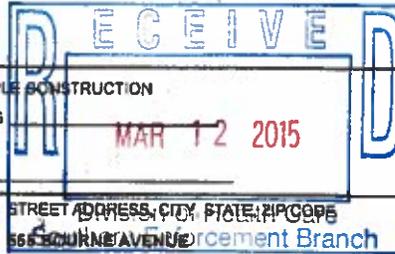


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2015
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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 565 BOURNE AVENUE Enforcement Branch SOMERSET, KY 42601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	DISCLAIMER: Somersetwoods Nursing and Rehabilitation Center (Somersetwoods) acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Somersetwoods' response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor that any deficiency is accurate. Further, Somersetwoods Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, independent informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to review/revise the Comprehensive Plan of Care for one (1) of twenty-four (24) sampled residents (Resident #11). Resident #11 was assessed on 11/27/14, using the Norton Scale for Predicting	F 280	[This Section Intentionally Blank]	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian Duggan</i> INAA CDP	TITLE Administrator	(X8) DATE 03/12/15
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Any deficiency statement beginning with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 666 BOURNE AVENUE SOMERSET, KY 42501		
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F 280	<p>Continued From page 1</p> <p>Risk of Pressure Ulcer, to be at high risk for pressure sore development. However, the facility failed to revise the Comprehensive Care Plan for Resident #11 to include interventions to address the potential for pressure sore development. Observation on 02/11/15 at 9:25 AM during a skin assessment revealed a previously unidentified open area on Resident #11's left outer heel.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Resident Care Plans," dated August 2012, revealed any new problem or need of the resident which is identified between his/her scheduled care plan review will be addressed on the care plan.</p> <p>Review of the medical record for Resident #11 revealed the facility admitted the resident on 12/31/13 with diagnoses of Dementia, Cellulitis, Edema, Hypertension, Dysphagia, and Psychosis. Review of the Annual Minimum Data Set (MDS) dated 12/10/14 revealed the facility assessed Resident #11 to be at high risk for developing a pressure ulcer. Review of the Comprehensive Care Plan revealed the care plan was initiated on 05/09/14. The care plan included interventions related to the resident's risk for skin breakdown related to Incontinence, Fragile Skin, and Dementia. Interventions included pressure-relieving devices, turning, and repositioning.</p> <p>Review of the Norton Scale for Predicting Risk of Pressure Ulcer completed on 08/25/14 revealed Resident #11 was assessed to be at moderate risk for the development of a pressure ulcer. On 10/31/14, Resident #11 was assessed as having dry, scaly, calloused tissue to both heels. There</p>	F 280	<p>The comprehensive plan of care for resident #11 was revised on 2/11/2015 to include intervention(s) to address the pressure sore, prevent worsening of the identified area and/or development of other pressure areas</p> <p>Evaluation by the facility Treatment Nurse on 03/05/15 determined the area to resident number 11's heel was healed and the treatment was discontinued.</p> <p>The licensed nurses responsible for maintaining/revising the comprehensive plans of care reviewed the most recent Norton Scale for Predicting Pressure Ulcer (Norton Scale) for each resident; and ensured that appropriate interventions were included in the comprehensive plan of care for all residents who scored at high risk for development of pressure areas.</p> <p>The Director of Nursing provided (re)education on 02/27/15 to the facility Treatment Nurse and MDS Nurses regarding completing and updating the comprehensive plan of care. This (re)education included that the Treatment Nurse would notify the appropriate MDS Nurse of any resident identified by the Norton Scale to be at high risk of developing a pressure area and the MDS Nurse would revised the comprehensive plan of care to include interventions to prevent development of pressure areas.</p> <p>A random sample of 10% of the in-house Residents, to include residents from each unit,</p>		

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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501		
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F 280	Continued From page 2 was no evidence the care plan was revised to address Resident #11's skin concerns after they were identified on 10/31/14. Further review of the medical record revealed a Norton Scale for Predicting Risk of Pressure Ulcer was conducted on 11/27/14 and revealed Resident #11 was identified to be at high risk for the development of a pressure ulcer. However there was no evidence the Comprehensive Care Plan was reviewed/revised to include new interventions to assure the prevention of a pressure ulcer. Observation on 02/11/15 at 9:25 AM during a skin assessment revealed an open area on Resident #11's left outer heel that was not previously identified by the facility. Interview with the MDS Coordinator on 02/12/15 at 3:50 PM revealed staff should notify her to add interventions to the care plan when new problems were identified. She further stated she was not notified of any new issues concerning Resident #11; therefore, care plan changes were not made. The MDS Coordinator further stated that new interventions should have been added. Interview with the Director of Nursing (DON) on 02/12/15 at 7:07 PM revealed when a new concern is identified with a resident the care plan should/would be updated to reflect the new concern and new interventions added. The DON further stated she had not identified any problems concerning the care plans.	F 280	will be selected monthly x 3 months, by the Quality Improvement Nurse or Quality Improvement Assistant. The score from the most recent Norton Scale will be reviewed. Residents with a score indicating high risk will be reviewed to determine appropriate interventions for pressure ulcer prevention are included in these plans of care. The auditing nurse will immediately report any identified issues to the Director of Nursing for correction and direction of further action. A summary of these audits will be reported to the Quality Improvement Team for Wound Care and Skin Assessment per the established meeting schedule during March, April and May 2015; and then per the schedule established by the Executive QI Team.	03/11/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	Investigation by the facility Administrator, Director of Nursing, and dispensing pharmacy concerning Resident 7's allergies was completed on 2/12/15. Information from the resident's family and physician		

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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 656 BOURNE AVENUE SOMERSET, KY 42501		
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F 281	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of standards of practice, it was determined the facility failed to ensure professional standards of quality were maintained for one (1) of twenty-four (24) sampled residents (Resident #7). Review of Resident #7's monthly physician orders for 08/01/14 through 02/12/15, revealed the resident had Tylenol (analgesic) listed as an allergy. However, a review of Resident #7's physician orders revealed an order for Tylenol 650 milligrams every four (4) hours as needed for pain or fever. The facility failed to ensure the standard of practice for administration of medications was followed and Resident #7 received medications which were indicated as an allergy on the resident's record.</p> <p>The findings include:</p> <p>Review of Lippincott's Nursing Center recommendations, dated 05/27/11, revealed there were eight rights of medication administration. Continued review of the recommendations revealed before administering medications, licensed staff should ensure it was the right medication and the right dose being administered to the right patient, via the right route, and at the right time. Continued review of the recommendations revealed licensed staff should confirm the rationale for the ordered medications, and document administration of the medications, after the medication has been administered. According to the recommendations, licensed staff should ensure medications had the desired effect for the patient receiving the medication.</p>	F 281	<p>was used to determine Resident 7 did not have an allergy to Tylenol. The monthly Physician's Orders and Medication Administration Record for Resident 7 was corrected to indicate Resident 7 was not allergic to Tylenol.</p> <p>The allergies listing on the monthly Physicians Orders and Medication Administration Records (MAR) of each resident were reviewed and compared to the resident's known allergy listing in Point Click Care (PCC) on 02/12/15 by Administrative Nurses as assigned by the Director of Nursing. Any discrepancies between the Physician Order, MAR and PCC were resolved by contacting the resident or resident's family and the resident's attending physician. Physician orders were obtained to update the MAR and PCC, if indicated. No resident received medication for which they had an allergy.</p> <p>Licensed and Registered staff nurses completing the changeover review of the March MAR validated the medication allergies listed on the MAR matched those in the Physician Orders and PCC.</p> <p>The Registered and Licensed Nurses passing the 1st round medications on 03/01/15 reviewed the Medication Administration Record for each resident to ensure residents with an allergy listed did not have that medication included in ordered medications. The House Supervisor verified</p>		

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F 281	<p>Continued From page 4</p> <p>Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/15/14, with diagnoses including Dementia, Fractured Femur, and Breast Cancer.</p> <p>Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 01/27/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was interviewable.</p> <p>Review of the physician's orders for Resident #7 from 08/01/14 to 02/12/15, revealed the physician prescribed Tylenol 650 milligrams every four (4) hours as needed for pain or fever. In addition, the physician orders had Tylenol (analgesic) listed as an allergy for Resident #7.</p> <p>Review of Resident #7's Medication Administration Records (MARs) from 08/01/14 to 02/12/15, revealed all MARs had Tylenol (analgesic) listed as an allergy for Resident #7. The MARs further revealed the facility staff administered Tylenol to Resident #7 on numerous occasions since admission to the facility.</p> <p>Interview with Resident #7 on 02/12/15, at 10:15 AM, revealed he/she had taken Tylenol (analgesic) for many years and was not allergic to the medication.</p> <p>Interview conducted with Registered Nurse (RN) #2 on 02/12/15, at 2:40 PM, revealed she reviewed Resident #7's physician orders for February 2015, and administered medications to the resident on multiple occasions. The RN stated she reviewed all physician orders as well as allergies and a resident's code status when</p>	F 281	<p>with each nurse on dayshift on 03/01/15 that s/he had reviewed the medications and that no issues were identified.</p> <p>The Unit Coordinators conducted a QI Audit on 3/2/15 to ensure the MAR's for residents did not have medications ordered that were listed as allergies on the MAR.</p> <p>Registered and Licensed Nurses received (re)education on March 3, 4, 5, and 7 by the Interim Staff Development Nurse or Director of Nursing. The in-service education included (re)training regarding the process of monthly changeover for Physician Orders and Medication Administration Records including comparison of the allergies listed on the monthly documents with the resident's allergy listing in PCC; and clarification/correction as needed. Education also included instruction for nurses to verify individual allergies as part of the medication pass; and no resident should receive medication which is listed on the MAR as an allergy. Nurses (on leave) not attending this in-service will be in-serviced prior to returning to the floor. New hire nurses will receive this education during orientation.</p> <p>A copy of the Lippincott's Eight Rights of Medication Administration was provided to each of the facility's licensed/registered nurses for review. A copy will be provided to new hire nurses during orientation.</p>		

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F 281	Continued From page 5 reviewing the monthly orders. RN #1 stated she should have identified Tylenol (analgesic) listed as an allergy for Resident #7 and should have questioned why the resident had physician orders for the medication. In addition, the RN stated she should have questioned the allergy when administering medications to the resident. The RN stated she was required to check allergies prior to administering a medication to ensure the resident was not allergic to the medications. Interview conducted with Unit Manager #2 on 02/12/15, at 1:55 PM, revealed she reviewed resident charts to ensure residents were being provided with the care they required. The Unit Manager stated she should have identified Resident #7 had Tylenol (analgesic) listed as an allergy and the resident had physician orders to receive the medication. The Unit Manager stated nursing staff was required to check a resident's allergies while passing medications and should have identified Resident #7's allergy to Tylenol (analgesic).	F 281	The Quality Improvement Nurse or Quality Improvement Assistant will select a random sample of 10% of in-house residents in each unit following the monthly changeover of Physician Orders and Medication Administration Records x 3 months. The list of sampled residents will be provided to the Unit Coordinator or MDS Nurse for each unit to audit the resident's known allergy listing against the Physician Orders, PCC and MAR. Any issues will be immediately corrected and reported to the Director of Nursing for review and direction. Results of the audits will be reported to the Quality Improvement Team during regularly scheduled meetings during the months of March, April and May 2015 and then per the schedule established by the Executive QI Committee.	03/11/15
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	The comprehensive plan of care was revised on 02/11/15 to include interventions to prevent the Identified pressure area from worsening or	

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F 314	<p>Continued From page 8</p> <p>resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure one (1) of twenty-four (24) sampled residents (Resident #11) did not develop a pressure sore. Observation on 02/11/15 at 9:25 AM revealed a previously unidentified open area on Resident # 11's left outer heel. The facility failed to develop interventions to prevent pressure sores when the resident was identified to have ill-fitting shoes.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Pressure Ulcer Prevention and Care," dated August 2012, revealed the facility would make every effort to prevent the development of pressure ulcers.</p> <p>Review of the medical record for Resident #11 revealed the facility admitted the resident on 12/31/13 with diagnoses of Dementia, Cellulitis, Edema, Hypertension, Dysphagia, and Psychosis. Review of the Annual Minimum Data Set (MDS) dated 12/10/14 revealed the facility assessed Resident #11 to be at high risk for developing a pressure ulcer. A review of the care plan dated 05/09/14 revealed the resident was</p>	F 314	<p>development of additional pressure areas. After discussion with the family, the resident will wear non-skid socks vs. shoes.</p> <p>Evaluation by the Treatment Nurse on 03/05/15 determined the identified area was healed. The comprehensive plan of care was updated to reflect this change.</p> <p>A skin audit of each resident in the facility was conducted by licensed nurses on 2/11 – 2/19/15 and revealed no other resident had any pressure areas not previously identified.</p> <p>The footwear being worn by all other residents in the facility was evaluated by the licensed nurse Unit Coordinators during the week of 3/2/15 – 3/6/15. Footwear identified to be ill fitting was removed/replaced.</p> <p>(Re)education was conducted on March 3, 4, 5, and 7 by the Interim Staff Development Nurse or Director of Nursing. This (Re)education included for SRNAs to monitor skin with every contact including closely looking at residents feet when applying/removing shoes and socks; and to report any identified areas to the licensed nurse immediately and for the licensed/registered nurses to immediately evaluate and follow the standards of practice related to skin care. SRNA's who did not attend the in-service will be in-serviced during their next shift. New hire</p> <p>SRNA's will receive this education during orientation.</p>		

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F 314	<p>Continued From page 7</p> <p>assessed to be at risk for skin breakdown and interventions were developed for prevention of pressure ulcers.</p> <p>A review of the medical record revealed a Norton Scale for Predicting Risk of Pressure Ulcer was conducted on 11/27/14 and revealed Resident #11 was identified to be at high risk for the development of a pressure ulcer. Skin assessments were done weekly and on 02/08/15 a skin assessment was done for Resident #11 with no concerns identified. The care plan was not updated or revised after 05/09/14.</p> <p>Observation on 02/11/15 at 9:25 AM during a skin assessment conducted with facility staff, revealed a necrotic open area on Resident #11's left outer heel. A second observation on 02/11/15 at 3:45 PM with the Treatment Nurse revealed staff was unaware of the open area to Resident #11's left outer heel, that measured .7 cm (centimeters) x 1.6 cm.</p> <p>Phone interview with Licensed Practical Nurse (LPN) #2 on 02/11/15 at 10:35 AM revealed skin assessments are done weekly, which consist of head to toe assessments, targeting pressure areas. LPN #2 revealed she completed a skin assessment on Resident #11 on 02/08/15 and had not identified any skin breakdown on Resident #11's feet.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 02/11/15 at 4:05 PM revealed CNA #2 had undressed Resident #11 on 02/10/15 in the evening to assist her to bed, propped her feet on a pillow, and had not noticed any skin breakdown on Resident #11's feet.</p>	F 314	<p>The Quality Improvement Nurse or Quality Improvement Assistant will select a random sample of 10% of in-house residents in each unit, monthly x 3, and will provide the Unit Coordinator with the list of sampled residents. The Unit Coordinator will review the footwear of the residents included in the sample to ensure that there is no ill-fitting footwear and review each resident's feet to ensure no undocumented skin issues exist. The Unit Coordinator will immediately correct any identified issue and will report to the Director of Nursing for further action. The results of the audits will be reported to the QI Committee during a regularly scheduled meeting during the months of March, April and May 2015; and per the schedule established by the Executive QI Committee thereafter.</p> <p>[This Section Intentionally Blank]</p>	3/11/15	

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F 314	Continued From page 8 Interview with the Treatment Nurse on 02/12/15 at 9:55 AM revealed Resident # 11 had been having problems with his/her shoes rubbing his/her heels as he/she propelled in the wheelchair and the open area was caused by the ill-fitting shoes. She further revealed it was her professional opinion that the open area did not happen overnight and the area was a Stage 2 pressure ulcer. Interview with the MDS Coordinator on 02/12/15 at 3:50 PM revealed staff should notify her to add interventions to the care plan when new problems were identified. She further stated she was not notified of any new issues concerning Resident #11, therefore, care plan changes were not made. The MDS Coordinator further stated new interventions should have been added to address ill-fitting shoes. Interview with the Director of Nursing (DON) on 02/12/15 at 7:07 PM revealed staff had been trained to report any type of skin breakdown on the residents. She further stated in her professional opinion the open area on Resident #11's left outer heel did not occur overnight and had probably been there for at least two to three days. She had not identified any problems with staff not observing/reporting any type of skin breakdown on the residents.	F 314	[This Section Intentionally Blank]		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428	The Attending Physician was notified/consulted on 02/11/2015 regarding the Tylenol allergy listed on the Medication Administration record for Resident number 7. It was confirmed the resident does not have an allergy to Tylenol. The resident's medical record was corrected.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2015
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 566 BOURNE AVENUE SOMERSET, KY 42501		
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F 428	<p>Continued From page 9</p> <p>the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the pharmacist reported irregularities to the resident's physician and the Director of Nursing (DON) for one (1) of twenty-four (24) sampled residents (Resident #7). Review of Resident #7's monthly physician orders for 08/01/14 through 02/12/15, revealed the resident had Tylenol (analgesic) listed as an allergy. However, a review of Resident #7's physician orders revealed an order for Tylenol 650 milligrams every four (4) hours as needed for pain or fever. The facility failed to assure the attending physician and the DON were notified of the irregularities in Resident #7's drug regimen as required.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Consultant Pharmacist Responsibilities," undated, revealed the pharmacist (RPh) would review each resident's medication regimen monthly, and after the review, the RPh would submit any irregular findings or recommendations to the DON for follow-up with the physician if needed.</p> <p>Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/15/14, with diagnoses including Dementia,</p>	F 428	<p>On 3/1/15 the Consultant Pharmacist reviewed all residents in the facility. The review determined the Pharmacist recommendations/notations from January and February 2015 had been addressed by the facility and Physician(s) for all residents and new recommendations were made.</p> <p>The Consultant Pharmacist provided a visit summary report to the Director of Nursing for the 03/01/15 review.</p> <p>The Director of Nursing Audited the 03/01/15 summary sheets against each of the individual resident medical records to ensure no discrepancy existed between the individual records and the summary report; and appropriate follow up was made with residents' Physician(s).</p> <p>This process will be repeated in April and May 2015 (pending no electronic system is implemented). The Director of Nursing will alert the Administrator and Corporate Nurse Consultant of any identified issues needing addressed.</p> <p>The consultant Pharmacist is evaluating different electronic records systems for tracking and reporting her reviews; and will be implementing an improved system in 2015.</p> <p>Results from the Audits will be presented to the QI Committee during regularly scheduled meetings in March, April and May 2015; and per the schedule established by the Executive QI Committee thereafter.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	Continued From page 10 Breast Cancer, and Fractured Femur. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 01/27/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was interviewable. Review of the physician orders for Resident #7 from 08/01/14 to 02/12/15, revealed Tylenol 650 milligrams every four (4) hours was prescribed by the physician as needed for pain or fever. Review of the Consultant Pharmacist reviews conducted monthly from 08/03/14 to 02/07/15, revealed no documentation the Pharmacist (RPh) reported to Resident #7's physician or to the DON that the resident had Tylenol (analgesic) listed as an allergy and that the resident had been receiving the medication. Interview with Resident #7 on 02/12/15, at 10:15 AM, revealed he/she had taken Tylenol (analgesic) for many years and was not allergic to the medication. Interview conducted with the RPh on 02/12/15, at 6:50 PM, revealed she reviewed all physician orders and physician progress notes on each resident every month. The RPh stated she should have identified Resident #7 had an allergy listed for Tylenol (analgesic) and should have reported the information to the DON and physician. The RPh stated she did not know why she had not identified the concern.	F 428	In the event the Consultant Pharmacist implements an electronic system during April or May 2015, the QI Committee will review the process and implement a monitoring plan tailored to that system. [This section intentionally blank]	03/11/15	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463	The issue identified by the surveyor for the bathroom in room 306 was identified to the Maintenance Department through the		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 463	<p>Continued From page 11</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to ensure a functioning communication/call system was in place for one (1) of six (6) resident bathrooms. Observations on 02/12/15 revealed the communication system utilized by residents was not functioning properly for the bathroom of a resident room (room 306).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Call Light," dated April 2013, revealed a call system was in place to alert staff to respond to residents' requests and needs. If a call bell was noted to be defective, staff was to immediately report the issue to Maintenance.</p> <p>Review of the facility's policy related to maintenance titled "Policy," with a revision date of December 1998, revealed the facility would provide a safe and properly maintained facility. The policy also stated the equipment would be properly maintained for the comfort and security of residents, staff, and visitors.</p> <p>Observation during the environmental tour on 02/12/15 at 9:53 AM, revealed the call light for the bathroom of resident room 306 was not illuminated in the hallway after the call light was</p>	F 463	<p>established work order system. The 3rd floor call system was inspected by the facility maintenance department on 2/11/15. Repairs were made and the computer monitor that had been placed in front of the call light system was returned to its proper location.</p> <p>Each of facility's call light systems was fully audited on 2/11/15 by the facility Maintenance and Environmental Services staff to ensure that the systems were functioning properly. No other issues were identified.</p> <p>Evaluation of the placement of the other unit's call light system by the facility Administrator on 2/27/15 determined it was unlikely the view of those systems would be blocked by the nurse moving a computer monitor. Signage was placed at the 3rd floor call light station stating not to block the view of the call light system.</p> <p>QI Review of the call light systems by the Director of Maintenance and Administrator determined an increased potential for future problems with the 3rd floor call system exists due to age. A new call light system was authorized and ordered by the Administrator on 2/27/15. The vendor installed a temporary call light system on the third floor on 03/06/15. The new permanent system is scheduled to be installed later in March 2015.</p> <p>Administrative staff have areas, including all patient rooms, assigned by the QI Nurse to conduct audits twice monthly. The audit tool</p>	
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F 463	<p>Continued From page 12 activated.</p> <p>Observation at the nurses' station on 02/12/15 at 9:57 AM, revealed the call light station was not visible. Further observation revealed the call light station was not illuminated or sounding after the call light was activated in the resident room 306 bathroom. The call light station was blocked by a computer monitor.</p> <p>During observations of the call system on 02/12/15, Certified Nursing Assistant (CNA) #1 was interviewed at 9:56 AM. The CNA stated the call light was supposed to illuminate in the hallway as well as at the nurses' station. The CNA verified that the communication system was not illuminated in either area.</p> <p>Interview with Registered Nurse (RN) #1 on 02/12/15 at 9:57 AM, revealed the call light station was not visible at the nursing station and the call light was not working. Further interview at 3:43 PM, revealed "when the call light is pulled, it should be blinking in the hall, and be buzzing at the nurses' station desk." RN #1 further stated she did not know the call system was not functioning because it should have been making a noise and flashing.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, who is also the Unit Coordinator on the third floor, on 02/12/15 at 9:58 AM and again at 4:57 PM revealed when a call light was activated a light buzzing sound should be audible at the nurses' station, and a light should illuminate in the hallway. LPN #1 further stated the Unit Managers or nurses conduct random call light audits. LPN #1 stated there were no identified problems with the call system and LPN #1 was not aware that</p>	F 463	<p>was revised to include auditing the call light in each patient room and bathroom for function. Administrative staff will follow the facility protocol for notifying maintenance of any issues and will report issues to the QI Nurse per the protocol of the Administrative Rounds Program.</p> <p>The Director of Maintenance, Administrator, or Chairman of the Safety Committee will conduct two additional audits during separate calendar weeks in March. Identified issues will be reported to the maintenance department through the established system and results of these audits will be presented to the QI Committee during a regularly scheduled meeting during the month of March.</p> <p>The QI Nurse will report any issues regarding call lights during a regularly scheduled QI Team Meeting during the months of March and April and per the schedule established by the Executive QI Team thereafter.</p> <p>The QI Committee will establish a monitoring system for sixty days following the install of the new system.</p> <p>[This Section Intentionally Blank]</p>	03/11/15	

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F 463	<p>Continued From page 13</p> <p>the call light for room 306 was not functioning properly.</p> <p>Interview with the Maintenance Supervisor on 02/12/15 at 10:00 AM, revealed the nursing staff performed audits on the call lights randomly. He stated he was unaware the call light was not working in the resident room 306 bathroom and had not received any work orders for call lights.</p> <p>Interview with the Director of Nursing (DON) on 02/12/15 at 5:12 PM, revealed when a call light is activated staff was to go into the resident's room to evaluate the needs of the resident. Further interview revealed staff was to be watching for call lights going off, and the DON stated she had not been notified of any call light issues. The DON also stated staff performs random call light audits to ensure the call lights are in working order.</p> <p>Review of documentation titled "Call Light Audits," revealed call lights were tested on 07/08/14, 08/12/14, 08/13/14, 08/14/14, 09/09/14, 09/29/14, and 10/09/14. There was no documented evidence of any further call light audits or testing.</p>	F 463		
F 502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed</p>	F 502	<p>The labs for resident number seven ordered for January were drawn on 02/12/15.</p> <p>The QI Nurse audited the labs scheduled for January and February for residents on the 2nd floor against the Physician Orders on 2/12/15. No additional discrepancies were identified.</p>	

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F 502	<p>Continued From page 14</p> <p>to obtain laboratory services to meet the needs of one (1) of twenty-four (24) sampled residents (Resident #7). Resident #7 had a physician order dated 07/28/14 to have laboratory tests completed for a Complete Blood Count (CBC), Thyroid Stimulating Hormone (TSH) level, and a Complete Metabolic Panel (CMP) to be completed every three (3) months in January, April, July, and October. However, a review of the laboratory reports for Resident #7 revealed the last CBC, TSH, and CMP laboratory tests completed for Resident #7 were on 10/02/14. There was no evidence in the medical record the laboratory tests had been completed in January 2015 as ordered by the physician.</p> <p>The findings include:</p> <p>Interview conducted with the Director of Nursing (DON) on 02/12/15, at 1:15 PM, revealed the facility did not have a policy related to obtaining laboratory specimens.</p> <p>Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/15/14, with diagnoses including Dementia, Breast Cancer, Diabetes Mellitus, Hypothyroidism, and Hypercholesterolemia.</p> <p>Review of the physician orders for Resident #7 revealed a Complete Blood Count (CBC), Thyroid Stimulating Hormone (TSH) level, and a Complete Metabolic Panel (CMP) were ordered on 07/28/14 to be completed every three (3) months, in January, April, July, and October.</p> <p>Review of the laboratory reports for Resident #7 revealed the last CBC, TSH, and CMP laboratory tests completed for Resident #7 were on</p>	F 502	<p>The Unit Coordinators and Director of Nursing audited the labs for January and February for residents in the other units on</p> <p>02/17/15. All labs in the other units were scheduled and completed in accordance with the Physician's orders.</p> <p>The Director of Nursing reviewed the process for scheduling labs in accordance with the Physicians orders with the Unit Managers during the Interdisciplinary Team QI Meeting on 02/27/15. Unit Managers are responsible for ensuring all labs are scheduled according to policy.</p> <p>The QI Nurse or QI Assistant will select a random sample of 10% of in-house residents from each unit, monthly x 3, and will provide the list to an alternate Unit Coordinator to audit. Audit will determine if labs were completed as scheduled and if future labs are scheduled according to policy. Any identified issues will be immediately corrected and reported to the Director of Nursing for additional action. Results of these audits will be reported during regularly scheduled QI Committee Meetings during the months of March, April and May 2015.</p>	03/11/15
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F 502	<p>Continued From page 15</p> <p>10/02/14. There was no evidence in the medical record the laboratory tests were completed in January 2015 as ordered by the physician.</p> <p>Interview conducted with the DON on 02/12/15, at 7:05 PM, revealed Resident #7's CBC, TSH, and CMP (laboratory tests) had been missed. The DON stated the Unit Managers were responsible for monitoring residents' laboratory orders and scheduling the laboratory tests to be done.</p> <p>Interview conducted with Unit Manager #1 on 02/12/15, at 1:55 PM, revealed she was responsible for monitoring all resident laboratory orders to ensure they have been completed as ordered by the physician. The Unit Manager stated she placed the routine laboratory orders on a calendar at the nurses' station to inform nurses when laboratory orders were due to be drawn. The Unit Manager stated she had overlooked Resident #7's CBC, TSH, and CMP (laboratory tests) orders for January 2015. The Unit Manager stated she was not aware how, she guessed she had just missed them.</p>	F 502	[This Page Intentionally Blank]	
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