

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

**R E C E I V E D**

PRINTED: 12/15/2011  
FORM APPROVED  
OMB NO. 0938-0391

DEC 15 2011

Division of Health Care  
Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/23/2011
NAME OF PROVIDER OR SUPPLIER  SOMERSET NURSING AND REHABILITATION FACILITY		STREET ADDRESS 106 GOVER STREET, P O BOX 1121 SOMERSET, KY 42502	

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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated standard survey (KY17195) was conducted on 11/22-23/11. The allegation was substantiated. Deficient practice was identified at 'G' level, with an opportunity to correct.</p>	F 000	<p>Somerset Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.</p>	
F 157 SS=G	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Somerset Nursing &amp; Rehabilitation reserves all rights to contest the survey findings through the informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Somerset Nursing and Rehabilitation reserves all rights to raise possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Somerset Nursing and Rehabilitation does not waive, and reserves the right to asset in any administrative, civil or criminal claim, action or proceeding. Somerset Nursing and Rehabilitation offers its response, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents.</p> <p>Somerset Nursing and Rehabilitation strives to provide the highest quality care while ensuring the rights and safety of all residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Guth Nelson, Administrator TITLE: \_\_\_\_\_ (X5) DATE: 12-15-11

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

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F 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on interview, record review, accident/incident report review, and a review of the facility's Changes in Resident's Condition or Status policy/procedure it was determined the facility failed to ensure the resident's physician was notified of a significant change in condition for one of three sampled residents (Resident #1). Resident #1 experienced a non-witnessed fall on 09/21/11 and was assessed by the facility at 4:05 AM to have sustained no injuries. However, on 09/21/11, at 10:00 AM, the facility assessed the resident and noted the resident had a dark purple/red discoloration to the right hand/lower arm area and the resident also complained of pain. The facility failed to notify Resident #1's physician of the change in the resident's condition. Documented assessments revealed Resident #1, continued to have discoloration, edema, and pain to the right upper extremity and was diagnosed on 09/27/11 by an orthopedic surgeon to have a right distal radius fracture. (Refer to F309.)  The findings include:  A review of the facility's Changes In A Resident's Condition or Status policy/procedure (dated 01/09/03) revealed Nursing Services would notify the resident's attending physician when the resident was involved in an accident or incident that involved injury, when the resident experienced a significant change in physical status, or when there was a need to significantly alter the resident's treatment.	F 157	F157 483.10(b)(11) NOTIFYING OF CHANGES  It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to immediately inform the resident, consult with the residents physician; and if known, notify the residents legal representative or interested family member when there is an incident or change of status that.  1. Resident # 1 is no longer a resident of this facility. 2. All residents with acute medical issues that could represent a change of status have been reviewed for proper notification. All incidents and their subsequent reports have been reviewed from the previous 30 days to determine if any other residents had issues that had not been addressed through the notification process required in F157. These reviews were done by the DON and RN House Supervisor. 3. The nursing model of this facility is being changed to implement Unit Coordinators over all 3 nursing units. This will provide unit based leadership with a more locus of control. All licensed staff have been educated 12/1/11, on this nursing model and F157 requirements of notification.	

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F 157	<p>Continued From page 2</p> <p>The facility admitted Resident #1 to the facility on 08/01/11. Documentation revealed the resident had fallen at home and sustained fractures to the left humerus and femur that required surgical intervention.</p> <p>A review of the admission Minimum Data Set (MDS) assessment dated 08/13/11, revealed the facility had assessed the resident to be cognitively impaired and to be at risk for falls. Resident #1's Comprehensive Care Plan dated 8/15/11 revealed the facility assessed the resident to have a potential for alteration in comfort related to the resident's history of falls and fractures.</p> <p>A review of an Accident/Incident report dated 09/20/11, at 4:05 AM, revealed Resident #1 was found on the floor after an apparent fall. Documentation revealed facility staff assessed the resident and noted the resident had sustained no injuries. A review of the incident report and nurse's notes dated 09/20/11, at 8:00 AM, indicated Resident #1's physician was contacted by telephone and notified of the resident's "no injury fall."</p> <p>A review of documentation in the nurse's notes revealed on 09/21/11, at 10:00 AM, Resident #1 complained of pain to the right hand/lower arm, was "guarding" the area, and the resident's right hand/wrist was "dark purple/red" in color. However the facility failed to notify Resident #1's physician of the assessment or the resident's complaints of pain. Continued review of the medical record revealed on 09/21/11, at 9:00 PM, Resident #1 complained of pain in his/her right</p>	F 157	<p>4. Unit Coordinators will evaluate all incident reports on a daily basis that occur on their unit Monday through Friday. Manager on Duty will review on weekends. An audit for proper notification of the resident/physician/responsible party will be done at that time. Correction and reinforcement of the process will occur at the time of the audit when any deficient practice is observed. In addition, these incident reports will be brought to the morning meeting for review by the interdisciplinary team.</p> <p>5. December 19, 2011</p>		

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F 157	<p>Continued From page 3</p> <p>hand/wrist when he/she attempted to make a fist. In addition, documentation revealed the resident's right hand/wrist was edematous and discolored.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 11/22/11, at 4:55 PM, revealed she had been assigned to provide care to Resident #1 on 09/21/11. According to the LPN, Resident #1 complained of pain to his/her right hand/wrist area on 09/21/11 and the resident's right hand/wrist was edematous and discolored. LPN #1 stated Resident #1 had not previously complained of pain in the right hand/wrist and acknowledged the resident had experienced a change in condition. However, LPN #1 stated Resident #1 could "move" his/her right hand/wrist "fine" and could "pick stuff up" therefore she did not notify the resident's physician of the change in the resident's condition at that time. According to LPN #1, Resident #1 had a follow-up appointment scheduled on 09/22/11 with the orthopedic surgeon who had treated and surgically repaired the resident's left humerus and femur fractures, and assumed the surgeon would evaluate the right hand/wrist area at that time. In addition, LPN #1 stated she notified the Director of Nursing (DON) of Resident #1's complaints of pain and the discolored area to his/her hand/wrist (unable to state date and time).</p> <p>Documentation in the medical record on 09/22/11, at 8:00 AM, and interview conducted with LPN #2 on 11/22/11, at 5:35 PM, revealed Resident #1 complained of pain and guarded the right extremity, and the right extremity was noted to be edematous. Based on documentation, the resident had a follow-up appointment that day (09/22/11) with the orthopedic surgeon and the</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>surgeon would evaluate the resident's right arm. However, nurse's notes dated 09/22/11, at 2:00 PM, revealed Resident #1 had been transported to the follow-up appointment with the orthopedic surgeon but the appointment had been rescheduled for 09/27/11, and the resident was not assessed by the physician. LPN #2 stated she was aware Resident #1 had not received an evaluation or treatment of the right hand/wrist when the resident returned to the facility, but since the resident had "good range of motion" and could move the extremity she "did not think it was an emergency," and Resident #1 could wait until the appointment on 09/27/11 to have the right hand/lower arm evaluated.</p> <p>Documentation on 9/22/11, at 9:00 PM, in the resident's medical record revealed LPN #3 had noted Resident #1's right extremity was discolored, the resident complained of pain to the right extremity, and the LPN administered pain medication to the resident. Interview with LPN #3 on 11/22/11, at 6:30 PM, revealed he "assumed the doctor had been notified" and was aware of the area on Resident #1's right wrist/arm, and took no further action.</p> <p>Further review of documentation revealed entries on 09/23/11, 09/24/11, 09/25/11, 09/26/11, and 09/27/11, that Resident #1 had continued to have edema, discoloration, and complaints of pain to his/her right hand/wrist, however, the facility staff failed to notify the physician of the resident's change in condition.</p> <p>The DON confirmed in interview on 11/22/11, at 5:00 PM, that she was notified of the area on Resident #1's right hand/wrist (unable to state</p>	F 157			

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F 157	Continued From page 5 date or time) and had "looked" at the area. The DON stated when she observed Resident #1's right hand/wrist, the area was discolored and edematous, but because the resident was walking in the hallway with the use of a walker, and since the resident was not complaining of pain, she did not feel further intervention was warranted. The DON stated she was unaware Resident #1 had complained of pain on several other occasions. However, after a review of the assessment in the resident's medical record conducted on 09/21/11, at 10:00 AM, by facility staff, the DON stated Resident #1's physician "should have been called" at that time.  An interview was conducted on 11/23/11, at 9:20 AM, with Resident #1's attending physician. The physician confirmed he had been notified on 09/20/11 that Resident #1 had fallen and reportedly had not sustained an injury. However, the physician stated he had not been notified that Resident #1's hand/arm had been edematous or discolored, or that the resident had complained of pain. The physician stated he should "absolutely" have been notified of the change in Resident #1's condition so appropriate evaluation and treatment could have been performed timely.  A review of documentation from Resident #1's office visit on 09/27/11 and interview with the orthopedic surgeon on 11/23/11, at 11:00 AM, revealed Resident #1 complained of right wrist pain during the follow-up appointment with the orthopedic surgeon on 09/27/11, and subsequent x-rays obtained on 09/27/11 revealed the resident had a minimally displaced radius fracture of the right extremity.	F 157		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to provide quality care and services for the resident's highest well being.	

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F 309 SS=G	<p>Continued From page 6 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, accident/incident report review, a review of facility policies, and documentation received from a physician's office, it was determined the facility failed to ensure necessary care and services were provided for one of three sampled residents (Resident #1) in order to maintain the resident's physical well-being. Resident #1 sustained a fall on 09/20/11 and was assessed by the facility to have no injuries. However, from 09/21/11 through 09/27/11, Resident #1 complained of pain to the right hand/wrist and/or was assessed by the facility to have dark purple/red discoloration to the area. The facility failed to seek further evaluation or treatment for the resident's right hand/wrist and on 09/27/11, six days after the onset of pain and the assessment of edema and discoloration to Resident #1's right hand/wrist, the resident was diagnosed with a right distal radius fracture. (Refer to F157.)</p> <p>The findings include:</p> <p>A review of the facility's Falls Follow Up Protocol (undated) revealed each resident who</p>	F 309	<ol style="list-style-type: none"> <li>1. Resident # 1 is no longer a resident of this facility.</li> <li>2. All residents with acute medical conditions or recent incidents have been reviewed by the DON and Quality Assurance Nurse to ensure that no subsequent services needed to be provided.</li> <li>3. The nursing model of this facility is being changed to implement Unit Coordinators over all 3 nursing units. This will provide unit based leadership with a more locus of control. Residents who have a change of condition that may indicate further services will be placed on the acute charting log and followed up daily for such an assessment of services by the Unit Coordinator.</li> <li>4. Physician orders, shift report and acute charting logs will be reviewed daily by the nurse management team(DON, Unit Coordinators, MDS Coordinators) following morning meeting to review for any subsequent need of services that may not have been identified previously. Managers on Duty will review on the weekends.</li> <li>5. December 19, 2011.</li> </ol>	

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F 309	<p>Continued From page 7</p> <p>experienced a fall would be assessed for complications from the fall for 24 hours, with the findings documented in the medical record. However, the protocol did not direct staff on what actions were to be taken if an abnormal finding or complication was found.</p> <p>The facility admitted Resident #1 on 08/01/11, after the resident had sustained a severe fall at home, was hospitalized, and underwent surgery for a fractured left humerus and left femur.</p> <p>A review of Resident #1's admission Minimum Data Set (MDS) assessment dated 08/13/11 revealed the facility assessed the resident to be cognitively impaired and at risk for falls. A review of Resident #1's Comprehensive Care Plan dated 08/15/11 revealed the facility assessed the resident to have a potential for alteration in comfort related to the resident's history of falls and fractures.</p> <p>A review of Nursing Notes and an Accident/Incident Report, both dated 09/20/11, revealed on 09/20/11, at 4:05 AM, staff observed Resident #1 on the floor in the hallway as a result of an apparent fall. The facility assessed Resident #1 to have no injuries as a result of the apparent fall.</p> <p>An interview on 11/22/11, at 4:55 PM, with Licensed Practical Nurse (LPN) #1 and review of documentation in Resident #1's record dated 09/21/11, at 10:00 AM, revealed facility staff noted Resident #1's right hand/wrist had a dark purple/red discoloration and the resident complained of pain when the area was touched. LPN #1 stated prior to this time Resident #1 had</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>not complained of pain nor had edema or discoloration to the right extremity and therefore had not exhibited a change in condition. The LPN stated she was aware the resident had sustained a fall on 09/20/11 and had notified the Director of Nursing (DON) (unable to recall date and time) of the discoloration, edema, and the resident's complaints of pain to the right hand/wrist. Based on an assessment on 09/21/11, at 9:00 PM, Resident #1 continued to have edema and discoloration of the right hand/wrist and complained of pain when he/she attempted to make a fist.</p> <p>Continued review of documentation and an interview conducted with LPN #2 on 11/22/11, at 5:35 PM, revealed on 09/22/11, at 8:00 AM, Resident #1 had edema, complained of pain, and guarded the right extremity. The entry also revealed the resident had a follow-up appointment that day (09/22/11) with the orthopedic surgeon and the surgeon would evaluate the resident's right arm at that time. However, documentation revealed the resident was transported to the physician's appointment but the physician was unable to assess the resident and the appointment was rescheduled for 09/27/11. Continued interview with LPN #2 revealed she was aware when Resident #1 returned to the facility on 09/22/11 and that the resident had received no evaluation or treatment of the right extremity. However, LPN #2 stated that due to the resident's ability to move the extremity with "good range of motion" she "did not think it was an emergency." Per interview she thought Resident #1 could wait to have the right extremity evaluated by the orthopedic surgeon on 09/27/11, six days after resident #1 started</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>complaining of pain and edema and discoloration was noted to the resident's right hand/wrist.</p> <p>In addition, documentation on 09/22/11, at 9:00 PM, revealed LPN #3 noted Resident #1 had discoloration of the right extremity, complained of pain, and pain medication was administered. Interview with LPN #3 on 11/22/11, at 6:30 PM, revealed he "assumed the doctor had been notified" and was aware of the area on Resident #1's right wrist/arm, and the LPN took no further action.</p> <p>Review of the nurse's notes revealed entries on 09/23/11, at 8:30 AM, of edema, purple discoloration to the extremity, and complaints of pain, and at 8:00 PM, of discoloration. Further review of Resident #1's nurse's notes revealed entries on 09/24/11, 09/25/11, 09/26/11, and 09/27/11, which continued to describe the edema and discoloration of the resident's right hand/wrist.</p> <p>An interview with the DON on 11/22/11, at 5:00 PM, revealed she had been notified of the area on Resident #1's right hand/wrist and had "looked" at the area, however, the DON was unable to recall the date or time. The DON stated because Resident #1 was able to move his/her right extremity, utilize a walker by grasping/holding onto it, and had not complained of pain, "nothing alerted me that anything else needed to be done." However, after a review of documentation in Resident #1's record the DON stated she was unaware the resident had complained of pain to the right hand/wrist prior to reviewing the documentation.</p>	F 309			

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

PRINTED: 12/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185218</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/23/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOMERSET NURSING AND REHABILITATION FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>106 GOVER STREET, P O BOX 1121 SOMERSET, KY 42502</b>		
(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 309	<p>Continued From page 10</p> <p>An interview with Resident #1's attending physician on 11/23/11, at 9:00 AM, revealed he should have been notified of Resident #1's change in condition so evaluation and treatment could have been provided timely.</p> <p>A review of nurse's notes dated 09/27/11, at 12:30 PM, revealed Resident #1 was transported to the orthopedic surgeon's appointment for the follow-up visit related to the prior left-sided fractures. A review of documentation from the physician's office revealed Resident #1 complained of right wrist pain during the evaluation, and subsequent x-rays obtained on 09/27/11 revealed the resident had a minimally displaced radius fracture of the right extremity.</p>	F 309			