reviewed by the 2:45 PM, the MDS Nurse at 2:15 PM, the QI Nurse ounds were being conducted twice daily. These idents for change in condition; staff to discuss followed. They were also monitoring to ensure y-up evaluations if needed. 22/15 through 03/26/15 revealed walking rounds fied. ultant at 3:15 PM, the DON at 2:45 PM, and the QI neeting daily to review daily audits for concerns gether esidents plans of care. through 03/26/15 revealed the facility had 11:00 AM, ealed the SRNAs had been trained to ensure accurate through 03/26/15 revealed the facility had 11:00 AM, ealed the SRNAs had been trained to ensure accurate through 03/26/15 revealed the facility had 11:00 AM, ealed the LPN had been trained and were tely document assessments and physician's 5 PM, revealed the Unit Manager had been making condition and assessments were accurately the Administrator at 2:50 PM revealed the to ensure changes of condition, assessments, and led the facility Quality Assurance committee had oing interventions.

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