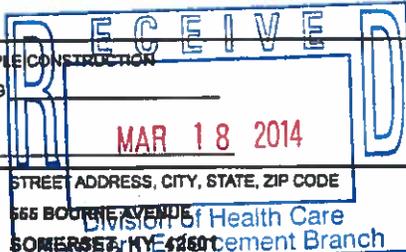


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended SOD

PRINTED: 03/10/2014
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 R 02/01/2014
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 666 BOULDER AVENUE SOMERSET, NY 11760 Division of Health Care Services - Cement Branch	
(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 AMENDED On 01/31/14 - 02/01/14, an on-site revisit for the annual survey (01/14/14 - 01/17/14) was conducted to determine the removal of Immediate Jeopardy (IJ) at 42 CFR 483.65 Infection Control (F441) and 42 CFR 483.75 Administration (F490, F493, and F520). An acceptable Allegation of Compliance (AOC) was received on 01/24/14 alleging removal of IJ on 01/23/14. However, it was determined the facility failed to ensure two (2) employees, who had a history of a past positive TB skin test and had documented signs/symptoms of TB, were referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing as required per the facility's Tuberculosis Testing and Screening Policy. In addition, the facility failed to ensure the Staff Development Coordinator (SDC) was knowledgeable on how to read a TB skin test. Based on the above findings, it was determined Immediate Jeopardy was removed on 02/01/14, with remaining noncompliance at 42 CFR 483.65 Infection Control (F441) and 42 CFR 483.75 Administration (F490, F493, and F520) at a scope and severity of "F." {F 441} 483.65 INFECTION CONTROL, PREVENT SS=F SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	{F 000}	<u>DISCLAIMER:</u> Somerswoods Nursing and Rehabilitation Center (Somerswoods) 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. Somerswoods' 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, Somerswoods 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. See 13 page attachment for: F 441 F 490 F 493 F 520 Pages 2 - 82 of 82 are intentionally blank	

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

Blair Kogawa

TITLE

Administrator

(X5) DATE

3/17/14

Any deficiency statement finding 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 555 BOURNE AVENUE SOMERSET, KY 42501		
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{F 441}	<p>Continued From page 1</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and Allegation of Compliance (AOC) it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 01/17/14, had been removed related to infection control. An acceptable AOC was</p>	{F 441}		

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{F 441}	<p>Continued From page 2</p> <p>received on 01/24/14 alleging removal of the IJ on 01/23/14. However, it was determined the IJ was not removed on 01/23/14 as alleged. The facility failed to ensure two (2) employees (Employees #2 and #51), out of fifteen (15) employee screenings reviewed, were referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing as required per the facility's Tuberculosis Testing and Screening Policy based on the employees' history of a past positive TB skin test and documented signs/symptoms of Tuberculosis (TB). In addition, the facility failed to ensure the Staff Development Coordinator (SDC) was knowledgeable on how to read a TB skin test.</p> <p>Based on the above findings, it was determined the IJ was removed on 02/01/14 with remaining noncompliance at a scope/severity of "F" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's AOC, dated 01/24/14, revealed the facility reverted to their August 2005 "Tuberculosis Screening and Testing" for employees, which stated if an employee had a documented positive Mantoux skin test (TB skin test) upon hire, a screening for Tuberculosis (TB) symptoms would be performed. If symptomology was present, the employee would be referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray.</p> <p>Review of employee screening forms for</p>	{F 441}		

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{F 441}	Continued From page 3 employees who had a history of a positive TB skin test revealed two staff members had documented symptoms of TB. Review of Employees #2 and #51's annual Tuberculosis Screenings, dated 01/17/14, revealed Employee #2 marked on the form that she had night sweats and Employee #51 marked that she had chest pain, weight loss, and excessive fatigue. These symptoms were listed as being signs and symptoms of Tuberculosis and according to the facility's policy, the employees would be sent to the local Health Department or referred to the Medical Director for further diagnostic evaluation and testing to include a chest x-ray. There was no evidence that the employees had been referred or had any diagnostic evaluation. Interview conducted with the Staff Development Coordinator (SDC) on 01/30/14 at 3:05 PM and 4:50 PM and on 01/31/14 at 12:35 PM and 1:10 PM revealed she oversaw and ensured all staff received a TB skin test or TB screening per the facility policy and reviewed all staff Tuberculosis screenings. She stated she was aware Employees #2 and #51 had documented signs/symptoms of tuberculosis, but she believed Employee #2 was having menopausal symptoms, not symptoms of Tuberculosis, and did not feel it was necessary to refer the employee to the Health Department. The SDC stated Employee #51 was being treated for pneumonia and she did not think the symptoms were from Tuberculosis, therefore she did not refer the employee to the local Health Department. Per interview, she did not report the screening information for Employees #2 and #51 to the Director of Nursing (DON). Interview conducted with the DON on 01/31/14, at 1:27 PM, revealed the SDC did not report any	{F 441}		

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{F 441}	<p>Continued From page 4</p> <p>concerns to her regarding the two employees with positive screenings for Tuberculosis.</p> <p>Interview conducted with the Administrator on 01/31/14, at 1:25 PM, revealed no Tuberculosis testing/screening issues were reported to him.</p> <p>Interview conducted with the Corporate Nurse on 01/31/14, at 10:00 AM, revealed she had reviewed all resident and employee Tuberculosis testing and screenings and had not identified that any employee had documented signs or symptoms on the Tuberculosis screening forms. However, review of the employee screenings revealed the employees should have been sent to the local Health Department or referred to the Medical Director for further diagnostic evaluation and testing to include a chest x-ray per the facility's policy.</p> <p>Further interview with the SDC on 01/30/14 at 3:05 PM and 4:50 PM and on 01/31/14 at 12:35 PM and 1:10 PM revealed she read a portion of the staff TB skin test results which were conducted as part of the facility's AOC. However, the SDC was unable to state in interview what measurement would be considered a positive TB skin test (induration greater than or equal to 15 mm is considered a positive skin test).</p> <p>Interview with the Administrator, DON, Quality Assurance Coordinator and Assistant Quality Assurance Coordinator on 01/31/14 at 11:35 PM, revealed the facility had not educated staff or ensured staff was knowledgeable on how to read a TB skin test.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 01/24/14. The facility</p>	{F 441}		

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{F 441}	<p>Continued From page 5 implemented the following actions to remove the Immediate Jeopardy:</p> <p>The facility Administrator met with the Regional Vice President, Director of Nursing, Quality Improvement (QI) Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (via phone), and Director of Corporate Policy (via phone) on 01/16/14. The investigation included review of the letters and documents from the Cabinet for Health and Family Services, Centers for Disease Control (CDC), and the Food Drug Administration (FDA), and resulted in the determination that an error had been made in the interpretation of these documents and the temporary policy was repealed on 01/16/14.</p> <p>On 01/16/14, the decision was made to immediately repeal the facility's "Tuberculosis Testing and Screening Temporary Measures" and revert to the facility's permanent policies for TB Testing entitled, "Tuberculosis Screening and Testing [Employee]" and "Resident Tuberculosis Testing and Screening Policy." Both of these policies have been in effect since August 2005. These policies include two-step TB testing for new-hires and new resident admissions and annual TB testing thereafter.</p> <p>On 01/16/14, the facility Administrator contacted the local Hospital and multiple pharmacies and was able to obtain enough Tubersol to conduct testing for all employees and all residents, with an additional supply for admissions and new hires for approximately 60 days.</p> <p>On 01/16/14, the facility Administrator met with the Director of Nursing and all Administrative Nurses and conducted re-education regarding the</p>	{F 441}		
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{F 441}	<p>Continued From page 6 TB Skin Testing Policy.</p> <p>On 01/17/14, the facility Administrator spoke with and reviewed the facility policy with the local Health Department Medical Director who advised to treat all staff and residents as if they were Day 1 employees and residents. Staff and residents who had already received a two-step TB skin test would not need the second step administered, nor was there a need to obtain new x-rays for those who have had a negative x-ray since exposure or treatment. The Health Department Medical Director advised that her opinion was that testing of employees during their next scheduled shift was sufficient to meet the regulation.</p> <p>On 01/17/14, the Director of Nursing spoke with the facility's Medical Director and received orders to administer TB skin testing in accordance with policy for all residents in the facility.</p> <p>The Staff Development Nurse began immediately conducting TB skin tests on all employees on the premises on 01/16/14 and 01/17/14. The other Administrative Nurses began TB testing for all residents on 01/17/14 to be completed before midnight on 01/17/14.</p> <p>Any positive resident PPDs will be addressed according to the facility's policy including screening, notification to MD, and follow-up chest x-ray. Any resident with signs/symptoms of active TB will be transferred to an acute care facility until after appropriate therapy is completed.</p> <p>Any positive staff PPDs will be addressed according to the facility's policy. The employee will be immediately placed on administrative leave and notification to the facility's Medical Director or</p>	{F 441}		

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{F 441}	<p>Continued From page 7</p> <p>physician on call, and local Health Department for further diagnostic testing, such as a chest x-ray or a statement, will be obtained stating a chest x-ray is not needed. The employee will be required to have a Physician's Statement to clear them for duty prior to the employee being allowed to work.</p> <p>Any positive resident or staff conversions of more than 10 mm induration will be immediately reported to the local Health Department by the Administrator or Director of Nursing.</p> <p>The reading of the resident PPDs will be conducted by licensed nurses per policy and will be overseen by the Unit Coordinator with a report to the Director of Nursing on 01/22/14 for the initial PPDs and 02/07/14 for the residents who required a second-step PPD.</p> <p>The reading of the staff PPDs will be conducted by licensed nurses per policy and will be overseen by the Staff Development Nurse with a report to the Director Nursing on 01/22/14 for the initial PPDs and 02/07/14 for the staff requiring a second-step PPD.</p> <p>A nurse assigned by the Director of Nursing will be present at the time clock each shift change until 100 percent of the staff in all departments has been tested per policy. No employee will be allowed to work until the employee has received a TB skin test or appropriate documentation is received for those who are unable to take the test.</p> <p>The QI Nurse and QI Assistant Nurse made copies of the Resident TB Skin Testing Policy and reviewed with all Licensed Nurses on the premises on 01/17/14 and will continue to retrain</p>	{F 441}		

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{F 441}	<p>Continued From page 8</p> <p>all licensed nurses who admit patients until 100 percent of the Licensed Nurses have been re-educated regarding elimination of the Temporary Measures and return to the prior policy.</p> <p>All residents on census have had a TB skin test or x-ray per policy. There are no residents out of the facility who have not had a TB test since 01/16/14.</p> <p>The Admissions Coordinator assigns residents to the beds and assembles the patient's medical record. On 01/17/14, the Admissions Coordinator was instructed by the Administrator to notify the QI Nurse or QI Assistant Nurse of any scheduled admissions.</p> <p>Only Licensed Nurses who have been retrained regarding the TB Testing Policy will be permitted to admit patients. The majority of the licensed nurses were re-educated on 01/16/14 and 01/17/14. The additional licensed nurses will be retrained by the QI Nurse or QI Assistant Nurse during their next working shift.</p> <p>The QI Nurse or QI Assistant Nurse will ensure the TB skin test is conducted per policy, by a licensed nurse who has been re-educated to the policy. The QI Nurse or QI Assistant Nurse will be available seven days per week until all licensed nurses have been retrained on the policy.</p> <p>The TB Testing Policy will be covered by the Staff Development Nurse or Instructor during orientation for all licensed nurse new hires.</p> <p>New hires will have PPDs administered per policy</p>	{F 441}		

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{F 441}	<p>Continued From page 9</p> <p>by the Staff Development Nurse during Day 1 of general orientation and the second step administered by the Staff Development Nurse per policy.</p> <p>The QI Nurse or Administrative Nurse assigned by the Director of Nursing will review all employee health files for new employees within 24 hours of orientation and three weeks after orientation for a period of 60 days and per the established schedule thereafter to ensure TB testing is being completed correctly.</p> <p>A Unit Coordinator, the Weekend House Supervisor, or Director of Nursing will review the immunization record daily for all new admissions for a period of 60 days and per the established schedule thereafter.</p> <p>The facility developed a policy, "Tuberculosis Testing and Screening Temporary Measures," regarding the possibility the facility becomes unable to obtain TB Testing Agent, the employee or resident will have a Blood Assay for Mycobacterium Tuberculosis (BAMT), QuantiFeron-TB Cold In-Tube Test (IGRA), or T-Spot TB (TST) (blood tests that test for the presence of tuberculosis infection). In the event the lab tests are unavailable, the facility Administrator or Director of Nursing will contact the local Health Department for direction. At this time, the facility has a sufficient quantity of Tuberculin to last 60 or more days without reorder. The Director of Nursing will develop written education for all licensed nurses regarding the contingency policy stating what to do if the TB testing agent becomes unavailable. This education will be distributed with payroll on 01/23/14.</p>	{F 441}		

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{F 441}	Continued From page 10 The Unit Coordinators, Staff Development Nurse, and/or House Supervisor will report the progress of the TB testing to the facility Administrator or Director of Nursing daily until all employees and residents have completed the initial round of testing initiated on 01/16/14. The Director of Nursing will present the 01/22/14 reports from the Unit Coordinators and the Staff Development Nurse regarding TB testing to the Administrator and QI Committee on 01/22/14, and will present the 02/07/14 reports from the Unit Coordinators and Staff Development Nurse to the Administrator and QI Committee on 02/12/14. The QI Committee will review TB testing weekly through 02/28/14, then at the meeting the week of 03/26/14, and then per the established calendar thereafter. The QI Reviews will be overseen by the facility Administrator. Any identified issues will be reported to the Regional Vice President. TB Control is listed in the Annual In-Service Plan. The next scheduled "TB Control" review is scheduled for 07/14-16/14. The policies will be reviewed with staff at that time. On 01/30/14, it was identified that two employees who were unable to receive a TB skin test had signs/symptoms of TB marked yes on their screening forms and the facility had not followed its TB Policy. Upon identification of the issue, both employees were immediately placed on administrative leave on 01/30/14 and referred to the local Health Department but were unable to	{F 441}			

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{F 441}	<p>Continued From page 11 be seen on 01/31/14.</p> <p>The facility's Medical Director was contacted on 01/31/14 and gave an order for both employees to have a chest x-ray. The employees were x-rayed on 01/31/14. Results were received on 01/31/14 and were negative.</p> <p>The Administrator, Director of Nursing, and Facility Nurse Consultant received education from the Vice President of Nursing and the Employee Health Coordinator at the local Hospital. The Hospital employees reviewed the facility's policy and determined that the Director of Nursing, Administrator, and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB skin tests including the varying millimeters of induration, "mm" for a positive result for immunocompromised patients, routine nursing facility patients, and individuals identified as low risk. The specifics of the method for reading a TB test were also reviewed. The Hospital's Employee Health Coordinator also reviewed when to conduct a screening form, e.g., past positive, and the facility's policies regarding referral to the Physicians, Medical Director, or Health Department.</p> <p>The Administrator and Director of Nursing have taken complete control of the TB Screening Program effective 01/31/14 for both employees and residents, including administration and reading of TB Skin Tests, Screening Forms, and QI Audits and reports until such time as all Licensed Nurses have successfully completed skills verification related to administration and reading of TSTs and Screening Forms. The Director of Nursing will conduct the TB skin tests</p>	{F 441}		

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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 655 BOURNE AVENUE SOMERSET, KY 42501		
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{F 441}	<p>Continued From page 12 and readings until all staff have received re-education and have demonstrated they are knowledgeable.</p> <p>In the absence of the Director of Nursing, the Administrator will observe a licensed nurse who has already been re-educated and demonstrated successful skills to administer and/or read the TB test in order to ensure it is administered/read correctly in the event it is "required" during the absence of the DON.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>A review of the facility's policy entitled, "Tuberculosis Screening and Testing," dated August 2005, revealed all employees upon hire would receive a two-step Mantoux skin test with the first step being given on the first day of work. Employees with a negative skin test would receive a second-step Mantoux skin test within seven to fourteen days, and annually by a one-step method. The policy stated if a new positive occurred, employees would be referred to the local Health Department or to the Medical Director for further diagnostic evaluation and testing to include a chest x-ray. The policy further stated if an employee had a documented positive Mantoux skin test upon hire, a screening for Tuberculosis symptoms would be performed. An employee with negative symptomology would have an annual screening thereafter. If symptomology was present, the employee would be referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray.</p> <p>Review of the facility's policy entitled, "Resident</p>	{F 441}		

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{F 441}	<p>Continued From page 13</p> <p>Tuberculosis Testing and Screening Policy," dated August 2005, revealed all residents without a known documented positive PPD reaction would receive Tuberculosis testing upon admission using a two-step method. The first step would be administered on admission and if negative, a second PPD would be administered seven to fourteen days thereafter. The policy stated if the second step was negative, annual testing would occur thereafter using a single-step method. The policy revealed evaluation of residents with a new positive PPD would occur by the attending physician or the Medical Director to determine the presence of active Tuberculosis. The policy also revealed residents with a known documented positive reaction to a Mantoux PPD test would be screened for any history and symptoms of Tuberculosis. A chest x-ray would be obtained for residents with a positive screening, and the attending physician or the Medical Director would be notified to determine if further testing, appropriate treatment, and management were necessary. The policy stated any resident with suspected or probable infectious Tuberculosis would be transferred to an alternate facility for treatment.</p> <p>Review of the facility's policy entitled, "Tuberculosis Testing and Screening Temporary Measures," dated 01/17/14, revealed in the event the Tuberculosis testing agent became unavailable due to the shortage of Tubersol and Aplisol, either a BAMT, IGRA, or TST test would be performed. If these tests were not available from the facility's laboratory, the facility would consult with the local Health Department for measures to be taken for Tuberculosis testing and/or screening.</p>	{F 441}		

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{F 441}	<p>Continued From page 14</p> <p>Interview with the Administrator on 01/31/14, at 11:35 AM, the DON on 01/31/14, at 11:40 AM, the Corporate Nurse on 01/31/14, at 11:42 AM, and the Vice President of Clinical Operations on 01/31/14 at 1:40 PM, verified they had attended the telephone conference on 01/16/14, and confirmed the group had decided to repeal the interim Tuberculosis policy and revert back to the old Tuberculosis policy dated 2005, for both employees and residents.</p> <p>Interview conducted with the Administrator on 01/31/14, at 11:35 AM and 1:20 PM, revealed he had contacted the local hospital as well as the local pharmacies, and obtained enough Tubersol to last at least 60 days based on the facility's average admission and new hire rate. The Administrator stated he had met with all administrative nurses, as well as the DON, to discuss the Tuberculosis testing policy. The Administrator stated they decided that the Staff Development Coordinator (SDC) would begin testing all employees on 01/16/14 and 01/17/14, the administrative nurses began testing residents on 01/17/14, and testing was completed by 01/17/14. The Administrator further stated the facility would revert to using the BAMT, IGRA, or TST in the event Tubersol was not available. The Administrator stated if the laboratory tests were not available at the facility's laboratory, he or the DON would consult the local Health Department for guidance.</p> <p>Interview conducted with the DON on 01/31/14, revealed either she or the Administrator would notify the local Health Department in the event the facility did not have Tubersol or Aplisol available to perform PPDs. The DON stated she had developed training and had trained all facility</p>	{F 441}			

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{F 441}	<p>Continued From page 15</p> <p>nurses on what to do in the event Tubersol or Aplisol was unavailable and all facility nurses had been trained on the policy and procedure.</p> <p>Review of in-services entitled, "Nurse Education of TB Screening Policy," revealed the DON educated staff on the new policy that required nursing staff to notify the DON should testing be required. The in-service was initiated on 01/17/14 and completed on 01/23/14.</p> <p>Review of an in-service roster entitled, "Administrator Review of Tuberculosis Test Issues," dated 01/16/14, revealed all administrative nurses attended an in-service regarding the facility's Tuberculosis policy, State Regulations concerning Tuberculosis testing, and Tuberculosis testing for all residents and staff.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they made and distributed a copy of the Resident Tuberculosis Testing Policies to all licensed nurses in the facility. The policy was used to retrain all nursing staff. The training was completed on 01/23/14.</p> <p>Observation of the facility's Tubersol in the facility on 01/30/14 revealed the facility had enough Tubersol on hand to provide 150 PPD tests.</p> <p>Review of an e-mail sent to the Administrator by the Health Department Medical Director dated 01/24/14, at 8:12 AM, revealed the Administrator had consulted with the Medical Director, who advised the facility to start all staff and resident annual testing. The e-mail revealed any staff or resident who had previously been tested would not require a two-step, and those staff members</p>	{F 441}		

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{F 441}	<p>Continued From page 16</p> <p>or residents who have had a previous positive PPD required a Tuberculosis assessment. The e-mail stated residents who did not have symptoms would not need a chest x-ray.</p> <p>Interview conducted with the local Health Department Medical Director on 01/30/14, at 2:50 PM, revealed she had consulted with the Administrator and had advised him to begin Tuberculosis testing for employees and residents. The Medical Director stated she had advised the Administrator to begin using the two-step method, unless the resident or staff member had already had a two-step TB test; and in that case, just to begin the annual testing. The Medical Director stated any staff or resident who had a past positive PPD would require a screening and would only require a chest x-ray if the resident or employee had a symptom of Tuberculosis. The physician stated she told the Administrator that waiting until the employee's next scheduled shift would be sufficient to do the PPD or screening.</p> <p>A review of signed physician's orders dated 01/17/14, at 8:14 PM, revealed orders for a TB skin test for all residents currently residing in the facility. The physician's order stated if a resident had already received a two-step PPD since admission to the facility, a one-step PPD test was sufficient.</p> <p>Interview conducted with Unit Coordinator #1 on 01/31/14, at 12:10 PM, Unit Coordinator #2 on 01/31/14, at 12:15 PM, and Unit Coordinator #3 on 01/31/14, at 12:20 PM revealed PPD skin tests or screenings for residents with a history of a positive PPD were completed on 01/17/14. The Unit Coordinators stated they had attended the in-service given by the Administrator and had</p>	{F 441}			

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{F 441}	<p>Continued From page 17</p> <p>discussed the repeal of the Tuberculosis policy and going back to the previous policy. The Unit Coordinators stated in the future all residents without a known past positive would receive a two-step PPD upon admission and a one-step annually. If after receiving the first PPD the resident had a reaction, the physician would be notified for further orders, including a chest x-ray. The Unit Coordinators stated all employees would be given a PPD as well, unless they had a positive past PPD, and in that case a screening would be completed. If the employee documented symptoms, the employee would be referred to the Health Department or the Medical Director for further testing including a chest x-ray. The Unit Coordinators each stated all resident PPDs were negative and they had reported that information to the DON, and would be sending a report to the DON after reading the second-step PPDs on 02/07/14.</p> <p>Interview with the weekend House Supervisor on 01/31/14, at 1:30 PM, revealed she had been assigned to the time clock on 01/18/14 and 01/19/14, to administer PPD skin tests or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview with Quality Improvement (QI) Nurse #2 on 01/31/14, at 12:47 PM, revealed she had been assigned to the time clock on 01/17/14, 01/18/14, and 01/19/14, to administer PPDs or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview conducted with Registered Nurse (RN) #3 on 01/30/14 at 4:30 PM, Licensed Practical</p>	{F 441}			

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{F 441}	<p>Continued From page 18</p> <p>Nurse (LPN) #4 on 01/30/14 at 4:40 PM, LPN #2 on 01/30/14 at 4:45 PM, LPN #3 on 01/30/14 at 4:50 PM, and LPN #1 on 01/30/14 at 5:05 PM revealed they had attended an in-service regarding the Tuberculosis policy and were knowledgeable of the facility's TB testing policy and the policy regarding the skin testing agent not being available. The nurses stated every resident had to have a two-step PPD upon admission and a one-step annually. If the resident had a past positive history of PPD or Tuberculosis, the physician or Medical Director must be notified for any additional testing and a chest x-ray must be obtained. If a resident had a positive PPD or had symptoms of TB, the physician or Medical Director, the Administrator, and the DON must be notified immediately. The nurses stated no nurse was allowed to admit residents until after they were trained on the Tuberculosis policy. The nurses further stated they were aware they had to notify the DON and the Unit Coordinator if Tubersol was not available and if the laboratory was not able to conduct BAMT, IGRA, or TST testing.</p> <p>Interview conducted with the Admissions Coordinator on 01/31/14, at 1:02 PM, revealed she was responsible for assigning beds to residents upon admission, and had been assigned by the Administrator to notify QI Nurse #1 or QI Nurse #2 of any scheduled admissions.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they had reviewed all resident TB skin tests to ensure they were conducted per policy and administered by a nurse who had been re-educated on the policy. There had been no new admissions to the facility.</p>	{F 441}			

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{F 441}	Continued From page 19 Review of Tuberculosis screenings and PPD test results for all residents dated 01/17/14, revealed all residents with a history of a positive PPD had been screened and all other residents received a PPD skin test on 01/17/14. All PPDs were negative and no resident had signs or symptoms documented on the screening form. The PPDs were read on 01/20/14. Review of PPD test results for all employees revealed all employees received a TB skin test on 01/16/14 or 01/17/14. All TB skin tests were documented as being zero (0) millimeters of induration (negative for Tuberculosis). The TB skin tests were read on 01/19/14 or 01/20/14. Review of Quality Improvement Documentation revealed QI Nurse #1 documented she reviewed three new employee health files. QI Nurse #1 stated the new employees were not nurses. The documentation revealed the employees began employment on 01/28/14, QI Nurse #1 reviewed the health files on 01/29/14, and found no concerns, and the policy was being followed. Interview conducted with QI Nurse #1 on 01/31/14, at 1:15 PM, revealed she was required to review all new employee health files within 24 hours to ensure any symptoms of Tuberculosis were followed up on per facility policy. Interview conducted with the DON on 01/31/14, at 1:15 PM, revealed she checked the computer daily, and reviewed all new admissions to ensure the policy was being followed and had not identified any concerns. Interview conducted with the weekend Nursing	{F 441}			

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{F 441}	<p>Continued From page 20</p> <p>Supervisor on 01/31/14, at 1:30 PM, revealed she reviewed any new admissions daily on the weekend to ensure the Tuberculosis policy was being followed and had not identified any concerns.</p> <p>Review of an Absence/Vacation Report dated 01/30/14, revealed Employee #2 and Employee #51 had both been placed on Administrative Leave of Absence until further notice.</p> <p>Interview conducted with the facility's Medical Director on 02/01/14, at 9:30 AM, revealed he had been contacted by the facility and had given the DON an order to obtain chest x-rays for both employees and had been notified that the x-rays were negative for Tuberculosis.</p> <p>Review of chest x-ray reports for Employee #2 and Employee #51 dated 01/31/14, revealed both were negative for Tuberculosis.</p> <p>Review of an e-mail and an in-service roster sent to the Administrator from the local Hospital Employee Health Nurse on 01/31/14, revealed the Administrator, DON, and Corporate Nurse, all attended an in-service provided by hospital staff regarding Centers for Disease Control (CDC) guidelines for Tuberculosis, administration of a PPD, and reading of PPDs.</p> <p>Interview conducted with the Corporate Nurse on 02/01/14, at 9:00 AM, revealed she had attended the in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD.</p> <p>Interview conducted with the DON on 02/01/14, at</p>	{F 441}		

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{F 441}	Continued From page 21 9:05 AM, revealed she had attended an in-service on 01/31/14, by the local hospital employee health nurse regarding CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The DON stated as of 01/31/14, she was responsible for administering all PPDs and reading all PPDs until nurses were re-educated on administration and reading of a PPD and the facility's policy on Tuberculosis testing for both employees and residents. The DON stated if she was not available, the Administrator was required to supervise a nurse who had been re-educated on administering and reading of a PPD. Interview conducted with the Administrator on 02/01/14, at 9:45 AM, revealed he had attended an in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The Administrator stated as of 01/31/14, the DON was responsible for administering all PPDs and reading all PPDs until nurses were re-educated. The Administrator stated if the DON was not available, the Administrator would supervise a nurse who had been re-educated on administering and reading a PPD.	{F 441}			
{F 490} SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	{F 490}			

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{ F 490 }	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and Allegation of Compliance (AOC), it was determined the Immediate Jeopardy (IJ) identified during the annual survey concluded on 01/17/14 had been removed related to Administration. An acceptable AOC was received on 01/24/14 alleging removal of the IJ on 01/23/14. However, it was determined the IJ was not removed on 01/23/14 as alleged. The facility failed to ensure two (2) employees (Employees #2 and #51), out of fifteen (15) employee screenings reviewed, were referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing as required per the facility's Tuberculosis Testing and Screening Policy based on the employees' history of a past positive TB skin test and documented signs/symptoms of Tuberculosis (TB). In addition, the facility failed to ensure the Staff Development Coordinator (SDC) was knowledgeable on how to read a TB skin test.</p> <p>Based on the above findings, it was determined the IJ was removed on 02/01/14 with remaining noncompliance at a scope/severity of "F" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's AOC dated 01/24/14 revealed the facility reverted to their August 2005 "Tuberculosis Screening and Testing" for employees, which stated if an employee had a</p>	{ F 490 }		

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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 490}	<p>Continued From page 23</p> <p>documented positive Mantoux skin test (TB skin test), a screening for Tuberculosis symptoms would be performed and if the employee had symptoms of TB, they would be referred for further evaluation and testing.</p> <p>Review of employee TB screening forms dated 01/17/14, revealed Employees #2 and #51, who had a past positive TB skin test, had documented symptoms of TB. Employee #2 marked on the form that she had night sweats and Employee #51 marked that she had chest pain, weight loss, and excessive fatigue. According to the facility's policy, the employees would be referred to the local Health Department or to the Medical Director for further diagnostic evaluation and testing to include a chest x-ray. There was no evidence that the employees had been referred or had any diagnostic evaluation. Interview revealed the Staff Development Coordinator (SDC) had reviewed the screenings and had identified no concerns. In addition, interview with the SDC revealed she had read the results of the TB skin tests; however, she could not convey what measurement would be considered a positive TB skin test.</p> <p>Interview conducted with the DON on 01/31/14 at 1:27 PM, revealed the SDC reviewed the employee screening forms; however, the SDC reported to the DON that there were no concerns. Further interview with the DON revealed she was not aware the SDC was not knowledgeable on how to read a TB skin test.</p> <p>Interview conducted with the Administrator on 01/31/14 at 1:25 PM, revealed no Tuberculosis testing/screening issues had been reported to him. In addition, the Administrator stated the</p>	{F 490}		

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{F 490}	<p>Continued From page 24</p> <p>facility had not identified that the SDC, who was reading TB skin test results, was not knowledgeable.</p> <p>Further interview with the Administrator and DON on 01/31/14 at 1:27 PM, revealed education on reading a TB skin test had not been provided to licensed staff.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 01/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The facility Administrator met with the Regional Vice President, Director of Nursing, Quality Improvement (QI) Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (via phone), and Director of Corporate Policy (via phone) on 01/16/14. The investigation included review of the letters and documents from the Cabinet for Health and Family Services, Centers for Disease Control (CDC), and the Food Drug Administration (FDA), and resulted in the determination that an error had been made in the interpretation of these documents and the temporary policy was repealed on 01/16/14.</p> <p>On 01/16/14, the decision was made to immediately repeal the facility's "Tuberculosis Testing and Screening Temporary Measures" and revert to the facility's permanent policies for TB Testing entitled, "Tuberculosis Screening and Testing [Employee]" and "Resident Tuberculosis Testing and Screening Policy." Both of these policies have been in effect since August 2005. These policies include two-step TB testing for new-hires and new resident admissions and annual TB testing thereafter.</p>	{F 490}		

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{F 490}	<p>Continued From page 25</p> <p>On 01/16/14, the facility Administrator contacted the local hospital and multiple pharmacies and was able to obtain enough Tubersol to conduct testing for all employees and all residents, with an additional supply for admissions and new hires for approximately 60 days.</p> <p>On 01/16/14, the facility Administrator met with the Director of Nursing and all Administrative Nurses and conducted re-education regarding the TB Skin Testing Policy.</p> <p>On 01/17/14, the facility Administrator spoke with and reviewed the facility policy with the local Health Department Medical Director who advised to treat all staff and residents as if they were Day 1 employees and residents. Staff and residents who had already received a two-step TB skin test would not need the second step administered, nor was there a need to obtain new x-rays for those who have had a negative x-ray since exposure or treatment. The Health Department Medical Director advised that her opinion was that testing of employees during their next scheduled shift was sufficient to meet the regulation.</p> <p>On 01/17/14, the Director of Nursing spoke with the facility's Medical Director and received orders to administer TB skin testing in accordance with policy for all residents in the facility.</p> <p>The Staff Development Nurse began immediately conducting TB skin tests on all employees on the premises on 01/16/14 and 01/17/14. The other Administrative Nurses began TB testing for all residents on 01/17/14 to be completed before midnight on 01/17/14.</p>	{F 490}		

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{F 490}	<p>Continued From page 26</p> <p>Any positive resident PPDs will be addressed according to the facility's policy including screening, notification to MD, and follow-up chest x-ray. Any resident with signs/symptoms of active TB will be transferred to an acute care facility until after appropriate therapy is completed.</p> <p>Any positive staff PPDs will be addressed according to the facility's policy. The employee will be immediately placed on administrative leave and notification will be made to the facility's Medical Director or physician on call and the local Health Department for further diagnostic testing such as a chest x-ray, or a statement will be obtained stating a chest x-ray is not needed. The employee will be required to have a Physician's Statement to clear them for duty prior to the employee being allowed to work.</p> <p>Any positive resident or staff conversions of more than 10 mm induration will be immediately reported to the local Health Department by the Administrator or Director of Nursing.</p> <p>The reading of the resident PPDs will be conducted by licensed nurses per policy and will be overseen by the Unit Coordinator with a report to the Director of Nursing on 01/22/14 for the initial PPDs and 02/07/14 for the residents who required a second-step PPD.</p> <p>The reading of the staff PPDs will be conducted by licensed nurses per policy and will be overseen by the Staff Development Nurse with a report to the Director Nursing on 01/22/14 for the initial PPDs and 02/07/14 for the staff requiring a second-step PPD.</p> <p>A nurse assigned by the Director of Nursing will</p>	{F 490}		

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{F 490}	<p>Continued From page 27</p> <p>be present at the time clock each shift change until 100 percent of the staff in all departments has been tested per policy. No employee will be allowed to work until the employee has received a TB skin test or appropriate documentation is received for those who are unable to take the test.</p> <p>The QI Nurse and QI Assistant Nurse made copies of the Resident TB Skin Testing Policy and reviewed with all Licensed Nurses on the premises on 01/17/14 and will continue to retrain all licensed nurses who admit patients until 100 percent of the Licensed Nurses have been re-educated regarding elimination of the Temporary Measures and return to the prior policy.</p> <p>All residents on census have had a TB skin test or x-ray per policy. There are no residents out of the facility who have not had a TB test since 01/16/14.</p> <p>The Admissions Coordinator assigns residents to the beds and assembles the patient's medical record. On 01/17/14, the Admissions Coordinator was instructed by the Administrator to notify the QI Nurse or QI Assistant Nurse of any scheduled admissions.</p> <p>Only Licensed Nurses who have been retrained regarding the TB Testing Policy will be permitted to admit patients. The majority of the licensed nurses were re-educated on 01/16/14 and 01/17/14. The additional licensed nurses will be retrained by the QI Nurse or QI Assistant Nurse during their next working shift.</p> <p>The QI Nurse or QI Assistant Nurse will ensure</p>	{F 490}			

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{F 490}	<p>Continued From page 28</p> <p>the TB skin test is conducted per policy, by a licensed nurse who has been re-educated to the policy. The QI Nurse or QI Assistant Nurse will be available seven days per week until all licensed nurses have been retrained on the policy.</p> <p>The TB Testing Policy will be covered by the Staff Development Nurse or Instructor during orientation for all licensed nurse new hires.</p> <p>New hires will have PPDs administered per policy by the Staff Development Nurse during Day 1 of general orientation and the second step administered by the Staff Development Nurse per policy.</p> <p>The QI Nurse or Administrative Nurse assigned by the Director of Nursing will review all employee health files for new employees within 24 hours of orientation and three weeks after orientation for a period of 60 days and per the established schedule thereafter to ensure TB testing is being completed correctly.</p> <p>A Unit Coordinator, the Weekend House Supervisor, or Director of Nursing will review the immunization record daily for all new admissions for a period of 60 days and per the established schedule thereafter.</p> <p>The facility developed a policy, "Tuberculosis Testing and Screening Temporary Measures," regarding the possibility the facility becomes unable to obtain TB Testing Agent, the employee or resident will have a Blood Assay for Mycobacterium Tuberculosis (BAMT), QuantiFeron-TB Cold In-Tube Test (IGRA), or T-Spot TB (TST) (blood tests that test for the</p>	{F 490}		

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{F 490}	<p>Continued From page 29</p> <p>presence of tuberculosis infection). In the event the lab tests are unavailable, the facility Administrator or Director of Nursing will contact the local Health Department for direction. At this time, the facility has a sufficient quantity of Tuberculin to last 60 or more days without reorder. The Director of Nursing will develop written education for all licensed nurses regarding the contingency policy stating what to do if the TB testing agent becomes unavailable. This education will be distributed with payroll on 01/23/14.</p> <p>The Unit Coordinators, Staff Development Nurse, and/or House Supervisor will report the progress of the TB testing to the facility Administrator or Director of Nursing daily until all employees and residents have completed the initial round of testing initiated on 01/16/14.</p> <p>The Director of Nursing will present the 01/22/14 reports from the Unit Coordinators and the Staff Development Nurse regarding TB testing to the Administrator and QI Committee on 01/22/14, and will present the 02/07/14 reports from the Unit Coordinators and Staff Development Nurse to the Administrator and QI Committee on 02/12/14.</p> <p>The QI Committee will review TB testing weekly through 02/28/14, then at the meeting the week of 03/26/14, and then per the established calendar thereafter.</p> <p>The QI Reviews will be overseen by the facility Administrator. Any identified issues will be reported to the Regional Vice President.</p> <p>TB Control is listed in the Annual In-Service Plan.</p>	{F 490}		

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{F 490}	<p>Continued From page 30</p> <p>The next scheduled "TB Control" review is scheduled for 07/14-16/14. The policies will be reviewed with staff at that time.</p> <p>On 01/30/14, it was identified that two employees who were unable to receive a TB skin test had signs/symptoms of TB marked yes on their screening forms and the facility had not followed its TB Policy. Upon identification of the issue, both employees were immediately placed on administrative leave on 01/30/14 and referred to the local Health Department but were unable to be seen on 01/31/14.</p> <p>The facility's Medical Director was contacted on 01/31/14 and gave an order for both employees to have a chest x-ray. The employees were x-rayed on 01/31/14. Results were received on 01/31/14 and were negative.</p> <p>The Administrator, Director of Nursing, and Facility Nurse Consultant received education from the Vice President of Nursing and the Employee Health Coordinator at the local Hospital. The Hospital employees reviewed the facility's policy and determined that the Director of Nursing, Administrator, and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB skin tests including the varying millimeters of induration, "mm" for a positive result for immunocompromised patients, routine nursing facility patients, and individuals identified as low risk. The specifics of the method for reading a TB test were also reviewed. The Hospital's Employee Health Coordinator also reviewed when to conduct a screening form, e.g., past positive, and the facility's policies regarding referral to the Physicians, Medical Director, or</p>	{F 490}		

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{F 490}	<p>Continued From page 31 Health Department.</p> <p>The Administrator and Director of Nursing have taken complete control of the TB Screening Program effective 01/31/14 for both employees and residents, including administration and reading of TB Skin Tests, Screening Forms, and QI Audits and reports until such time as all Licensed Nurses have successfully completed skills verification related to administration and reading of TSTs and Screening Forms. The Director of Nursing will conduct the TB skin tests and readings until all staff have received re-education and have demonstrated they are knowledgeable.</p> <p>In the absence of the Director of Nursing, the Administrator will observe a licensed nurse who has already been re-educated and demonstrated successful skills to administer and/or read the TB test in order to ensure it is administered/read correctly in the event it is "required" during the absence of the DON.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>A review of the facility's policy entitled, "Tuberculosis Screening and Testing," dated August 2005, revealed all employees upon hire would receive a two-step Mantoux skin test with the first step being given on the first day of work. Employees with a negative skin test would receive a second-step Mantoux skin test within seven to fourteen days, and annually by a one-step method. The policy stated if a new positive occurred, employees would be referred to the local Health Department or to the Medical Director for further diagnostic evaluation and</p>	{F 490}		

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{F 490}	Continued From page 32 testing to include a chest x-ray. The policy further stated if an employee had a documented positive Mantoux skin test upon hire, a screening for Tuberculosis symptoms would be performed. An employee with negative symptomology would have an annual screening thereafter. If symptomology was present, the employee would be referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray. Review of the facility's policy entitled, "Resident Tuberculosis Testing and Screening Policy," dated August 2005, revealed all residents without a known documented positive PPD reaction would receive Tuberculosis testing upon admission using a two-step method. The first step would be administered on admission and if negative, a second PPD would be administered seven to fourteen days thereafter. The policy stated if the second step was negative, annual testing would occur thereafter using a single-step method. The policy revealed evaluation of residents with a new positive PPD would occur by the attending physician or the Medical Director to determine the presence of active Tuberculosis. The policy also revealed residents with a known documented positive reaction to a Mantoux PPD test would be screened for any history and symptoms of Tuberculosis. A chest x-ray would be obtained for residents with a positive screening, and the attending physician or the Medical Director would be notified to determine if further testing, appropriate treatment, and management were necessary. The policy stated any resident with suspected or probable infectious Tuberculosis would be transferred to an alternate facility for treatment.	{F 490}			

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{F 490}	<p>Continued From page 33</p> <p>Review of the facility's policy entitled, "Tuberculosis Testing and Screening Temporary Measures," dated 01/17/14, revealed in the event the Tuberculosis testing agent became unavailable due to the shortage of Tubersol and Aplisol, either a BAMT, IGRA, or TST test would be performed. If these tests were not available from the facility's laboratory, the facility would consult with the local Health Department for measures to be taken for Tuberculosis testing and/or screening.</p> <p>Interview with the Administrator on 01/31/14, at 11:35 AM, the DON on 01/31/14, at 11:40 AM, the Corporate Nurse on 01/31/14, at 11:42 AM, and the Vice President of Clinical Operations on 01/31/14 at 1:40 PM, verified they had attended the telephone conference on 01/16/14, and confirmed the group had decided to repeal the interim Tuberculosis policy and revert back to the old Tuberculosis policy dated 2005, for both employees and residents.</p> <p>Interview conducted with the Administrator on 01/31/14, at 11:35 AM and 1:20 PM, revealed he had contacted the local Hospital as well as the local pharmacies, and obtained enough Tubersol to last at least 60 days based on the facility's average admission and new hire rate. The Administrator stated he had met with all administrative nurses, as well as the DON, to discuss the Tuberculosis testing policy. The Administrator stated they decided that the Staff Development Coordinator (SDC) would begin testing all employees on 01/16/14 and 01/17/14, the administrative nurses began testing residents on 01/17/14, and testing was completed by 01/17/14. The Administrator further stated the facility would revert to using the BAMT, IGRA, or</p>	{F 490}		

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{F 490}	<p>Continued From page 34</p> <p>TST in the event Tubersol was not available. The Administrator stated if the laboratory tests were not available at the facility's laboratory, he or the DON would consult the local Health Department for guidance.</p> <p>Interview conducted with the DON on 01/31/14, revealed either she or the Administrator would notify the local Health Department in the event the facility did not have Tubersol or Aplisol available to perform PPDs. The DON stated she had developed training and had trained all facility nurses on what to do in the event Tubersol or Aplisol was unavailable and all facility nurses had been trained on the policy and procedure.</p> <p>Review of in-services entitled, "Nurse Education of TB Screening Policy," revealed the DON educated staff on the new policy that required nursing staff to notify the DON should testing be required. The in-service was initiated on 01/17/14 and completed on 01/23/14.</p> <p>Review of an in-service roster entitled, "Administrator Review of Tuberculosis Test Issues," dated 01/16/14, revealed all administrative nurses attended an in-service regarding the facility's Tuberculosis policy, State Regulations concerning Tuberculosis testing, and Tuberculosis testing for all residents and staff.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they made and distributed a copy of the Resident Tuberculosis Testing Policies to all licensed nurses in the facility. The policy was used to retrain all nursing staff. The training was completed on 01/23/14.</p>	{F 490}			

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{F 490}	<p>Continued From page 35</p> <p>Observation of the facility's Tubersol in the facility on 01/30/14 revealed the facility had enough Tubersol on hand to provide 150 PPD tests.</p> <p>Review of an e-mail sent to the Administrator by the Health Department Medical Director dated 01/24/14, at 8:12 AM, revealed the Administrator had consulted with the Medical Director, who advised the facility to start all staff and resident annual testing. The e-mail revealed any staff or resident who had previously been tested would not require a two-step, and those staff members or residents who have had a previous positive PPD required a Tuberculosis assessment. The e-mail stated residents who did not have symptoms would not need a chest x-ray.</p> <p>Interview conducted with the local Health Department Medical Director on 01/30/14, at 2:50 PM, revealed she had consulted with the Administrator and had advised him to begin Tuberculosis testing for employees and residents. The Medical Director stated she had advised the Administrator to begin using the two-step method, unless the resident or staff member had already had a two-step TB test; and in that case, just to begin the annual testing. The Medical Director stated any staff or resident who had a past positive PPD would require a screening and would only require a chest x-ray if the resident or employee had a symptom of Tuberculosis. The physician stated she told the Administrator that waiting until the employee's next scheduled shift would be sufficient to do the PPD or screening.</p> <p>A review of signed physician's orders dated 01/17/14, at 8:14 PM, revealed orders for a TB skin test for all residents currently residing in the facility. The physician's order stated if a resident</p>	{F 490}			

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{F 490}	<p>Continued From page 36</p> <p>had already received a two-step PPD since admission to the facility, a one-step PPD test was sufficient.</p> <p>Interview conducted with Unit Coordinator #1 on 01/31/14, at 12:10 PM, Unit Coordinator #2 on 01/31/14, at 12:15 PM, and Unit Coordinator #3 on 01/31/14, at 12:20 PM revealed PPD skin tests or screenings for residents with a history of a positive PPD were completed on 01/17/14. The Unit Coordinators stated they had attended the in-service given by the Administrator and had discussed the repeal of the Tuberculosis policy and going back to the previous policy. The Unit Coordinators stated in the future, all residents without a known past positive would receive a two-step PPD upon admission and a one-step annually. If after receiving the first PPD the resident had a reaction, the physician would be notified for further orders, including a chest x-ray. The Unit Coordinators stated all employees would be given a PPD as well, unless they had a positive past PPD, and in that case a screening would be completed. If the employee documented symptoms, the employee would be referred to the Health Department or the Medical Director for further testing including a chest x-ray. The Unit Coordinators each stated all resident PPDs were negative and they had reported that information to the DON, and would be sending a report to the DON after reading the second step PPDs on 02/07/14.</p> <p>Interview with the weekend House Supervisor on 01/31/14, at 1:30 PM, revealed she had been assigned to the time clock on 01/18/14 and 01/19/14, to administer PPD skin tests or complete screenings for employees. Employees were not allowed to work until after the PPDs or</p>	{F 490}		

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{F 490}	<p>Continued From page 37 screenings were done.</p> <p>Interview with Quality Improvement (QI) Nurse #2 on 01/31/14, at 12:47 PM, revealed she had been assigned to the time clock on 01/17/14, 01/18/14, and 01/19/14, to administer PPDs or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview conducted with Registered Nurse (RN) #3 on 01/30/14, at 4:30 PM, Licensed Practical Nurse (LPN) #4 on 01/30/14, at 4:40 PM, LPN #2 on 01/30/14, at 4:45 PM, LPN #3 on 01/30/14, at 4:50 PM, and LPN #1 on 01/30/14, at 5:05 PM revealed they had attended an in-service regarding the Tuberculosis policy and were knowledgeable of the facility's TB testing policy and the policy regarding the skin testing agent not being available. The nurses stated every resident had to have a two-step PPD on admission and a one-step annually. If the resident had a past positive history of PPD or Tuberculosis, the physician or Medical Director must be notified for any additional testing and a chest x-ray must be obtained. If a resident had a positive PPD or had symptoms of TB, the physician or Medical Director, the Administrator, and the DON must notified immediately. The nurses stated no nurse was allowed to admit residents until after they were trained on the Tuberculosis policy. The nurses further stated they were aware they had to notify the DON and the Unit Coordinator if Tubersol was not available and if the laboratory was not able to conduct BAMT, IGRA, or TST testing.</p> <p>Interview conducted with the Admissions Coordinator on 01/31/14, at 1:02 PM, revealed</p>	{F 490}		

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{F 490}	<p>Continued From page 38</p> <p>she was responsible for assigning beds to residents upon admission, and had been assigned by the Administrator to notify QI Nurse #1 or QI Nurse #2 of any scheduled admissions.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they had reviewed all resident TB skin tests to ensure they were conducted per policy and administered by a nurse who had been re-educated on the policy. There had been no new admissions to the facility.</p> <p>Review of Tuberculosis screenings and PPD test results for all residents dated 01/17/14, revealed all residents with a history of a positive PPD had been screened and all other residents received a PPD skin test on 01/17/14. All PPDs were negative and no resident had signs or symptoms documented on the screening form. The PPDs were read on 01/20/14.</p> <p>Review of PPD test results for all employees revealed all employees received a TB skin test on 01/16/14 or 01/17/14. All TB skin tests were documented as being zero (0) millimeters of induration (negative for Tuberculosis). The TB skin tests were read on 01/19/14 or 01/20/14.</p> <p>Review of Quality Improvement Documentation revealed QI Nurse #1 documented she reviewed three new employee health files. QI Nurse #1 stated the new employees were not nurses. The documentation revealed the employees began employment on 01/28/14, QI Nurse #1 reviewed the health files on 01/29/14, and found no concerns, and the policy was being followed.</p> <p>Interview conducted with QI Nurse #1 on</p>	{F 490}			

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{F 490}	<p>Continued From page 39</p> <p>01/31/14, at 1:15 PM, revealed she was required to review all new employee health files within 24 hours to ensure any symptoms of Tuberculosis were followed up on per facility policy.</p> <p>Interview conducted with the DON on 01/31/14, at 1:15 PM, revealed she checked the computer daily, and reviewed all new admissions to ensure the policy was being followed and had not identified any concerns.</p> <p>Interview conducted with the weekend Nursing Supervisor on 01/31/14, at 1:30 PM, revealed she reviewed any new admissions daily on the weekend to ensure the Tuberculosis policy was being followed and had not identified any concerns.</p> <p>Review of an Absence/Vacation Report dated 01/30/14, revealed Employee #2 and Employee #51 had both been placed on Administrative Leave of Absence until further notice.</p> <p>Interview conducted with the facility's Medical Director on 02/01/14, at 9:30 AM, revealed he had been contacted by the facility and had given the DON an order to obtain chest x-rays for both employees and had been notified that the x-rays were negative for Tuberculosis.</p> <p>Review of chest x-ray reports for Employee #2 and Employee #51 dated 01/31/14, revealed both were negative for Tuberculosis.</p> <p>Review of an e-mail and an in-service roster sent to the Administrator from the local Hospital Employee Health Nurse on 01/31/14, revealed the Administrator, DON, and Corporate Nurse, all attended an in-service provided by hospital staff</p>	{F 490}			

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{F 490}	Continued From page 40 regarding Center For Disease Control (CDC) guidelines for Tuberculosis, administration of a PPD, and reading of PPDs. Interview conducted with the Corporate Nurse on 02/01/14, at 9:00 AM, revealed she had attended the in-service on 01/31/14, by the local Hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. Interview conducted with the DON on 02/01/14, at 9:05 AM, revealed she had attended an in-service on 01/31/14, by the local hospital employee health nurse regarding CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The DON stated as of 01/31/14, she was responsible for administering all PPDs and reading all PPDs until nurses were re-educated on administration and reading of a PPD and the facility's policy on Tuberculosis testing for both employees and residents. The DON stated if she was not available, the Administrator was required to supervise a nurse who had been re-educated on administering and reading of a PPD. Interview conducted with the Administrator on 02/01/14, at 9:45 AM, revealed he had attended an in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The Administrator stated as of 01/31/14, the DON was responsible for administering all PPDs and reading all PPDs until nurses were re-educated. The Administrator stated if the DON was not available; the Administrator would supervise a nurse who had been re-educated on administering and reading a	{F 490}			

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{F 490}	Continued From page 41 PPD.	{F 490}			
{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and Allegation of Compliance (AOC) it was determined the Immediate Jeopardy (IJ) identified during the annual survey concluded on 01/17/14, had been removed related to Governing Body. An acceptable AOC was received on 01/24/14 alleging removal of the IJ on 01/23/14. However, it was determined the IJ was not removed on 01/23/14 as alleged. The facility failed to ensure two (2) employees (Employees #2 and #51), out of fifteen (15) employee screenings reviewed, were referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing as required per the facility's Tuberculosis Testing and Screening Policy based on the employees' history of a past positive TB skin test and documented signs/symptoms of Tuberculosis (TB). In addition, the facility failed to ensure the Staff Development Coordinator (SDC) was	{F 493}			

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{F 493}	<p>Continued From page 42</p> <p>knowledgeable on how to read a TB skin test.</p> <p>Based on the above findings, it was determined the IJ was removed on 02/01/14, with remaining noncompliance at a scope/severity of "F" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's AOC dated 01/24/14 revealed the facility alleged removal of Immediate Jeopardy on 01/23/14. A review of the AOC revealed the facility reverted to their August 2005 "Tuberculosis Screening and Testing" for employees, which stated if an employee had a documented positive Mantoux skin test (TB skin test), a screening for Tuberculosis symptoms would be performed. If symptomology was present, the employee would be referred to the local health department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray.</p> <p>Review of Employees #2 and #51's annual Tuberculosis Screenings, dated 01/17/14, revealed Employee #2 marked on the form that she had night sweats and Employee #51 marked that she had chest pain, weight loss, and excessive fatigue. There was no evidence that the employees had been referred or had any diagnostic evaluation as stated in the facility's policy.</p> <p>Interview conducted with the Director of Nursing (DON) on 01/31/14 at 1:27 PM, revealed the facility's SDC was responsible for reporting</p>	{F 493}		

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{F 493}	<p>Continued From page 43</p> <p>positive screenings to the DON and the DON reported the information to the Administrator and to the Quality Assurance (QA) Committee. The DON stated the SDC had not reported that anyone had documented symptoms of TB on a screening.</p> <p>Interview conducted with the Administrator on 01/31/14, at 1:25 PM, revealed no Tuberculosis testing/screening issues were reported to him. The Administrator stated he was required to report any issues identified to the Regional Vice President; however, none had been identified.</p> <p>Interview conducted with the Corporate Nurse on 01/31/14, at 10:00 AM, revealed she had reviewed all resident and employee Tuberculosis testing and screenings; however, she had not identified that any employee had documented signs or symptoms on the Tuberculosis screening forms.</p> <p>An interview with the Regional Vice President on 01/31/14, at 1:40 PM, revealed the Administrator was required to report any identified concerns with Tuberculosis testing or screening. The Regional Vice President stated he had not been notified of any identified concerns.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 01/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The facility Administrator met with the Regional Vice President, Director of Nursing, Quality Improvement (QI) Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (via phone), and Director of Corporate Policy (via</p>	{F 493}			

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{F 493}	<p>Continued From page 44</p> <p>phone) on 01/16/14. The investigation included review of the letters and documents from the Cabinet for Health and Family Services, Centers for Disease Control (CDC), and the Food Drug Administration (FDA), and resulted in the determination that an error had been made in the interpretation of these documents and the temporary policy was repealed on 01/16/14.</p> <p>On 01/16/14, the decision was made to immediately repeal the facility's "Tuberculosis Testing and Screening Temporary Measures" and revert to the facility's permanent policies for TB Testing entitled, "Tuberculosis Screening and Testing [Employee]" and "Resident Tuberculosis Testing and Screening Policy." Both of these policies have been in effect since August 2005. These policies include two-step TB testing for new-hires and new resident admissions and annual TB testing thereafter.</p> <p>On 01/16/14, the facility Administrator contacted the local hospital and multiple pharmacies and was able to obtain enough Tubersol to conduct testing for all employees and all residents, with an additional supply for admissions and new hires for approximately 60 days.</p> <p>On 01/16/14, the facility Administrator met with the Director of Nursing and all Administrative Nurses and conducted re-education regarding the TB Skin Testing Policy.</p> <p>On 01/17/14, the facility Administrator spoke with and reviewed the facility policy with the local Health Department Medical Director who advised to start all staff and residents as if they were Day 1 employees and residents. Staff and residents who had already received a two-step TB skin test</p>	{F 493}			

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{F 493}	<p>Continued From page 45</p> <p>would not need the second step administered, nor was there a need to obtain new x-rays for those who have had a negative x-ray since exposure or treatment. The Health Department Medical Director advised that her opinion was that testing of employees during their next scheduled shift was sufficient to meet the regulation.</p> <p>On 01/17/14, the Director of Nursing spoke with the facility's Medical Director and received orders to administer TB skin testing in accordance with policy for all residents in the facility.</p> <p>The Staff Development Nurse began immediately conducting TB skin tests on all employees on the premises on 01/16/14 and 01/17/14. The other Administrative Nurses began TB testing for all residents on 01/17/14 to be completed before midnight on 01/17/14.</p> <p>Any positive resident PPDs will be addressed according to the facility's policy including screening, notification to MD, and follow-up chest x-ray. Any resident with signs/symptoms of active TB will be transferred to an acute care facility until after appropriate therapy is completed.</p> <p>Any positive staff PPDs will be addressed according to the facility's policy. The employee will be immediately placed on administrative leave and notification made to the facility's Medical Director or physician on call and the local Health Department for further diagnostic testing such as a chest x-ray, or a statement will be obtained stating a chest x-ray is not needed. The employee will be required to have a Physician's Statement to clear them for duty prior to the employee being allowed to work.</p>	{F 493}			

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{F 493}	<p>Continued From page 46</p> <p>Any positive resident or staff conversions of more than 10 mm induration will be immediately reported to the local Health Department by the Administrator or Director of Nursing.</p> <p>The reading of the resident PPDs will be conducted by licensed nurses per policy and will be overseen by the Unit Coordinator with a report to the Director of Nursing on 01/22/14 for the initial PPDs, and 02/07/14 for the residents who required a second-step PPD.</p> <p>The reading of the staff PPDs will be conducted by licensed nurses per policy and will be overseen by the Staff Development Nurse with a report to the Director Nursing on 01/22/14 for the initial PPDs, and 02/07/14 for the staff requiring a second-step PPD.</p> <p>A nurse assigned by the Director of Nursing will be present at the time clock each shift change until 100 percent of the staff in all departments has been tested per policy. No employee will be allowed to work until the employee has received a TB skin test or appropriate documentation is received for those who are unable to take the test.</p> <p>The QI Nurse and QI Assistant Nurse made copies of the Resident TB Skin Testing Policy and reviewed with all Licensed Nurses on the premises on 01/17/14 and will continue to retrain all licensed nurses who admit patients until 100 percent of the Licensed Nurses have been re-educated regarding elimination of the Temporary Measures and return to the prior policy.</p> <p>All residents on census have had a TB skin test</p>	{F 493}			

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{F 493}	<p>Continued From page 47</p> <p>or x-ray per policy. There are no residents out of the facility who have not had a TB test since 01/16/14.</p> <p>The Admissions Coordinator assigns residents to the beds and assembles the patient's medical record. On 01/17/14, the Admissions Coordinator was instructed by the Administrator to notify the QI Nurse or QI Assistant Nurse of any scheduled admissions.</p> <p>Only Licensed Nurses who have been retrained regarding the TB Testing Policy will be permitted to admit patients. The majority of the licensed nurses were re-educated on 01/16/14 and 01/17/14. The additional licensed nurses will be retrained by the QI Nurse or QI Assistant Nurse during their next working shift.</p> <p>The QI Nurse or QI Assistant Nurse will ensure the TB skin test is conducted per policy, by a licensed nurse who has been re-educated to the policy. The QI Nurse or QI Assistant Nurse will be available seven days per week until all licensed nurses have been retrained on the policy.</p> <p>The TB Testing Policy will be covered by the Staff Development Nurse or Instructor during orientation for all licensed nurse new hires.</p> <p>New hires will have PPDs administered per policy by the Staff Development Nurse during Day 1 of general orientation and the second step administered by the Staff Development Nurse per policy.</p> <p>The QI Nurse or Administrative Nurse assigned by the Director of Nursing will review all employee</p>	{F 493}		

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{F 493}	<p>Continued From page 48</p> <p>health files for new employees within 24 hours of orientation and three weeks after orientation for a period of 60 days and per the established schedule thereafter to ensure TB testing is being completed correctly.</p> <p>A Unit Coordinator, the Weekend House Supervisor, or Director of Nursing will review the immunization record daily for all new admissions for a period of 60 days and per the established schedule thereafter.</p> <p>The facility developed a policy, "Tuberculosis Testing and Screening Temporary Measures," regarding the possibility the facility becomes unable to obtain TB Testing Agent, the employee or resident will have a Blood Assay for Mycobacterium Tuberculosis (BAMT), QuantiFeron-TB Cold In-Tube Test (IGRA), or T-Spot TB (TST) (blood tests that test for the presence of tuberculosis infection). In the event the lab tests are unavailable, the facility Administrator or Director of Nursing will contact the local Health Department for direction. At this time, the facility has a sufficient quantity of Tuberculin to last 60 or more days without reorder. The Director of Nursing will develop written education for all licensed nurses regarding the contingency policy stating what to do if the TB testing agent becomes unavailable. This education will be distributed with payroll on 01/23/14.</p> <p>The Unit Coordinators, Staff Development Nurse, and/or House Supervisor will report the progress of the TB testing to the facility Administrator or Director of Nursing daily until all employees and residents have completed the initial round of testing initiated on 01/16/14.</p>	{F 493}			

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{F 493}	Continued From page 49 The Director of Nursing will present the 01/22/14 reports from the Unit Coordinators and the Staff Development Nurse regarding TB testing to the Administrator and QI Committee on 01/22/14, and will present the 02/07/14 reports from the Unit Coordinators and Staff Development Nurse to the Administrator and QI Committee on 02/12/14. The QI Committee will review TB testing weekly through 02/28/14, then at the meeting the week of 03/26/14, and then per the established calendar thereafter. The QI Reviews will be overseen by the facility Administrator. Any identified issues will be reported to the Regional Vice President. TB Control is listed in the Annual In-Service Plan. The next scheduled "TB Control" review is scheduled for 07/14-16/14. The policies will be reviewed with staff at that time. On 01/30/14, it was identified that two employees who were unable to receive a TB skin test had signs/symptoms of TB marked yes on their screening forms and the facility had not followed its TB Policy. Upon identification of the issue, both employees were immediately placed on administrative leave on 01/30/14 and referred to the local Health Department but were unable to be seen on 01/31/14. The facility's Medical Director was contacted on 01/31/14 and gave an order for both employees to have a chest x-ray. The employees were x-rayed on 01/31/14. Results were received on 01/31/14 and were negative.	{F 493}			

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{F 493}	<p>Continued From page 50</p> <p>The Administrator, Director of Nursing, and Facility Nurse Consultant received education from the Vice President of Nursing and the Employee Health Coordinator at the local Hospital. The Hospital employees reviewed the facility's policy and determined that the Director of Nursing, Administrator, and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB skin tests including the varying millimeters of induration, "mm" for a positive result for immunocompromised patients, routine nursing facility patients, and individuals identified as low risk. The specifics of the method for reading a TB test were also reviewed. The Hospital's Employee Health Coordinator also reviewed when to conduct a screening form, e.g., past positive, and the facility's policies regarding referral to the Physicians, Medical Director, or Health Department.</p> <p>The Administrator and Director of Nursing have taken complete control of the TB Screening Program effective 01/31/14 for both employees and residents, including administration and reading of TB Skin Tests, Screening Forms, and QI Audits and reports until such time as all Licensed Nurses have successfully completed skills verification related to administration and reading of TSTs and Screening Forms. The Director of Nursing will conduct the TB skin tests and readings until all staff have received re-education and have demonstrated they are knowledgeable.</p> <p>In the absence of the Director of Nursing, the Administrator will observe a licensed nurse who has already been re-educated and demonstrated</p>	{F 493}		
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{F 493}	<p>Continued From page 51</p> <p>successful skills to administer and/or read the TB test in order to ensure it is administered/read correctly in the event it is "required" during the absence of the DON.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>A review of the facility's policy entitled, "Tuberculosis Screening and Testing," dated August 2005, revealed all employees upon hire would receive a two-step Mantoux skin test with the first step being given on the first day of work. Employees with a negative skin test would receive a second-step Mantoux skin test within seven to fourteen days, and annually by a one-step method. The policy stated if a new positive occurred, employees would be referred to the local Health Department or to the Medical Director for further diagnostic evaluation and testing to include a chest x-ray. The policy further stated if an employee had a documented positive Mantoux skin test upon hire, a screening for Tuberculosis symptoms would be performed. An employee with negative symptomology would have an annual screening thereafter. If symptomology was present, the employee would be referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray.</p> <p>Review of the facility's policy entitled, "Resident Tuberculosis Testing and Screening Policy," dated August 2005, revealed all residents without a known documented positive PPD reaction would receive Tuberculosis testing upon admission using a two-step method. The first step would be administered on admission and if negative, a second PPD would be administered</p>	{F 493}		

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{F 493}	<p>Continued From page 52</p> <p>seven to fourteen days thereafter. The policy stated if the second step was negative, annual testing would occur thereafter using a single-step method. The policy revealed evaluation of residents with a new positive PPD would occur by the attending physician or the Medical Director to determine the presence of active Tuberculosis. The policy also revealed residents with a known documented positive reaction to a Mantoux PPD test would be screened for any history and symptoms of Tuberculosis. A chest x-ray would be obtained for residents with a positive screening, and the attending physician or the Medical Director would be notified to determine if further testing, appropriate treatment, and management were necessary. The policy stated any resident with suspected or probable infectious Tuberculosis would be transferred to an alternate facility for treatment.</p> <p>Review of the facility's policy entitled, "Tuberculosis Testing and Screening Temporary Measures," dated 01/17/14, revealed in the event the Tuberculosis testing agent became unavailable due to the shortage of Tubersol and Aplisol, either a BAMT, IGRA, or TST test would be performed. If these tests were not available from the facility's laboratory, the facility would consult with the local Health Department for measures to be taken for Tuberculosis testing and/or screening.</p> <p>Interview with the Administrator on 01/31/14, at 11:35 AM, the DON on 01/31/14, at 11:40 AM, the Corporate Nurse on 01/31/14, at 11:42 AM, and the Vice President of Clinical Operations on 01/31/14 at 1:40 PM, verified they had attended the telephone conference on 01/16/14, and confirmed the group had decided to repeal the</p>	{F 493}		

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{F 493}	<p>Continued From page 53</p> <p>interim Tuberculosis policy and revert back to the old Tuberculosis policy dated 2005, for both employees and residents.</p> <p>Interview conducted with the Administrator on 01/31/14, at 11:35 AM and 1:20 PM, revealed he had contacted the local Hospital as well as the local pharmacies, and obtained enough Tubersol to last at least 60 days based on the facility's average admission and new hire rate. The Administrator stated he had met with all administrative nurses, as well as the DON, to discuss the Tuberculosis testing policy. The Administrator stated they decided that the Staff Development Coordinator (SDC) would begin testing all employees on 01/16/14 and 01/17/14, the administrative nurses began testing residents on 01/17/14, and testing was completed by 01/17/14. The Administrator further stated the facility would revert to using the BAMT, IGRA, or TST in the event Tubersol was not available. The Administrator stated if the laboratory tests were not available at the facility's laboratory, he or the DON would consult the local Health Department for guidance.</p> <p>Interview conducted with the DON on 01/31/14, revealed either she or the Administrator would notify the local Health Department in the event the facility did not have Tubersol or Aplisol available to perform PPDs. The DON stated she had developed training and had trained all facility nurses on what to do in the event Tubersol or Aplisol was unavailable and all facility nurses had been trained on the policy and procedure.</p> <p>Review of in-services entitled, "Nurse Education of TB Screening Policy," revealed the DON educated staff on the new policy that required</p>	{F 493}		

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{F 493}	<p>Continued From page 54</p> <p>nursing staff to notify the DON should testing be required. The in-service was initiated on 01/17/14 and completed on 01/23/14.</p> <p>Review of an in-service roster entitled, "Administrator Review of Tuberculosis Test Issues," dated 01/16/14, revealed all administrative nurses attended an in-service regarding the facility's Tuberculosis policy, State Regulations concerning Tuberculosis testing, and Tuberculosis testing for all residents and staff.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they made and distributed a copy of the Resident Tuberculosis Testing Policies to all licensed nurses in the facility. The policy was used to retrain all nursing staff. The training was completed on 01/23/14.</p> <p>Observation of the facility's Tubersol in the facility on 01/30/14 revealed the facility had enough Tubersol on hand to provide 150 PPD tests.</p> <p>Review of an e-mail sent to the Administrator by the Health Department Medical Director dated 01/24/14, at 8:12 AM, revealed the Administrator had consulted with the Medical Director, who advised the facility to start all staff and resident annual testing. The e-mail revealed any staff or resident who had previously been tested would not require a two-step, and those staff members or residents who have had a previous positive PPD required a Tuberculosis assessment. The e-mail stated residents who did not have symptoms would not need a chest x-ray.</p> <p>Interview conducted with the local Health Department Medical Director on 01/30/14, at 2:50</p>	{F 493}		

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{F 493}	<p>Continued From page 55</p> <p>PM, revealed she had consulted with the Administrator and had advised him to begin Tuberculosis testing for employees and residents. The Medical Director stated she had advised the Administrator to begin using the two-step method, unless the resident or staff member had already had a two-step TB test; and in that case, just to begin the annual testing. The Medical Director stated any staff or resident who had a past positive PPD would require a screening and would only require a chest x-ray if the resident or employee had a symptom of Tuberculosis. The physician stated she told the Administrator that waiting until the employee's next scheduled shift would be sufficient to do the PPD or screening.</p> <p>A review of signed physician's orders dated 01/17/14, at 8:14 PM, revealed orders for a TB skin test for all residents currently residing in the facility. The physician's order stated if a resident had already received a two-step PPD since admission to the facility, a one-step PPD test was sufficient.</p> <p>Interview conducted with Unit Coordinator #1 on 01/31/14, at 12:10 PM, Unit Coordinator #2 on 01/31/14, at 12:15 PM, and Unit Coordinator #3 on 01/31/14, at 12:20 PM revealed PPD skin tests or screenings for residents with a history of a positive PPD were completed on 01/17/14. The Unit Coordinators stated they had attended the in-service given by the Administrator and had discussed the repeal of the Tuberculosis policy and going back to the previous policy. The Unit Coordinators stated in the future, all residents without a known past positive would receive a two-step PPD upon admission and a one-step annually. If after receiving the first PPD the resident had a reaction, the physician would be</p>	{F 493}			

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{F 493}	<p>Continued From page 56</p> <p>notified for further orders, including a chest x-ray. The Unit Coordinators stated all employees would be given a PPD as well, unless they had a positive past PPD, and in that case a screening would be completed. If the employee documented symptoms, the employee would be referred to the Health Department or the Medical Director for further testing including a chest x-ray. The Unit Coordinators each stated all resident PPDs were negative and they had reported that information to the DON, and would be sending a report to the DON after reading the second step PPDs on 02/07/14.</p> <p>Interview with the weekend House Supervisor on 01/31/14, at 1:30 PM, revealed she had been assigned to the time clock on 01/18/14 and 01/19/14, to administer PPD skin tests or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview with Quality Improvement (QI) Nurse #2 on 01/31/14, at 12:47 PM, revealed she had been assigned to the time clock on 01/17/14, 01/18/14, and 01/19/14, to administer PPDs or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview conducted with Registered Nurse (RN) #3 on 01/30/14, at 4:30 PM, Licensed Practical Nurse (LPN) #4 on 01/30/14, at 4:40 PM, LPN #2 on 01/30/14, at 4:45 PM, LPN #3 on 01/30/14, at 4:50 PM, and LPN #1 on 01/30/14, at 5:05 PM revealed they had attended an in-service regarding the Tuberculosis policy and were knowledgeable of the facility's TB testing policy and the policy regarding the skin testing agent not</p>	{F 493}			

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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 R 02/01/2014
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501		
(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 493}	<p>Continued From page 57</p> <p>being available. The nurses stated every resident had to have a two-step PPD on admission and a one-step annually. If the resident had a past positive history of PPD or Tuberculosis, the physician or Medical Director must be notified for any additional testing and a chest x-ray must be obtained. If a resident had a positive PPD or had symptoms of TB, the physician or Medical Director, the Administrator, and the DON must notified immediately. The nurses stated no nurse was allowed to admit residents until after they were trained on the Tuberculosis policy. The nurses further stated they were aware they had to notify the DON and the Unit Coordinator if Tubersol was not available and if the laboratory was not able to conduct BAMT, IGRA, or TST testing.</p> <p>Interview conducted with the Admissions Coordinator on 01/31/14, at 1:02 PM, revealed she was responsible for assigning beds to residents upon admission, and had been assigned by the Administrator to notify QI Nurse #1 or QI Nurse #2 of any scheduled admissions.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they had reviewed all resident TB skin tests to ensure they were conducted per policy and administered by a nurse who had been re-educated on the policy. There had been no new admissions to the facility.</p> <p>Review of Tuberculosis screenings and PPD test results for all residents dated 01/17/14, revealed all residents with a history of a positive PPD had been screened and all other residents received a PPD skin test on 01/17/14. All PPDs were negative and no resident had signs or symptoms</p>	{F 493}			

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{F 493}	<p>Continued From page 58</p> <p>documented on the screening form. The PPDs were read on 01/20/14.</p> <p>Review of PPD test results for all employees revealed all employees received a TB skin test on 01/16/14 or 01/17/14. All TB skin tests were documented as being zero (0) millimeters of induration (negative for Tuberculosis). The TB skin tests were read on 01/19/14 or 01/20/14.</p> <p>Review of Quality Improvement Documentation revealed QI Nurse #1 documented she reviewed three new employee health files. QI Nurse #1 stated the new employees were not nurses. The documentation revealed the employees began employment on 01/28/14, QI Nurse #1 reviewed the health files on 01/29/14, and found no concerns, and the policy was being followed.</p> <p>Interview conducted with QI Nurse #1 on 01/31/14, at 1:15 PM, revealed she was required to review all new employee health files within 24 hours to ensure any symptoms of Tuberculosis were followed up on per facility policy.</p> <p>Interview conducted with the DON on 01/31/14, at 1:15 PM, revealed she checked the computer daily, and reviewed all new admissions to ensure the policy was being followed and had not identified any concerns.</p> <p>Interview conducted with the weekend Nursing Supervisor on 01/31/14, at 1:30 PM, revealed she reviewed any new admissions daily on the weekend to ensure the Tuberculosis policy was being followed and had not identified any concerns.</p> <p>Review of an Absence/Vacation Report dated</p>	{F 493}		

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{F 493}	<p>Continued From page 59</p> <p>01/30/14, revealed Employee #2 and Employee #51 had both been placed on Administrative Leave of Absence until further notice.</p> <p>Interview conducted with the facility's Medical Director on 02/01/14, at 9:30 AM, revealed he had been contacted by the facility and had given the DON an order to obtain chest x-rays for both employees and had been notified that the x-rays were negative for Tuberculosis.</p> <p>Review of chest x-ray reports for Employee #2 and Employee #51 dated 01/31/14, revealed both were negative for Tuberculosis.</p> <p>Review of an e-mail and an in-service roster sent to the Administrator from the local Hospital Employee Health Nurse on 01/31/14, revealed the Administrator, DON, and Corporate Nurse, all attended an in-service provided by hospital staff regarding Centers for Disease Control (CDC) guidelines for Tuberculosis, administration of a PPD, and reading of PPDs.</p> <p>Interview conducted with the Corporate Nurse on 02/01/14, at 9:00 AM, revealed she had attended the in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD.</p> <p>Interview conducted with the DON on 02/01/14, at 9:05 AM, revealed she had attended an in-service on 01/31/14, by the local hospital employee health nurse regarding CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The DON stated as of 01/31/14, she was responsible for administering all PPDs and reading all PPDs until nurses were</p>	{F 493}			

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{F 493}	Continued From page 60 re-educated on administration and reading of a PPD and the facility's policy on Tuberculosis testing for both employees and residents. The DON stated if she was not available, the Administrator was required to supervise a nurse who had been re-educated on administering and reading of a PPD. Interview conducted with the Administrator on 02/01/14, at 9:45 AM, revealed he had attended an in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The Administrator stated as of 01/31/14, the DON was responsible for administering all PPDs and reading all PPDs until nurses were re-educated. The Administrator stated if the DON was not available, the Administrator would supervise a nurse who had been re-educated on administering and reading a PPD.	{F 493}			
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	{F 520}			

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{F 520}	<p>Continued From page 61</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the Allegation of Compliance (AOC), and the Quality Assurance Report it was determined the Immediate Jeopardy (IJ) identified during the annual survey concluded on 01/17/14, had been removed related to Quality Assurance. An acceptable AOC was received on 01/24/14 alleging removal of the IJ on 01/23/14. However, it was determined the IJ was not removed on 01/23/14 as alleged. The facility failed to ensure two (2) employees (Employees #2 and #51), out of fifteen (15) employee screenings reviewed, were referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing as required per the facility's Tuberculosis Testing and Screening Policy based on the employees' history of a past positive TB skin test and documented signs/symptoms of Tuberculosis (TB). In addition, the facility failed to ensure the Staff Development Coordinator (SDC) was knowledgeable on how to read a TB skin test.</p> <p>Based on the above findings, it was determined</p>	{F 520}		

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{F 520}	<p>Continued From page 62</p> <p>the IJ was removed on 02/01/14, with remaining noncompliance at a scope/severity of "F" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 01/24/14. The facility alleged removal of Immediate Jeopardy on 01/23/14. A review of the AOC revealed the facility reverted to their August 2005 "Tuberculosis Screening and Testing" for employees, which if an employee had a documented positive Mantoux skin test (TB skin test) upon hire, a screening for Tuberculosis symptoms would be performed. If symptomology was present, the employee would be referred to the local health department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray.</p> <p>Review of employee screening forms for employees who had a history of a positive TB skin test revealed two staff members had documented symptoms of TB. Review of Employee #2 and #51's annual Tuberculosis Screenings, dated 01/17/14, revealed Employee #2 marked on the form that she had night sweats and Employee #51 marked that she had chest pain, weight loss, and excessive fatigue. There was no evidence that the employees were referred for further testing/evaluation as required per the facility's policy.</p> <p>Interview conducted with the Staff Development Coordinator (SDC) on 01/30/14 at 3:05 PM and</p>	{F 520}			

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{F 520}	<p>Continued From page 63</p> <p>4:50 PM and on 01/31/14 at 12:35 PM and 1:10 PM revealed she oversaw and ensured all staff received a TB skin test or TB screening per the facility policy and reviewed all staff Tuberculosis screenings. The SDC stated she was aware Employees #2 and #51 had documented signs/symptoms of tuberculosis per the screenings, but did not refer the employee to the local health department and did not record the information on the QA audit tool or report the screening information to the Director of Nursing (DON) for presentation to the Quality Assurance (QA) Committee.</p> <p>Interview conducted with the Corporate Nurse on 01/31/14, at 10:00 AM, revealed she had also reviewed all employee Tuberculosis screenings and had not identified that any employee had documented signs or symptoms on the Tuberculosis screening forms.</p> <p>Interview conducted with the DON on 01/31/14, at 1:27 PM, revealed the SDC was responsible for reviewing employee screening forms and reporting any employees who had symptoms; however, the SDC had not reported any concerns regarding the two employees with positive screenings for Tuberculosis; therefore, the DON reported there were no concerns to the QA Committee.</p> <p>Interview with the Administrator on 01/31/14, at 1:25 PM, revealed no Tuberculosis testing/screening issues were reported to him or during the QA Committee meeting on 01/22/14, and 01/29/14. Per interview, he had not reviewed the actual TB testing or screening results. He did review the QA audit tool; however, the SDC had not recorded the information related to</p>	{F 520}			

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{F 520}	<p>Continued From page 64</p> <p>Employees #2 and #51 screening results on the audit tool.</p> <p>Review of the Quality Assurance Report presented to the Quality Assurance Committee and Administrator on 01/22/14, regarding Tuberculosis testing and screening for all residents and staff revealed no concerns had been identified by the Committee. The reports were signed by the Administrator, Corporate Nurse, DON, QI Nurse #1, QI Nurse #2, SDC, MDS Nurse #1, MDS Nurse #2, Unit Coordinator #1, Unit Coordinator #2, and Unit Coordinator #3 as having been reviewed.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 01/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The facility Administrator met with the Regional Vice President, Director of Nursing, Quality Improvement (QI) Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (via phone), and Director of Corporate Policy (via phone) on 01/16/14. The investigation included review of the letters and documents from the Cabinet for Health and Family Services, Centers for Disease Control (CDC), and the Food Drug Administration (FDA), and resulted in the determination that an error had been made in the interpretation of these documents and the temporary policy was repealed on 01/16/14.</p> <p>On 01/16/14, the decision was made to immediately repeal the facility's "Tuberculosis Testing and Screening Temporary Measures" and revert to the facility's permanent policies for TB Testing entitled, "Tuberculosis Screening and</p>	{F 520}		

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{F 520}	<p>Continued From page 65</p> <p>Testing [Employee]" and "Resident Tuberculosis Testing and Screening Policy." Both of these policies have been in effect since August 2005. These policies include two-step TB testing for new hires and new resident admissions and annual TB testing thereafter.</p> <p>On 01/16/14, the facility Administrator contacted the local hospital and multiple pharmacies and was able to obtain enough Tubersol to conduct testing for all employees and all residents, with an additional supply for admissions and new hires for approximately 60 days.</p> <p>On 01/16/14, the facility Administrator met with the Director of Nursing and all Administrative Nurses and conducted re-education regarding the TB Skin Testing Policy.</p> <p>On 01/17/14, the facility Administrator spoke with and reviewed the facility policy with the local Health Department Medical Director who advised to start all staff and residents as if they were Day 1 employees and residents. Staff and residents who had already received a two-step TB skin test would not need the second step administered, nor was there a need to obtain new x-rays for those who have had a negative x-ray since exposure or treatment. The Health Department Medical Director advised that her opinion was that testing of employees during their next scheduled shift was sufficient to meet the regulation.</p> <p>On 01/17/14, the Director of Nursing spoke with the facility's Medical Director and received orders to administer TB skin testing in accordance with policy for all residents in the facility.</p> <p>The Staff Development Nurse began immediately</p>	{F 520}			

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{F 520}	<p>Continued From page 66</p> <p>conducting TB skin tests on all employees on the premises on 01/16/14 and 01/17/14. The other Administrative Nurses began TB testing for all residents on 01/17/14 to be completed before midnight on 01/17/14.</p> <p>Any positive resident PPDs will be addressed according to the facility's policy including screening, notification to MD, and follow-up chest x-ray. Any resident with signs/symptoms of active TB will be transferred to an acute care facility until after appropriate therapy is completed.</p> <p>Any positive staff PPDs will be addressed according to the facility's policy. The employee will be immediately placed on administrative leave and notification made to the facility's Medical Director or physician on call and the local Health Department for further diagnostic testing such as a chest x-ray, or a statement will be obtained stating a chest x-ray is not needed. The employee will be required to have a Physician's Statement to clear them for duty prior to the employee being allowed to work.</p> <p>Any positive resident or staff conversions of more than 10 mm induration will be immediately reported to the local Health Department by the Administrator or Director of Nursing.</p> <p>The reading of the resident PPDs will be conducted by licensed nurses per policy and will be overseen by the Unit Coordinator with a report to the Director of Nursing on 01/22/14 for the initial PPDs, and 02/07/14 for the residents who required a second-step PPD.</p> <p>The reading of the staff PPDs will be conducted by licensed nurses per policy and will be</p>	{F 520}			

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{F 520}	<p>Continued From page 67</p> <p>overseen by the Staff Development Nurse with a report to the Director Nursing on 01/22/14 for the initial PPDs, and 02/07/14 for the staff requiring a second-step PPD.</p> <p>A nurse assigned by the Director of Nursing will be present at the time clock each shift change until 100 percent of the staff in all departments has been tested per policy. No employee will be allowed to work until the employee has received a TB skin test or appropriate documentation is received for those who are unable to take the test.</p> <p>The QI Nurse and QI Assistant Nurse made copies of the Resident TB Skin Testing Policy and reviewed with all Licensed Nurses on the premises on 01/17/14 and will continue to retrain all licensed nurses who admit patients until 100 percent of the Licensed Nurses have been re-educated regarding elimination of the Temporary Measures and return to the prior policy.</p> <p>All residents on census have had a TB skin test or x-ray per policy. There are no residents out of the facility who have not had a TB test since 01/16/14.</p> <p>The Admissions Coordinator assigns residents to the beds and assembles the patient's medical record. On 01/17/14, the Admissions Coordinator was instructed by the Administrator to notify the QI Nurse or QI Assistant Nurse of any scheduled admissions.</p> <p>Only Licensed Nurses who have been retrained regarding the TB Testing Policy will be permitted to admit patients. The majority of the licensed</p>	{F 520}			

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{F 520}	<p>Continued From page 68</p> <p>nurses were re-educated on 01/16/14 and 01/17/14. The additional licensed nurses will be retrained by the QI Nurse or QI Assistant Nurse during their next working shift.</p> <p>The QI Nurse or QI Assistant Nurse will ensure the TB skin test is conducted per policy, by a licensed nurse who has been re-educated to the policy. The QI Nurse or QI Assistant Nurse will be available 7 days per week until all licensed nurses have been retrained on the policy.</p> <p>The TB Testing Policy will be covered by the Staff Development Nurse or Instructor during orientation for all licensed nurse new hires.</p> <p>New hires will have PPDs administered per policy by the Staff Development Nurse during Day 1 of general orientation and the second step administered by the Staff Development Nurse per policy.</p> <p>The QI Nurse or Administrative Nurse assigned by the Director of Nursing will review all employee health files for new employees within 24 hours of orientation and three weeks after orientation for a period of 60 days and per the established schedule thereafter to ensure TB testing is being completed correctly.</p> <p>A Unit Coordinator, the Weekend House Supervisor, or Director of Nursing will review the immunization record daily for all new admissions for a period of 60 days and per the established schedule thereafter.</p> <p>The facility developed a policy, "Tuberculosis Testing and Screening Temporary Measures," regarding the possibility the facility becomes</p>	{F 520}			

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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 520}	<p>Continued From page 69</p> <p>unable to obtain TB Testing Agent, the employee or resident will have a Blood Assay for Mycobacterium Tuberculosis (BAMT), QuantiFeron-TB Cold In-Tube Test (IGRA), or T-Spot TB (TST) (blood tests that test for the presence of tuberculosis infection). In the event the lab tests are unavailable, the facility Administrator or Director of Nursing will contact the local Health Department for direction. At this time, the facility has a sufficient quantity of Tuberculin to last 60 or more days without reorder. The Director of Nursing will develop written education for all licensed nurses regarding the contingency policy stating what to do if the TB testing agent becomes unavailable. This education will be distributed with payroll on 01/23/14.</p> <p>The Unit Coordinators, Staff Development Nurse, and/or House Supervisor will report the progress of the TB testing to the facility Administrator or Director of Nursing daily until all employees and residents have completed the initial round of testing initiated on 01/16/14.</p> <p>The Director of Nursing will present the 01/22/14 reports from the Unit Coordinators and the Staff Development Nurse regarding TB testing to the Administrator and QI Committee on 01/22/14, and will present the 02/07/14 reports from the Unit Coordinators and Staff Development Nurse to the Administrator and QI Committee on 02/12/14.</p> <p>The QI Committee will review TB testing weekly through 02/28/14, then at the meeting the week of 03/26/14, and then per the established calendar thereafter.</p>	{F 520}			

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{F 520}	<p>Continued From page 70</p> <p>The QI Reviews will be overseen by the facility Administrator. Any identified issues will be reported to the Regional Vice President.</p> <p>TB Control is listed in the Annual In-Service Plan. The next scheduled "TB Control" review is scheduled for 07/14-16/14. The policies will be reviewed with staff at that time.</p> <p>On 01/30/14, it was identified that two employees who were unable to receive a TB skin test had signs/symptoms of TB marked yes on their screening forms and the facility had not followed its TB Policy. Upon identification of the issue, both employees were immediately placed on administrative leave on 01/30/14 and referred to the local Health Department but were unable to be seen on 01/31/14.</p> <p>The facility's Medical Director was contacted on 01/31/14 and gave an order for both employees to have a chest x-ray. The employees were x-rayed on 01/31/14. Results were received on 01/31/14 and were negative.</p> <p>The Administrator, Director of Nursing, and Facility Nurse Consultant received education from the Vice President of Nursing and the Employee Health Coordinator at the local Hospital. The Hospital employees reviewed the facility's policy and determined that the Director of Nursing, Administrator, and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB skin tests including the varying millimeters of induration, "mm" for a positive result for immunocompromised patients, routine nursing facility patients, and individuals identified as low risk. The specifics of the method for reading a</p>	{F 520}		

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{F 520}	<p>Continued From page 71</p> <p>TB test were also reviewed. The Hospital's Employee Health Coordinator also reviewed when to conduct a screening form, e.g., past positive, and the facility's policies regarding referral to the Physicians, Medical Director, or Health Department.</p> <p>The Administrator and Director of Nursing have taken complete control of the TB Screening Program effective 01/31/14 for both employees and residents, including administration and reading of TB Skin Tests, Screening Forms, and QI Audits and reports until such time as all Licensed Nurses have successfully completed skills verification related to administration and reading of TSTs and Screening Forms. The Director of Nursing will conduct the TB skin tests and readings until all staff have received re-education and have demonstrated they are knowledgeable.</p> <p>In the absence of the Director of Nursing, the Administrator will observe a licensed nurse who has already been re-educated and demonstrated successful skills to administer and/or read the TB test in order to ensure it is administered/read correctly in the event it is "required" during the absence of the DON.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>A review of the facility's policy entitled, "Tuberculosis Screening and Testing," dated August 2005, revealed all employees upon hire would receive a two-step Mantoux skin test with the first step being given on the first day of work. Employees with a negative skin test would receive a second-step Mantoux skin test within</p>	{F 520}			

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{F 520}	<p>Continued From page 72</p> <p>seven to fourteen days, and annually by a one-step method. The policy stated if a new positive occurred, employees would be referred to the local Health Department or to the Medical Director for further diagnostic evaluation and testing to include a chest x-ray. The policy further stated if an employee had a documented positive Mantoux skin test upon hire, a screening for Tuberculosis symptoms would be performed. An employee with negative symptomology would have an annual screening thereafter. If symptomology was present, the employee would be referred to the local Health Department or the Medical Director for further diagnostic evaluation and testing to include a chest x-ray.</p> <p>Review of the facility's policy entitled, "Resident Tuberculosis Testing and Screening Policy," dated August 2005, revealed all residents without a known documented positive PPD reaction would receive Tuberculosis testing upon admission using a two-step method. The first step would be administered on admission and if negative, a second PPD would be administered seven to fourteen days thereafter. The policy stated if the second step was negative, annual testing would occur thereafter using a single-step method. The policy revealed evaluation of residents with a new positive PPD would occur by the attending physician or the Medical Director to determine the presence of active Tuberculosis. The policy also revealed residents with a known documented positive reaction to a Mantoux PPD test would be screened for any history and symptoms of Tuberculosis. A chest x-ray would be obtained for residents with a positive screening, and the attending physician or the Medical Director would be notified to determine if further testing, appropriate treatment, and</p>	{F 520}			

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{F 520}	<p>Continued From page 73</p> <p>management were necessary. The policy stated any resident with suspected or probable infectious Tuberculosis would be transferred to an alternate facility for treatment.</p> <p>Review of the facility's policy entitled, "Tuberculosis Testing and Screening Temporary Measures," dated 01/17/14, revealed in the event the Tuberculosis testing agent became unavailable due to the shortage of Tubersol and Aplisol, either a BAMT, IGRA, or TST test would be performed. If these tests were not available from the facility's laboratory, the facility would consult with the local Health Department for measures to be taken for Tuberculosis testing and/or screening.</p> <p>Interview with the Administrator on 01/31/14, at 11:35 AM, the DON on 01/31/14, at 11:40 AM, the Corporate Nurse on 01/31/14, at 11:42 AM, and the Vice President of Clinical Operations on 01/31/14 at 1:40 PM, verified they had attended the telephone conference on 01/16/14, and confirmed the group had decided to repeal the interim Tuberculosis policy and revert back to the old Tuberculosis policy dated 2005, for both employees and residents.</p> <p>Interview conducted with the Administrator on 01/31/14, at 11:35 AM and 1:20 PM, revealed he had contacted the local Hospital as well as the local pharmacies, and obtained enough Tubersol to last at least 60 days based on the facility's average admission and new hire rate. The Administrator stated he had met with all administrative nurses, as well as the DON, to discuss the Tuberculosis testing policy. The Administrator stated they decided that the Staff Development Coordinator (SDC) would begin</p>	{F 520}		

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{F 520}	<p>Continued From page 74</p> <p>testing all employees on 01/16/14 and 01/17/14, the administrative nurses began testing residents on 01/17/14, and testing was completed by 01/17/14. The Administrator further stated the facility would revert to using the BAMT, IGRA, or TST in the event Tubersol was not available. The Administrator stated if the laboratory tests were not available at the facility's laboratory, he or the DON would consult the local Health Department for guidance.</p> <p>Interview conducted with the DON on 01/31/14, revealed either she or the Administrator would notify the local Health Department in the event the facility did not have Tubersol or Aplisol available to perform PPDs. The DON stated she had developed training and had trained all facility nurses on what to do in the event Tubersol or Aplisol was unavailable and all facility nurses had been trained on the policy and procedure.</p> <p>Review of in-services entitled, "Nurse Education of TB Screening Policy," revealed the DON educated staff on the new policy that required nursing staff to notify the DON should testing be required. The in-service was initiated on 01/17/14 and completed on 01/23/14.</p> <p>Review of an in-service roster entitled, "Administrator Review of Tuberculosis Test Issues," dated 01/16/14, revealed all administrative nurses attended an in-service regarding the facility's Tuberculosis policy, State Regulations concerning Tuberculosis testing, and Tuberculosis testing for all residents and staff.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they made and</p>	{F 520}			

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{F 520}	<p>Continued From page 75</p> <p>distributed a copy of the Resident Tuberculosis Testing Policies to all licensed nurses in the facility. The policy was used to retrain all nursing staff. The training was completed on 01/23/14.</p> <p>Observation of the facility's Tubersol in the facility on 01/30/14 revealed the facility had enough Tubersol on hand to provide 150 PPD tests.</p> <p>Review of an e-mail sent to the Administrator by the Health Department Medical Director dated 01/24/14, at 8:12 AM, revealed the Administrator had consulted with the Medical Director, who advised the facility to start all staff and resident annual testing. The e-mail revealed any staff or resident who had previously been tested would not require a two-step, and those staff members or residents who have had a previous positive PPD required a Tuberculosis assessment. The e-mail stated residents who did not have symptoms would not need a chest x-ray.</p> <p>Interview conducted with the local Health Department Medical Director on 01/30/14, at 2:50 PM, revealed she had consulted with the Administrator and had advised him to begin Tuberculosis testing for employees and residents. The Medical Director stated she had advised the Administrator to begin using the two-step method, unless the resident or staff member had already had a two-step TB test; and in that case, just to begin the annual testing. The Medical Director stated any staff or resident who had a past positive PPD would require a screening and would only require a chest x-ray if the resident or employee had a symptom of Tuberculosis. The physician stated she told the Administrator that waiting until the employee's next scheduled shift would be sufficient to do the PPD or screening.</p>	{F 520}			

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{F 520}	<p>Continued From page 76</p> <p>A review of signed physician's orders dated 01/17/14, at 8:14 PM, revealed orders for a TB skin test for all residents currently residing in the facility. The physician's order stated if a resident had already received a two-step PPD since admission to the facility, a one-step PPD test was sufficient.</p> <p>Interview conducted with Unit Coordinator #1 on 01/31/14, at 12:10 PM, Unit Coordinator #2 on 01/31/14, at 12:15 PM, and Unit Coordinator #3 on 01/31/14, at 12:20 PM revealed PPD skin tests or screenings for residents with a history of a positive PPD were completed on 01/17/14. The Unit Coordinators stated they had attended the in-service given by the Administrator and had discussed the repeal of the Tuberculosis policy and going back to the previous policy. The Unit Coordinators stated in the future, all residents without a known past positive would receive a two-step PPD upon admission and a one-step annually. If after receiving the first PPD the resident had a reaction, the physician would be notified for further orders, including a chest x-ray. The Unit Coordinators stated all employees would be given a PPD as well, unless they had a positive past PPD, and in that case a screening would be completed. If the employee documented symptoms, the employee would be referred to the Health Department or the Medical Director for further testing including a chest x-ray. The Unit Coordinators each stated all resident PPDs were negative and they had reported that information to the DON, and would be sending a report to the DON after reading the second step PPDs on 02/07/14.</p> <p>Interview with the weekend House Supervisor on</p>	{F 520}		

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{F 520}	<p>Continued From page 77</p> <p>01/31/14, at 1:30 PM, revealed she had been assigned to the time clock on 01/18/14 and 01/19/14, to administer PPD skin tests or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview with Quality Improvement (QI) Nurse #2 on 01/31/14, at 12:47 PM, revealed she had been assigned to the time clock on 01/17/14, 01/18/14, and 01/19/14, to administer PPDs or complete screenings for employees. Employees were not allowed to work until after the PPDs or screenings were done.</p> <p>Interview conducted with Registered Nurse (RN) #3 on 01/30/14, at 4:30 PM, Licensed Practical Nurse (LPN) #4 on 01/30/14, at 4:40 PM, LPN #2 on 01/30/14, at 4:45 PM, LPN #3 on 01/30/14, at 4:50 PM, and LPN #1 on 01/30/14, at 5:05 PM revealed they had attended an in-service regarding the Tuberculosis policy and were knowledgeable of the facility's TB testing policy and the policy regarding the skin testing agent not being available. The nurses stated every resident had to have a two-step PPD on admission and a one-step annually. If the resident had a past positive history of PPD or Tuberculosis, the physician or Medical Director must be notified for any additional testing and a chest x-ray must be obtained. If a resident had a positive PPD or had symptoms of TB, the physician or Medical Director, the Administrator, and the DON must notified immediately. The nurses stated no nurse was allowed to admit residents until after they were trained on the Tuberculosis policy. The nurses further stated they were aware they had to notify the DON and the Unit Coordinator if Tubersol was not available and if the laboratory</p>	{F 520}		

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{F 520}	<p>Continued From page 78</p> <p>was not able to conduct BAMT, IGRA, or TST testing.</p> <p>Interview conducted with the Admissions Coordinator on 01/31/14, at 1:02 PM, revealed she was responsible for assigning beds to residents upon admission, and had been assigned by the Administrator to notify QI Nurse #1 or QI Nurse #2 of any scheduled admissions.</p> <p>Interview conducted with QI Nurse #2 on 01/31/14, at 11:45 AM, and QI Nurse #1 on 01/31/14, at 1:00 PM, revealed they had reviewed all resident TB skin tests to ensure they were conducted per policy and administered by a nurse who had been re-educated on the policy. There had been no new admissions to the facility.</p> <p>Review of Tuberculosis screenings and PPD test results for all residents dated 01/17/14, revealed all residents with a history of a positive PPD had been screened and all other residents received a PPD skin test on 01/17/14. All PPDs were negative and no resident had signs or symptoms documented on the screening form. The PPDs were read on 01/20/14.</p> <p>Review of PPD test results for all employees revealed all employees received a TB skin test on 01/16/14 or 01/17/14. All TB skin tests were documented as being zero (0) millimeters of induration (negative for Tuberculosis). The TB skin tests were read on 01/19/14 or 01/20/14.</p> <p>Review of Quality Improvement Documentation revealed QI Nurse #1 documented she reviewed three new employee health files. QI Nurse #1 stated the new employees were not nurses. The documentation revealed the employees began</p>	{F 520}			

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{F 520}	<p>Continued From page 79</p> <p>employment on 01/28/14, QI Nurse #1 reviewed the health files on 01/29/14, and found no concerns, and the policy was being followed.</p> <p>Interview conducted with QI Nurse #1 on 01/31/14, at 1:15 PM, revealed she was required to review all new employee health files within 24 hours to ensure any symptoms of Tuberculosis were followed up on per facility policy.</p> <p>Interview conducted with the DON on 01/31/14, at 1:15 PM, revealed she checked the computer daily, and reviewed all new admissions to ensure the policy was being followed and had not identified any concerns.</p> <p>Interview conducted with the weekend Nursing Supervisor on 01/31/14, at 1:30 PM, revealed she reviewed any new admissions daily on the weekend to ensure the Tuberculosis policy was being followed and had not identified any concerns.</p> <p>Review of an Absence/Vacation Report dated 01/30/14, revealed Employee #2 and Employee #51 had both been placed on Administrative Leave of Absence until further notice.</p> <p>Interview conducted with the facility's Medical Director on 02/01/14, at 9:30 AM, revealed he had been contacted by the facility and had given the DON an order to obtain chest x-rays for both employees and had been notified that the x-rays were negative for Tuberculosis.</p> <p>Review of chest x-ray reports for Employee #2 and Employee #51 dated 01/31/14, revealed both were negative for Tuberculosis.</p>	{F 520}		

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{F 520}	<p>Continued From page 80</p> <p>Review of an e-mail and an in-service roster sent to the Administrator from the local Hospital Employee Health Nurse on 01/31/14, revealed the Administrator, DON, and Corporate Nurse, all attended an in-service provided by hospital staff regarding Centers for Disease Control (CDC) guidelines for Tuberculosis, administration of a PPD, and reading of PPDs.</p> <p>Interview conducted with the Corporate Nurse on 02/01/14, at 9:00 AM, revealed she had attended the in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD.</p> <p>Interview conducted with the DON on 02/01/14, at 9:05 AM, revealed she had attended an in-service on 01/31/14, by the local hospital employee health nurse regarding CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The DON stated as of 01/31/14, she was responsible for administering all PPDs and reading all PPDs until nurses were re-educated on administration and reading of a PPD and the facility's policy on Tuberculosis testing for both employees and residents. The DON stated if she was not available, the Administrator was required to supervise a nurse who had been re-educated on administering and reading of a PPD.</p> <p>Interview conducted with the Administrator on 02/01/14, at 9:45 AM, revealed he had attended an in-service on 01/31/14, by the local hospital employee health nurse on CDC guidelines for Tuberculosis, administration of a PPD, and reading of a PPD. The Administrator stated as of 01/31/14, the DON was responsible for</p>	{F 520}		

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

PRINTED: 03/10/2014
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 R 02/01/2014
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501		
(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 520}	Continued From page 81 administering all PPDs and reading all PPDs until nurses were re-educated. The Administrator stated if the DON was not available the Administrator would supervise a nurse who had been re-educated on administering and reading a PPD.	{F 520}		

F 441 **Criteria 1**

On January 16, 2014, the policy "Tuberculosis Testing and Screening Temporary Measures" was repealed by the facility Administrator with direction given to the Director of Nursing and Infection Control Coordinator to immediately revert to the facility's permanent policies for both resident and employee TB Screening regarding TB Testing located in the facility's Infection Control Manual. These policies have been in effect since August 2005, include 2 Step TB Skin Testing for new-hires and new admits and annual TB Skin Testing thereafter.

On January 17, 2014, the facility Administrator spoke with the Medical Director of the Lake Cumberland District Health Department. The Medical Director advised that the 2 Step TB Skin Testing as outlined in the facility policy is compliant with the State regulation. She also approved the facility's plan to restart testing on all employees and residents as if they were day 1 employees and residents or as if his/her annual was due. The Physician stated that it was not necessary to conduct a 2nd step or an x-ray on individuals already within the facility who had previously had a negative TB skin test or negative chest x-ray, or statement of non-necessity from a physician or appropriate agency. The Physician advised that employees could be tested during their next shift and work during the time period between having TB Tests administered and read.

On January 17, 2014, The Administrator met with the clinical Department Managers and Administrative Nurses including the Staff Development Nurse (SDC), The QI Nurse, QI Assistant Nurse (QI Nurses) and Unit Coordinators (UC's) as well as others and reviewed the regulatory requirements and policies for employee and resident TB Screening from the Infection Control Manual, the LCDHD Medical Director's recommendations, and that the temporary policy had been repealed. The Administrator instructed to begin testing all residents and employees in accordance with the policies and directives.

On January 17, 2014, The Director of Nursing obtained a Physician's order from the facility Medical Director for all residents to have TB Skin Testing completed per the policy and recommendation. All residents received TB Testing per policy on January 17, and January 18, 2014. All 1st step tests were completed and read by January 22, 2014.

Employees were screened on their next date worked. All employees' first step tests were completed and read by January 23, 2014.

These actions were enacted for all residents and employees including both those in the survey sample as well as those not included. There were no positive PPD conversions for any resident or employee.

F441 Criteria 2

The facility Administrator met with the Regional Vice President, Director of Nursing, QI Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (Via Phone), and Director of Corporate Policy (via phone) on January 16, 2014. The discussion included that the temporary policy was in effect for all residents and staff in all departments.

The determination was that all current residents, all current employees as well as all future residents and all future employees would be affected by the policy.

On January 30, 2014 it was determined that all residents TB Screening had been completed per policy and no further issues were present.

On January 30, 2014 it was identified that two employees who were unable to have a TST had been screened per policy. The employees had marked "yes" to questions in symptomology. The reviewer stated she had investigated and determined that the answers did not reflect true symptomology of TB; but there was not sufficient documentation to support this. Upon Identification of this issue, the Administrator immediately placed both employees on administrative leave and the issue was identified to the facility Medical Director.

The employees had Chest x-rays on January 31, 2014. The employees remained on administrative leave until the negative x-ray results were received by the Administrator. Results were received on 01/31/2014. The Administrator and Unit Coordinator reviewed the questionnaires for all staff unable to take the TB Skin Test on January 30, 2013 and determined no other issues existed.

On January 31, 2013 memos were issued from the Administrator to the SDC and to all nurses including that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

The Administrator has reviewed all admissions and all new-hires within 24 hours to ensure that the policy is being followed. No issues have been identified.

F441 Criteria 3

The Administrator repealed the policy titled "Tuberculosis Testing and Screening Temporary Measures" on January 16, 2017, gave direction and consulted with the LCDHD Medical Director as outlined in Criteria 1.

TB Tests were administered and read for all residents and employees as outlined in Criteria 1.

On January 17, 2014, the Administrator directed the QI Nurses to review and provide a copy of the TB Testing Policy pages from the infection control manual with/to all licensed Nurses upon their next scheduled shift.

Note: This was the policy in effect prior to implementation of the "Temporary Policy."

Re-education of all licensed Nurses by the QI Nurses was completed on January 23, 2014.

The Governing Body issued a policy addendum effective January 17, 2014 regarding required action in the event Tubersol is unavailable. The policy directs use of the BAMT, IGRA or T-Spot blood test.

The Director of Nursing reviewed the policy addendum with all licensed nurses with completion on 01/23/14.

The Admissions Coordinator was instructed by the Administrator on January 17, 2014 to alert the QI Nurses of any pending admissions and the QI Nurses would ensure appropriate Resident TB Testing occurred until all licensed Nurses had been (re) educated.

The TB Testing Policy is scheduled for annual review in July 2014 as per the Annual In-service Education Plan.

The SDC or instructor will provide education regarding Resident TB Testing as well as the policy addendum during orientation for all newly hired Licensed and Registered Nurses; and during annual in-service education as per the established calendar.

The Director of Nursing or Administrative Nurse Assigned by the Director of Nursing will provide education to any newly hired SDC.

The Administrator and Director of Nursing and Facility Nurse Consultant received education from Cheryl Glasscock, RN, VP of Nursing and Julie Stevens, RN, Employee Health Coordinator at Lake Cumberland Regional Hospital. The LCRH employees reviewed the facility policy and determined that the Director of Nursing, Administrator and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB Skin Tests including the varying millimeters of induration, "mmi" for a positive result of immunocompromised patients, routine Nursing Facility patients and individuals identified as low risk. Review of the correct method of reading a TB test was also reviewed. Ms. Stevens also reviewed when to conduct a screening form, i.e. past positive, etc... and the facility policies regarding referral to the Physicians, Medical Director or Health Department

On January 31, 2013 memos were issued from the Administrator to all nurses including the SDC that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

On January 31, 2014 the Director of Nursing began in person (re)education of all licensed nurses, including the SDC regarding:

902 KAR 20:200

The facility policy for Resident TB Testing / Screening including the addendum regarding procedures if TST Agent becomes unavailable.

The requirement to contact the Administrator / Director of Nursing for any resident unable to have a TST

Review of TST administration and reading , interpretation - Use of US Dept. Health & Human Services and Centers for Disease Control Training Material for guidance of Mantoux TST.
The Nurses completed the Lake Cumberland Regional Hospital Mantoux Validation Exam.

The facility implemented the temporary plan:

The Director of Nursing conducted the TB Skin Tests and readings until all nurses received (re)education and successfully completed the validation exam.

In the absence of the Director of Nursing, the Administrator observed a licensed nurse who had been (re)educated and had a successful skills verification administer and/or read the TB Test in order to ensure it is administered/read correctly in the event it was required during the absence of the DON.

All nurses completed the re-education effective 02/06/14

F441 Criteria 4

Effective January 31, 2014, the Director of Nursing and Administrator overtook all administering, reading and monitoring of the TB Screening program until such time as all licensed nurses completed the (re)education including a validation exam. All Nurses completed the (re)education effective 02/06/14.

The QI Committee determined that all resident TB Testing was compliant and policy was implemented and effective on January 29, 2014 and that all employees were compliant on January 31, 2014.

The Administrator has reviewed all patients who admitted and/or returned to the facility since January 31, 2014 and new hires orientating since January 31, 2014. No issues were identified. Reports have been submitted to the QI Committee Weekly.

The Administrator will continue to review all admissions/readmissions and new hires within 24 hours of admission, readmission or new hire and will report to the QI Committee weekly through February 26, 2014. In the absence of the Administrator, an Administrative Nurse assigned by the Administrator will conduct the review. The TB program will be reviewed again on March 26, 2014 and then as per the established QI Calendar.

QI Committee Minutes regarding the TB program will be presented to the Regional Vice President for review and direction from the Governing Body

The Infection Control Coordinator will continue to review and monitor all residents with diagnosed infections; residents receiving antibiotic therapy or (re)admitted with infection and/or showing signs and symptoms until they are resolved. The Infection Control Coordinator will continue to report to the QI Committee as per the established schedule.

The Infection Control Coordinator will continue to conduct the infection control section of the general orientation for new hires.

Administrative rounds are conducted throughout the facility on a daily basis by the Administrator, Director of Nursing and Administrative Staff in part to monitor for, identify and immediately correct infection control issues and/or identify needs for staff (re)education.

F 441 Date of Compliance

02/07/14

F490 Criteria 1

On January 16, 2014, the policy "Tuberculosis Testing and Screening Temporary Measures" was repealed by the facility Administrator. Notification of the decision to repeal the policy was made to the Regional Vice President, Vice President of Clinical Services, Corporate Director of Policy and Facility Nurse Consultant.

Direction was given to the Director of Nursing and Infection Control Coordinator to immediately revert to the facility's permanent policies for both resident and employee TB Screening regarding TB Testing located in the facility's Infection Control Manual. These policies have been in effect since August 2005, include 2 Step TB Skin Testing for new-hires and new admits and annual TB Skin Testing thereafter.

On January 17, 2014, the facility Administrator spoke with the Medical Director of the Lake Cumberland District Health Department. The Medical Director advised that the 2 Step TB Skin Testing as outlined in the facility policy is compliant with the State regulation. She also approved the facility's plan to restart testing on all employees and residents as if they were day 1 employees and residents. The Physician stated that it was not necessary to conduct a 2nd step or an x-ray on individuals already within the facility who had previously had a negative TB skin test or negative chest x-ray, or statement of non-necessity from a physician or appropriate agency. The Physician advised that employees could be tested during their next shift and work during the time period between having TB Tests administered and read.

On January 17, 2014, The Administrator met with the clinical Department Managers and Administrative Nurses including the Staff Development Nurse (SDC), The QI Nurse, QI Assistant Nurse (QI Nurses) and Unit Coordinators (UC's) as well as others and reviewed the regulatory requirements and policies for employee and resident TB Screening from the Infection Control Manual, the LCDHD Medical Director's recommendations, and that the temporary policy had been repealed. The Administrator instructed to begin testing all residents and employees in accordance with the policies and directives.

On January 17, 2014, The Director of Nursing obtained a Physician's order from the facility Medical Director for all of the residents to have TB Skin Testing completed per the policy and recommendation. All residents received TB Testing per policy on January 17, and January 18, 2014. All 1st step tests were completed and read by January 22, 2014.

Employees were screened on their next date worked. All employees' first step tests were completed and read by January 23, 2014.

These actions were enacted for all residents and employees including both those in the survey sample as well as those not included. There were no positive PPD conversions for any resident or employee.

F490 Criteria 2

The facility Administrator met with the Regional Vice President, Director of Nursing, QI Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (Via Phone), and Director of Corporate Policy (via phone) on January 16, 2014. The discussion included that the temporary policy was in effect for all residents and staff in all departments.

The determination was that all current residents, all current employees as well as all future residents and all future employees would be affected by the policy.

On January 30, 2014 it was determined that all residents TB Screening had been completed per policy and no further issues were present.

On January 30, 2014 it was identified that two employees who were unable to have a TST had been screened per policy. The employees had marked yes to symptomology. The reviewer stated she had investigated and determined that the answers did not reflect true symptomology of TB; but there was not sufficient documentation to support this. Upon Identification of this issue, the Administrator immediately placed both employees on administrative leave and the issue was identified to the facility Medical Director.

The employees had Chest x-rays on January 31, 2014. The employees remained on administrative leave until the negative x-ray results were received by the Administrator. Results were received on 01/31/2014. The Administrator and Unit Coordinator reviewed the questionnaires for all staff unable to take the TB Skin Test on January 30, 2013 and determined no other issues existed.

On January 31, 2013 memos were issued from the Administrator to the SDC and to all nurses including that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

F490 Criteria 3

The Administrator repealed the policy titled "Tuberculosis Testing and Screening Temporary Measures" on January 16, 2017, gave direction and consulted with the LCDHD Medical Director as outlined in Criteria 1.

TB Tests were administered and read for all residents and employees as outlined in Criteria 1.

On January 17, 2014, the Administrator directed the QI Nurses to copy the TB Testing Policy pages from the infection control manual and to review these documents with all licensed Nurses upon their next scheduled shift. Note: This was the policy in effect prior to implementation of the "Temporary Policy."

Re-education of all licensed Nurses by the QI Nurses was completed on January 23, 2014.

The Governing Body issued a policy addendum effective January 17, 2014 regarding required action in the event Tubersol is unavailable. The policy directs use of the BAMT, IGRA or T-Spot blood test. The Director of Nursing reviewed the policy addendum with all licensed nurses with completion on 01/23/14.

The Admissions Coordinator was instructed by the Administrator on January 17, 2014 to alert the QI Nurses of any pending admissions and the QI Nurses would ensure appropriate Resident TB Testing occurred until all licensed Nurses had been (re) educated.

The TB Testing Policy is scheduled for annual review in July 2014 as per the Annual In-service Education Plan.

The SDC or instructor will provide education regarding Resident TB Testing as well as the policy addendum during orientation for all newly hired Licensed and Registered Nurses; and during annual in-service education as per the established calendar.

The Director of Nursing or Administrative Nurse Assigned by the Director of Nursing will provide education to any newly hired SDC.

The Administrator and Director of Nursing and Facility Nurse Consultant received education from the Vice President of Nursing and Employee Health Coordinator of Lake Cumberland Regional Hospital. The LCRH employees reviewed the facility policy and determined that the Director of Nursing, Administrator and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB Skin Tests including the varying millimeters of induration, "mmi" for a positive result of immunocompromised patients, routine Nursing Facility patients and individuals identified as low risk. The specific method of reading a TB test was also reviewed. Ms. Stevens also reviewed when to conduct a screening form, i.e. past positive, etc... and the facility policies regarding referral to the Physicians, Medical Director or Health Department

On January 31, 2013 memos were issued from the Administrator to all nurses including the SDC that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

On January 31, 2014 the Director of Nursing began in person (re)education of all licensed nurses, including the SDC regarding:

902 KAR 20:200

The facility policy for Resident TB Testing / Screening including the addendum regarding procedures if TST Agent becomes unavailable.

The requirement to contact the Administrator / Director of Nursing for any resident unable to have a TST Review of TST administration and reading , interpretation - Use of US Dept. Health & Human Services and Centers for Disease Control Training Material for guidance of Mantoux TST.
The Nurses completed the Lake Cumberland Regional Hospital Mantoux Validation Exam.

The facility implemented the temporary plan:
The Director of Nursing conducted TB Skin Tests and readings until all nurses received (re)education and successfully completed the validation exam.

In the absence of the Director of Nursing, the Administrator observed a licensed nurse who had already been (re)educated and had a successful skills verification administer and/or read the TB Test in order to ensure it is administered/read correctly in the event it is required during the absence of the DON.

All nurses completed the re-education effective 02/06/14

The UC's administered TB Skin Tests and screening per the policy for all residents as described in Criteria 1.

F490 Criteria 4

Effective January 31, 2014, the Director of Nursing and Administrator overtook all administering, reading and monitoring of the TB Screening program until such time as all licensed nurses completed the (re)education including a validation exam. All Nurses completed the (re)education effective 02/06/14.

The QI Committee determined that all resident TB Testing was compliant and policy was implemented and effective on January 29, 2014 and that all employees were compliant on January 31, 2014.

The Administrator reviewed all patients who have returned/admitted to the facility and new hires after January 31, 2014 regarding TB Screening activity. No issues have been identified. Reports have been submitted to the QI Committee weekly.

The Administrator will continue to review all admissions/readmissions and new hires within 24 hours of admission, readmission or new hire and will report to the QI Committee weekly through February 26, 2014. In the absence of the Administrator, an Administrative Nurse assigned by the Administrator will conduct the review. The TB program will be reviewed again on March 26, 2014 and then as per the established QI Calendar.

QI Committee Minutes regarding the TB program will be presented to the Regional Vice President for review and direction from the Governing Body.

The Infection Control Coordinator will continue to review and monitor all residents with diagnosed infections; residents receiving antibiotic therapy or (re)admitted with infection and/or showing signs and symptoms until they are resolved. The Infection Control Coordinator will continue to report to the QI Committee as per the established schedule.

The Infection Control Coordinator will continue to conduct the infection control section of the general orientation for new hires.

Administrative rounds are conducted throughout the facility on a daily basis by the Administrator, Director of Nursing and Administrative Staff in part to monitor for, identify and immediately correct infection control issues and/or identify needs for staff (re)education.

F 493 Criteria 1

On January 16, 2014, the policy "Tuberculosis Testing and Screening Temporary Measures" was repealed by the facility Administrator who is an appointed member of the Governing Body of the facility. Notification was made to other members of the Governing Body including Regional Vice President, Vice President of Clinical Services, and Corporate Director of Policy of the decision to repeal the policy at the facility level.

On January 16, 2014, the policy "Tuberculosis Testing and Screening Temporary Measures" was repealed by the facility Administrator with direction given to the Director of Nursing and Infection Control Coordinator to immediately revert to the facility's permanent policies for both resident and employee TB Screening regarding TB Testing located in the facility's Infection Control Manual. These policies have been in effect since August 2005, include 2 Step TB Skin Testing for new-hires and new admits and annual TB Skin Testing thereafter.

On January 17, 2014, the facility Administrator spoke with the Medical Director of the Lake Cumberland District Health Department. The Medical Director advised that the 2 Step TB Skin Testing as outlined in the facility policy is compliant with the State regulation. She also approved the facility's plan to restart testing on all employees and residents as if they were day 1 employees and residents. The Physician stated that it was not necessary to conduct a 2nd step or an x-ray on individuals already within the facility who had previously had a negative TB skin test or negative chest x-ray, or statement of non-necessity from a physician or appropriate agency. The Physician advised that employees could be tested during their next shift and work during the time period between having TB Tests administered and read.

On January 17, 2014, The Administrator met with the clinical Department Managers and Administrative Nurses including the Staff Development Nurse (SDC), The QI Nurse, and QI Assistant Nurse (QI Nurses) and Unit Coordinators (UC's) as well as others and reviewed the regulatory requirements and policies for employee and resident TB Screening from the Infection Control Manual, the LCDHD Medical Director's recommendations, and that the temporary policy had been repealed. The Administrator instructed to begin testing all residents and employees in accordance with the policies and directives.

On January 17, 2014, The Director of Nursing obtained a Physician's order from the facility Medical Director for all of the residents to have TB Skin Testing completed per the policy and recommendation. All residents received TB Testing per policy on January 17, and January 18, 2014. All 1st step tests were completed and read by January 22, 2014.

Employees were screened on their next date worked. All employees' first step tests were completed and read by January 23, 2014.

These actions were enacted for all residents and employees including both those in the survey sample as well as those not included. There were no positive PPD conversions for any resident or employee.

F493 Criteria 2

The facility Administrator met with members of the Governing Body including the Regional Vice President, Director of Nursing, QI Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (Via Phone), and Director of Corporate Policy (via phone) on January 16, 2014. The discussion included that the temporary policy was in effect for all residents and staff in all departments.

The determination was that all current residents, all current employees as well as all future residents and all future employees would be affected by the policy.

On January 30, 2014 it was determined that all residents TB Screening had been completed per policy and no further issues were present.

On January 30, 2014 it was identified that two employees who were unable to have a TST had been screened per policy. The employees had marked yes to symptomology. The reviewer stated she had investigated and determined that the answers did not reflect true symptomology of TB; but there was not sufficient documentation to support this.

Upon Identification of this issue, the Administrator immediately placed both employees on administrative leave and the issue was identified to the facility Medical Director.

The employees had Chest x-rays on January 31, 2014. The employees remained on administrative leave until the negative x-ray results were received by the Administrator. Results were received on 01/31/2014. The Administrator and Unit Coordinator reviewed the questionnaires for all staff unable to take the TB Skin Test on January 30, 2013 and determined no other issues existed.

On January 31, 2013 memos were issued from the Administrator to the SDC and to all nurses including that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

F493 Criteria 3

(Cont) The Administrator repealed the policy titled "Tuberculosis Testing and Screening Temporary Measures" on January 16, 2017, gave direction and consulted with the LCDHD Medical Director as outlined in Criteria 1.

TB Tests were administered and read for all residents and employees as outlined in Criteria 1.

On January 17, 2014, the Administrator directed the QI Nurses to copy the TB Testing Policy pages from the infection control manual and to review these documents with all licensed Nurses upon their next scheduled shift. Note: This was the policy in effect prior to implementation of the "Temporary Policy." Re-education of all licensed Nurses by the QI Nurses was completed on January 23, 2014.

The Governing Body issued a policy addendum effective January 17, 2014 regarding required action in the event Tubersol is unavailable. The policy directs use of the BAMT, IGRA or T-Spot blood test. The Director of Nursing reviewed the policy addendum with all licensed nurses with completion on 01/23/14.

The Admissions Coordinator was instructed by the Administrator on January 17, 2014 to alert the QI Nurses of any pending admissions and the QI Nurses would ensure appropriate Resident TB Testing occurred until all licensed Nurses had been (re) educated.

The TB Testing Policy is scheduled for annual review in July 2014 as per the Annual In-service Education Plan.

The SDC or instructor will provide education regarding Resident TB Testing as well as the policy addendum during orientation for all newly hired Licensed and Registered Nurses; and during annual in-service education as per the established calendar.

The Director of Nursing or Administrative Nurse Assigned by the Director of Nursing will provide education to any newly hired SDC.

The Administrator and Director of Nursing and Facility Nurse Consultant received education from Cheryl Glasscock, RN, VP of Nursing and Julie Stevens, RN, Employee Health Coordinator at Lake Cumberland Regional Hospital. The LCRH employees reviewed the facility policy and determined that the Director of Nursing, Administrator and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB Skin Tests including the varying millimeters of induration, "mmi" for a positive result of immunocompromised patients, routine Nursing Facility patients and individuals identified as low risk. The specific method of reading a TB test was also reviewed. Ms. Stevens also reviewed when to conduct a screening form, i.e. past positive, etc... and the facility policies regarding referral to the Physicians, Medical Director or Health Department

On January 31, 2013 memos were issued from the Administrator to all nurses including the SDC that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

On January 31, 2014 the Director of Nursing began in person (re)education of all licensed nurses, including the SDC regarding:

902 KAR 20:200

The facility policy for Resident TB Testing / Screening including the addendum regarding procedures if TST Agent becomes unavailable.

The requirement to contact the Administrator / Director of Nursing for any resident unable to have a TST Review of TST administration and reading , interpretation - Use of US Dept. Health & Human Services and Centers for

Disease Control Training Material for guidance of Mantoux TST.

The Nurses completed the Lake Cumberland Regional Hospital Mantoux Validation Exam.

The facility implemented the temporary plan:

The Director of Nursing conducted the TB Skin Tests and readings until all nurses received (re)education and successfully completed the validation exam.

In the absence of the Director of Nursing, the Administrator observed a licensed nurse who has already been (re)educated and had a successful skills verification administer and/or read the TB Test in order to ensure it is administered/read correctly in the event it is required during the absence of the DON.

All nurses completed the re-education effective 02/06/14

The UC's administered TB Skin Tests and screening per the policy for all residents as described in Criteria 1.

F493 Criteria 4

Effective January 31, 2014, the Director of Nursing and Administrator overtook all administering, reading and monitoring of the TB Screening program until such time as all licensed nurses completed the (re)education including a validation exam. All Nurses completed the (re)education effective 02/06/14.

The QI Committee determined that all resident TB Testing was compliant and policy was implemented and effective on January 29, 2014 and that all employees were compliant on January 31, 2014.

The Administrator reviewed all patients who returned/admitted to the facility after January 31, 2014 and the new hires regarding TB Screening. No issues were identified. Reports have been submitted weekly to the QI Committee.

The Administrator will continue to review all admissions/readmissions and new hires within 24 hours of admission, readmission or new hire and will report to the QI Committee weekly through February 26, 2014. In the absence of the Administrator, an Administrative Nurse assigned by the Administrator will conduct the review. The TB program will be reviewed again on March 26, 2014 and then as per the established QI Calendar.

QI Committee Minutes regarding the TB program will be presented to the Regional Vice President for review and direction from the Governing Body

F 493 Date of Compliance

02/07/2014

F 520 **Criteria 1**

On January 16, 2014, the policy "Tuberculosis Testing and Screening Temporary Measures" was repealed by the facility Administrator who has oversight of the Quality Improvement Team (QI).

Direction was given to the Director of Nursing and Infection Control Coordinator by the Administrator on January 16, 2014, to immediately revert to the facility's permanent policies for both resident and employee TB Screening regarding TB Testing located in the facility's Infection Control Manual. These policies have been in effect since August 2005, include 2 Step TB Skin Testing for new-hires and new admits and annual TB Skin Testing thereafter.

On January 17, 2014, the facility Administrator consulted with the Medical Director of the Lake Cumberland District Health Department for guidance to the QI Team. The Medical Director advised that the 2 Step TB Skin Testing as outlined in the facility policy is compliant with the State regulation. She also approved the facility's plan to restart testing on all employees and residents as if they were day 1 employees and residents. The Physician stated that it was not necessary to conduct a 2nd step or an x-ray on individuals already within the facility who had previously had a negative TB skin test or negative chest x-ray, or statement of non-necessity from a physician or appropriate agency. The Physician advised that employees could be tested during their next shift and work during the time period between having TB Tests administered and read.

On January 17, 2014, The Administrator met with the clinical Department Managers and Administrative Nurses including the Staff Development Nurse (SDC), The QI Nurse, and QI Assistant Nurse (QI Nurses) and Unit Coordinators (UC's) as well as other members of the QI Team and reviewed the regulatory requirements and policies for employee and resident TB Screening from the Infection Control Manual, the LCDHD Medical Director's recommendations, and that the temporary policy had been repealed. The Administrator instructed to begin testing all residents and employees in accordance with the policies and directives and advised of the time frames for reporting data and summaries back to the QI Team.

On January 17, 2014, The Director of Nursing obtained a Physician's order from the facility Medical Director for all of the residents to have TB Skin Testing completed per the policy and recommendation. All residents received TB Testing per policy on January 17, and January 18, 2014. All 1st step tests were completed and read by January 22, 2014.

Employees were screened on their next date worked. All employees' first step tests were completed and read by January 23, 2014.

These actions were enacted for all residents and employees including both those in the survey sample as well as those not included. There were no positive PPD conversions for any resident or employee.

F520 Criteria 2

The facility Administrator met with the Regional Vice President, Director of Nursing, QI Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (Via Phone), and Director of Corporate Policy (via phone) on January 16, 2014. The discussion included that the temporary policy was effective for all residents and staff in all departments.

The determination was that all current residents, all current employees as well as all future residents and all future employees would be affected by the policy.

On January 30, 2014 it was determined that all residents TB Screening had been completed per policy and no further issues were present.

On January 30, 2014 it was identified that two employees who were unable to have a TST had been screened per policy. The employees had marked yes to symptomology. Further investigated and determined that the answers did not reflect true symptomology of TB; but there was not sufficient documentation to support this. Upon Identification of this issue to the DON & Administrator the employees were immediately placed on administrative leave and the issue was identified to the facility Medical Director.

The employees had Chest x-rays on January 31, 2014 with same day results which were negative for signs of TB before being allowed to return to work.

The Administrator and Unit Coordinator reviewed the questionnaires for all staff unable to take the TB Skin Test on January 30, 2013 and determined no other issues existed.

On January 31, 2013 memos were issued from the Administrator to all nurses including the SDC that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction

F520 Criteria 3

On January 16, 2014, The facility Administrator met with the Regional Vice President, Director of Nursing, QI Nurse, Corporate Nurse Consultant, Vice President of Clinical Operations (Via Phone), and Director of Corporate Policy (via phone) and discussed the issues related to the TB Skin Testing Policy as identified by the OIG Inspector.

On January 17, 2014, The Administrator met with the clinical Department Managers and Administrative Nurses including the Staff Development Nurse (SDC), The QI Nurse, and QI Assistant Nurse (QI Nurses) and Unit Coordinators (UC's) as well as other members of the QI Team and reviewed the regulatory requirements and policies for employee and resident TB Screening from the Infection Control Manual, the LCDHD Medical Director's recommendations, and that the temporary policy had been repealed. The Administrator instructed to begin testing all residents and employees in accordance with the policies and directives and advised of the time frames for reporting data and summaries back to the QI Team.

The Administrator instructed the members of the QI Team to ensure that when conducting audits, they not only review that the item or form was complete but that they also review for accuracy and follow through by the direct care staff and that they provide re-education as necessary.

The Administrator and Director of Nursing had identified that the former SDC was clerically challenged and removed that individual from the position in November 2013. Although the SDC was conducting further investigations and ruling out the need for additional testing she was not correcting nor having the employee correct the screening tool or properly filing the supporting documentation as it related to TB Testing.

The New SDC was trained by a Unit Coordinator and the Director of Nursing regarding proper documentation and filing of documents upon hire in November 2013. An audit conducted by the Facility Nurse Consultant January 27, 28 & 29, 2014 revealed no concerns with filing and charting in employee files regarding TB Screening by the current person in the position. This was reported to the QI Committee on January 29, 2014.

The Facility Nurse Consultant also audited behind the QI Nurses on January 27, 28 & 29, 2014 and noted no concerns with TB Screening or with auditing by the QI Committee members as related to TB Screening.

The Administrator repealed the policy titled "Tuberculosis Testing and Screening Temporary Measures" on January 16, 2017, gave direction and consulted with the LCDHD Medical Director as outlined in Criteria 1.

TB Tests were administered and read for all residents and employees as outlined in Criteria 1.

On January 17, 2014, the Administrator directed the QI Nurses to copy the TB Testing Policy pages from the infection control manual and to review these documents with all licensed Nurses upon their next scheduled shift. Note: This was the policy in effect prior to implementation of the "Temporary Policy." Re-education of all licensed Nurses by the QI Nurses was completed on January 23, 2014.

The Governing Body issued a policy addendum effective January 17, 2014 regarding required action in the event Tubersol is unavailable. The policy directs use of the BAMT, IGRA or T-Spot blood test. The Director of Nursing reviewed the policy addendum with all licensed nurses 01/23/14.

The Admissions Coordinator was instructed by the Administrator on January 17, 2014 to alert the QI Nurses of any pending admissions and the QI Nurses would ensure appropriate Resident TB Testing occurred until all licensed Nurses had been (re) educated.

The TB Testing Policy is scheduled for annual review in July 2014 as per the Annual In-service Education Plan.

The SDC or instructor will provide education regarding Resident TB Testing as well as the policy addendum during orientation for all newly hired Licensed and Registered Nurses; and during annual in-service education as per the established calendar.

The Director of Nursing or Administrative Nurse Assigned by the Director of Nursing will provide education to any newly hired SDC.

The Administrator and Director of Nursing and Facility Nurse Consultant received education from Cheryl Glasscock, RN, VP of Nursing and Julie Stevens, RN, Employee Health Coordinator at Lake Cumberland Regional Hospital. The LCRH employees reviewed the facility policy and determined that the Director of Nursing, Administrator and Facility Nurse Consultant were knowledgeable regarding proper placement, administration, and reading of TB Skin Tests including the varying millimeters of induration, "mmi" for a positive result of immunocompromised patients, routine Nursing Facility patients and individuals identified as low risk. The specific method of reading a TB test was also reviewed. Ms. Stevens also reviewed when to conduct a screening form, i.e. past positive, etc... and the facility policies regarding referral to the Physicians, Medical Director or Health Department

On January 31, 2013 memos were issued from the Administrator to all nurses including the SDC that any resident or employee who is unable to have a TST conducted required immediate notification to the Administrator or Director of Nursing for review and direction.

On January 31, 2014 the Director of Nursing began in person (re)education of all licensed nurses, including the SDC regarding:

902 KAR 20:200

The facility policy for Resident TB Testing / Screening including the addendum regarding procedures if TST Agent becomes unavailable.

The requirement to contact the Administrator / Director of Nursing for any resident unable to have a TST Review of TST administration and reading , interpretation - Use of US Dept. Health & Human Services and Centers for Disease Control Training Material for guidance of Mantoux TST.

The Nurses completed the Lake Cumberland Regional Hospital Mantoux Validation Exam.

The facility implemented the temporary plan:

The Director of Nursing conducted the TB Skin Tests and readings until all nurses received (re)education and successfully completed the validation exam.

In the absence of the Director of Nursing, the Administrator observed a licensed nurse who has already been (re)educated and had a successful skills verification administer and/or read the TB Test in order to ensure it is administered/read correctly in the event it is required during the absence of the DON.

All nurses have completed the re-education effective 02/06/14

The UC's administered TB Skin Tests and screening per the policy for all residents as described in Criteria 1.

The QI Committee determined that all resident TB Testing was compliant and policy was implemented and effective on January 29, 2014. On January 30, 2014 continued potential issues were identified with employee screening.

Effective January 31, 2014, the Director of Nursing and Administrator overtook all administering, reading and monitoring of the TB Screening program until such time as all licensed nurses successfully completed skills verification related to administration and reading of TST's and screening.

F520 Criteria 4

Effective January 31, 2014, the Director of Nursing and Administrator overtook all administering, reading and monitoring of the TB Screening program until such time as all licensed nurses completed the (re)education including a validation exam. All Nurses completed the (re)education effective 02/06/14.

The QI Committee determined that all resident TB Testing was compliant and policy was implemented and effective on January 29, 2014 and that all employees were compliant on January 31, 2014.

The Administrator reviewed all patients who returned to the facility between January 31, 2014 and February 5, 2014 and the new hires orientating on February 5, 2014 and reported to the QI Committee regarding TB Screening activity on February 5, 2014. No issues were identified.

The Administrator will continue to review all admissions/readmissions and new hires within 24 hours of admission, readmission or new hire and will report to the QI Committee weekly through February 26, 2014. In the absence of the Administrator, an Administrative Nurse assigned by the Administrator will conduct the review. The TB program will be reviewed again on March 26, 2014 and then as per the established QI Calendar.

QI Committee Minutes regarding the TB program will be presented to the Regional Vice President for review and direction from the Governing Body.

F 520 Date of Compliance

02/07/2014

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

Amended 587D



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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 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/14/2014
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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS 556 BOURNEMAN SOMERSET, KY 42601	CITY/STATE/ZIP CODE 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
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K 000	<p>INITIAL COMMENTS</p> <p>**Amended**</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1975</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: Twelve</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 01/14/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p> <p>K 020 NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 000	<p><u>DISCLAIMER:</u></p> <p>Somerwoods Nursing and Rehabilitation Center (Somerwoods) 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. Somerwoods' 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, Somerwoods 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.</p> <p>See 8 page attachment for:</p> <p>K 020 K 025 K 029 K 038 K 056 K 070 K 147</p> <p>Pages 2 – 16 of 16 are intentionally blank.</p>	
		K 020		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Brian Stinson, LHA, CDP

TITLE
Admin

(X6) DATE
03/17/14

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

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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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K 020 SS=D	<p>Continued From page 1</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that ceiling areas were maintained according to NFPA standards. This deficient practice affected two (2) of twelve (12) smoke compartments, staff, and resident care and use areas. The facility has the capacity for 136 beds with a census of 131 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/14/14 at 11:05 AM, with the Director of Maintenance (DOM) the Environmental Services office located in the basement level was observed to have a large opening in the ceiling area around a heat and air unit. Ceiling areas must remain smoke tight in order to help prevent fire/smoke from reaching other areas of the building.</p> <p>An interview with the DOM on 01/14/14 at 11:05 AM revealed this area was breached when the facility added a fire sprinkler system to the building. The DOM stated he was not aware this area had been breached.</p> <p>During the survey, other office ceiling areas were</p>	K 020		

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K 020	Continued From page 2 observed to be breached in this same manner and included, but were not limited to, the Therapy, Administrator, Consultants, and the Environmental Services offices. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 8.2.5.1 Every floor that separates stories in a building shall be constructed as a smoke barrier to provide a basic degree of compartmentation. (See 3.3.182 for definition of Smoke Barrier.)	K 020		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers with at least a one-half (1/2) hour fire resistance rating as required. This deficient practice affected four (4) of twelve (12) smoke	K 025		

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K 025	<p>Continued From page 3</p> <p>compartments, staff, and approximately twenty-four (24) residents. The facility has the capacity for 136 beds with a census of 131 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/14/14 at 11:45 AM, with the Director of Maintenance (DOM), an approximate three-inch gap was observed around a sprinkler pipe in the smoke barrier wall located above the ceiling in the employee bathroom on the basement level office floor. In a fire situation, defective fire/smoke barrier walls aid in the spread of smoke and fire to other parts of the building.</p> <p>During the survey, the smoke barrier wall located on the third floor was observed to have the same type of damage.</p> <p>An interview with the DOM on 01/14/14 at 11:45 AM revealed he thought these areas were properly repaired after the fire sprinkler system was installed.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining</p>	K 025		

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K 025	Continued From page 4 the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	<p>Continued From page 5</p> <p>fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that hazardous areas maintained a smoke resistant rating and doors were equipped with door closures as required. This deficient practice affected three (3) of twelve (12) smoke compartments, staff, and approximately twenty (20) residents. The facility has the capacity for 136 beds with a census of 131 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/14/14 at 10:55 AM, with the Director of Maintenance (DOM), the Accounts Payable office located in the basement level offices was observed to have a substantial amount of combustible supplies (records/files) that would deem this area to be classified as a hazardous area. The door to this office did not have a door-closing device. Doors to hazardous areas are required to be equipped with a door-closing device.</p>	K 029		

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K 029	Continued From page 6 An interview with the DOM on 01/14/14 at 10:55 AM revealed he had not been in this area of the building before and he did not know a combustible supply was there. During the survey, other rooms were observed to need door-closing devices because of combustible storage within the rooms including, but not limited to, the Environmental Services, Medical Records, and Therapy and storage rooms in the Laundry/Supply building. Observation on 01/14/14 at 3:35 PM, with the DOM revealed an oxygen storage room located on the second floor that had gaps around the conduit and plumbing fixtures. These areas are required to be properly sealed to help prevent smoke and fire from spreading to other parts of the facility. An interview with the DOM on 01/14/14 at 3:35 PM revealed he was aware hazardous areas were required to be maintained and stated the rooms must have been overlooked. During the survey, the Community Room storage area was also observed to be missing a ceiling tile. The findings were revealed to the Administrator upon exit.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors were maintained according to NFPA standards. This deficient practice affected eight (8) of twelve (12) smoke compartments, staff, and approximately seventy (70) residents. The facility has the capacity for 136 beds with a census of 131 on the day of the survey. The findings include: During the Life Safety Code survey on 01/14/14 at 10:45 AM, with the Director of Maintenance (DOM), a door to the MD office located in the basement level office area was observed to have a doorknob located approximately five feet high on the door from the floor level. Releasing devices are required to be located not less than 34 inches, and not more than 48 inches, above the finished floor. Doors are required to be operable with not more than one releasing device. An interview with the DOM on 01/14/14 at 10:45 AM revealed he was not aware of this requirement. During the survey, other doors located in the facility were observed not to meet the height or number of releasing devices requirement including, but not limited to, the QI Nurse's office, Mail Room, Administrator's office, Treatment Nurse's office, Kitchen area, Dietary area, and	K 038		

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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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K 038	<p>Continued From page 8 rooms 203 and 238.</p> <p>On 01/14/14 at 11:00 AM with the DOM, a delayed egress sign attached to an exterior exit door in the basement level lobby area was observed not to have the releasing time on the signage as required. This signage lets occupants of the building know how long it takes for the magnetic locking device to release for exiting purposes in case of an emergency.</p> <p>An interview with the DOM on 01/14/14 at 11:00 AM revealed he did not know why the signage had been altered.</p> <p>During the survey, delayed exit signage on the first and second floors was observed to have lettering that was less than the required one inch in height and 1/8 inch in width. An interview with the DOM on 01/14/14 at 4:00 PM revealed he was not aware of the required size of lettering for delayed egress signage.</p> <p>On 01/14/14 at 12:05 PM, with the DOM, a stairwell exit door located in the basement office level was observed not to have a latching mechanism on the door and doorframe as required.</p> <p>An interview with the DOM on 01/14/14 at 12:05 PM revealed he was not aware stairwell doors should latch.</p> <p>On 01/14/14 at 2:40 PM, with the DOM, four gates to resident rooms 303, 321, 334, and 338 were observed to be attached to the doorframes on the third floor. These gates impede egress and make it difficult to shut the door from the corridor side in case of an emergency. An</p>	K 038			

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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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K 038	<p>Continued From page 9</p> <p>interview with the DOM on 01/14/14 at 2:40 PM revealed he was unaware these types of barriers should not be used on doorways. The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.5.4*</p> <p>A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p> <p>7.2.1.6.1 Delayed-Egress Locks.</p> <p>Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power</p>	K 038		

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NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 665 BOURNE AVENUE SOMERSET, KY 42501	
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K 038	Continued From page 10 controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056		

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K 056	<p>Continued From page 11</p> <p>supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that the building sprinkler system was installed throughout the facility according to NFPA standards. This deficient practice affected two (2) of twelve (12) smoke compartments, staff, and approximately twelve (12) residents. The facility has the capacity for 136 beds with a census of 131 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/14/14 at 12:00 PM, with the Director of Maintenance (DOM), a sprinkler head was observed to be missing from the Environmental Services closet. There must be complete coverage by the sprinkler system in all areas of the building.</p> <p>An interview with the DOM on 01/14/14 at 12:00 PM revealed he was aware the building required complete sprinkler coverage; however, he was unaware this room was missing a sprinkler head.</p> <p>During the survey, a closet located in the third floor shower room was also observed to be missing a sprinkler head.</p> <p>The findings were revealed to the Administrator at</p>	K 056		

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K 056	Continued From page 12 exit. Reference: NFPA 101 (2000 Edition). 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.	K 056		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the safety of residents, staff, and other occupants of the building by allowing unapproved portable space heating units in office areas. This deficient practice affected one (1) of twelve (12) smoke compartments and staffing. The facility has the capacity for 136 beds with a census of 131 on the day of the survey.	K 070		

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K 070	Continued From page 13 The findings include: During the Life Safety Code tour on 01/14/14 at approximately 10:50 AM, with the Director of Maintenance (DOM), a portable space heater was observed in the Payroll office in the basement level of the facility. Facilities must provide factory documentation that the heater is approved for use in these areas. During the survey, an unapproved space heater was also observed in the QI Nurse's office in the basement level of the facility. An interview with the DOM on 01/14/14 at 3:10 PM revealed he was unaware of the requirements for the proper use of portable space heaters. The findings were revealed to the Administrator upon exit.	K 070			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical wiring and standards met NFPA requirements. This deficient practice affected two (2) of twelve (12) smoke compartments, staff, and approximately twelve (12) residents. The facility has the capacity for 136 beds with a census of 131 on the day of the	K 147			

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K 147	<p>Continued From page 14 survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/14/14 at 11:55 AM, with the Director of Maintenance (DOM), exposed electrical wiring was observed in the Medical Supply storage area in the basement level office area. This wiring is required to be secured in a junction box for safety reasons.</p> <p>An interview with the DOM on 01/14/14 at 11:55 AM revealed he was aware wiring should be in a junction box; however, he was not aware there was exposed wiring in the storage area.</p> <p>On 01/14/14 at 3:05 PM, with the DOM, the third floor shower room closet was observed to have an electrical appliance cord passing through the doorway. This could cause damage to the cord and become a fire/safety issue. An interview with the DOM on 01/14/14 at 3:05 PM revealed he was aware cords should not be used in this manner; however, he was not aware of the cord passing through the doorway.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section</p>	K 147		

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K 147	Continued From page 15 370-22, Exception. 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147			

Somerwoods Nursing and Rehabilitation Center 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. Somerwoods Nursing and Rehabilitation Center response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor is that any deficiency accurate. Further, Somerwoods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.

K 020

Criteria 1

The Director of Maintenance inspected each of the offices on the ground floor on 01/27/2014 to determine where breaches in the ceilings around HVAC units existed. The Director Maintenance created a worklist for the identified breaches to be sealed to meet a basic degree of compartmentation by February 4, 2014.

Criteria 2

The DOM inspected the ceilings around each of the HVAC units throughout the facility on 01/27/2014 and no ceiling breaches were identified.

Criteria 3

The Administrator met with the Director of Maintenance and Director of Environmental Services and Safety on January 28, 2014 and provided (re)education regarding the Standards cited at K020.

Criteria 4

A member of the Maintenance Department will be assigned by the Director of Maintenance to audit the facility ceilings semi-annually to identify any issues with life safety code. Identified issues will be immediately corrected. Results of these audits will be reported to the QI Committee for one year and will continue per the established schedule thereafter.

Date of Compliance February 7, 2014.

K025

Criteria 1

The gap identified in the smoke barrier above the ceiling in the employee bathroom on the ground floor was sealed by a member of the facility Maintenance Team on January 14, 2014.

The contractor who installed the sprinkler system was contacted to seal the piping area on the 3rd floor.

Criteria 2

During the week of January 20, 2014, the Director of Maintenance inspected each of the smoke barrier walls for unsealed penetrations around the sprinkler system. All fire walls are identified to be sealed.

Criteria 3

The Administrator met with the Director of Maintenance and Director of Environmental Services and Safety on January 28, 2014 and reviewed the Standard cited at K025 regarding fire walls.

The Director of Maintenance will thoroughly inspect firewalls after any contractor installs equipment which penetrates the firewalls. The Director of Maintenance will recall the contractor to make the repair or have the facility Maintenance Department seal the fire wall.

Criteria 4

A member of the Maintenance Department will be assigned by the Director of Maintenance to audit the fire walls semi-annually to identify any unsealed penetrations. Identified issues will be immediately corrected. Results of these audits will be reported to the QI Committee for one year and will continue per the established schedule thereafter.

Date of compliance: February 7, 2014

K029

Criteria 1

The ceiling tile in the community room storage area was replaced by Maintenance Staff on 01/14/2014.

Door closers were installed on the doors in the Accounts Payable office, the Environmental Services, closets, Medical Records Office, and Therapy Office; and the penetrations identified in the O2 storage room were sealed by Maintenance Staff on January 28, and 29, 2014.

Criteria 2

The Maintenance Director inspected the facility additional doors requiring automatic door closers on January 28, 2014. No other doors were identified to need a door closer.

The Maintenance director inspected the facility for additional missing ceiling tiles on 01/17/2014. No additional missing ceiling tiles were identified.

The facility only has one oxygen storageroom in the Nursing Facility building.

Criteria 3

The facility Administrator Met with the Director of Maintenance and the Director of Environmental Services and Safety on January 28, 2014 and reviewed the standards cited at K029. The Director of Maintenance has a staff member assigned to maintain the ceiling tiles throughout the facility. The Director of Maintenance reviewed that the drop ceilings must be kept complete at all times to meet life safety codewith the employee on January 17, 2014.

The Director of Maintenance will oversee any additional renovations or repurposing of rooms and inspect those areas to determine if they have been converted to a hazardous storage area and will ensure the rooms are compliant after being repurposed.

Criteria 4

The Director of Maintenance will audit the facility monthly for one month and then quarterly for two quarters and then per the established QI Calendar. Identified issues will be immediatel corrected and Results of the Audits will be presented to the QI Committee.

Date of Compliance February 7, 2014

K 038

Criteria 1

The Director of Maintenance contacted a contractor on January 21, 2014. The contractor ordered new doors and/or hardware necessary to bring each of the doors identified during the survey into compliance.

The doors and hardware are set to be installed with completion on or before February 7, 2014.

The facility Administrator is obtaining new exit egress signage with the required one inch height and 1/8 inch in width lettering on a contrasting background with the time and method for delayed egress included. The signage will be installed on or before February 7, 2014.

All gates were removed and discarded the Maintenance Department on January 14, 2014.

The Deadbolt locks on office doors will be removed or disabled on or before February 7, 2014.

Criteria 2

All doors and doorways were inspected by the Director of Maintenance and the door contractor on January 24, 2014 to identify any additional doors that did not meet the life safety code regulation, NFPA 101. No other door or doorways concerns were identified.

Criteria 3

The Life Safety Inspectors provided information on January 14, 2014 that the door gates similar to a screen door were not allowable in the nursing facility. The Administrator provided this information to the Maintenance Team and the Nursing Administration on January 14, 2014.

The Life Safety Inspectors provided information to the Administrator on January 14, 2014 regarding the revised requirement for exact letter sizing for delayed egress signage. This information was provided to the Director of Maintenance and Director of Environmental Services and Safety on January 28, 2014.

The Life Safety Inspectors provided information to the Administrator on January 14, 2014 that all doors to stairs including those that only exit up must have latching panic hardware. This information was passed on to the Maintenance Team and Director of Environmental Services and Safety on January 14, 2014.

The code requirements cited at K038 were reviewed with the Director of Maintenance and the Director of Environmental Services and Safety on January 28, 2014.

All doors and doorways were inspected by the Director of Maintenance and the door contractor on January 24, 2014 to identify any additional doors that did not meet the life safety code regulation, NFPA 101.

Criteria 4

The Maintenance Director will audit all doors at the time of completion of the install by the contractor to ensure proper function and latching mechanisms are in place. Any areas of concern will be required to be corrected immediately. He will present the results of his audit to Administrator at the time of the project completion and to the QI Committee on February 12, 2014.

The Director of Maintenance will oversee any future door renovations and ensure they are compliant with the life safety .

Date completed February 7, 2014.

K056

Criteria 1

The sprinkler contractor was recalled and installed the missing sprinkler head in the ES Office closet and the additionally required head in the shower-room closet on January 27, 2014.

Criteria 2

All Additional Rooms were inspected by the Director of Maintenance, Director of Environmental Services, Administrator and Sprinkler Contractor on various dates concluding on January 27, 2014. There were no areas identified as needing additional sprinkler heads.

Criteria 3

All rooms were inspected by the Director of Maintenance, Director of Environmental Services, Administrator and Sprinkler Contractor on various dates concluding on January 27, 2014. The Sprinkler Contractor has deemed the entire system to meet Life Safety Code.

Criteria 4

The facility will maintain a contracted company to complete inspections of the facility's fire suppression and detections systems as per the life safety code. The contracted company will produce reports to the Administrator and/or Director of Maintenance in accordance with the different time frames set forth in the code. Any identified issues will be corrected immediately.

Any modifications to the fire suppression system will be overseen by the Director of Maintenance with approval by the facility Administrator.

Date completed - February 7, 2014.

K070

Criteria 1

All Staff with Offices were notified by the Administrator on January 30, 2014 that portable space heaters must be removed from the facility.

Criteria 2

The Director of Environmental Services will inspect all offices on or before February 7, 2014 to ensure that no space heaters remain.

Criteria 3

The Administrator (re)educated all Department Heads on January 30, 2013 related to elimination of space heaters from the facility.

Criteria 4

The Director of Environmental Services and Safety will periodically check all offices for appliances that do not meet the life safety code. Any identified items will be removed immediately and reported to the Administrator

Date of compliance February 7, 2014.

K147

Criteria 1

The exposed electrical wiring in the Medical supply storage area in the basement level office was secured in a junction box by the Maintenance Staff on January 14, 2014. The blow dryer plugged into an outlet with a door closed on the cord was immediately removed from service by the Administrator on January 14, 2014.

Criteria 2

The Director of Maintenance inspected all rooms for exposed wiring and damaged cords on 01/20/14. No other exposed wires or damaged cords were found.

Criteria 3

The Administrator discussed with all department heads the life safety code related to exposed wiring and damaged electrical cords on January 20, 2014. The Director of Nursing placed signage in the shower rooms advising staff not to run appliance cords through the doors to the storage area.

The Administrator has ordered hotel style, wall mounted hair dryers for the shower rooms to be installed upon arrival.

Criteria 4

All patient care areas in the facility have an individual assigned to conduct quality rounds twice monthly, with identified issues corrected immediately and/or addressed through the QI Program as needed. The QI Nurse oversees this program. The QI Nurse was instructed by the Administrator on January 30, to expand this program to include storage areas and offices beginning February 1, 2014.

Date completed February 7, 2014.