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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED MAY 4 2012 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185218		04/12/2012

NAME OF PROVIDER OR SUPPLIER: SOMERSET NURSING AND REHABILITATION FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 106 GOVER STREET, P O BOX 1121, SOMERSET, KY 42502

(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 A standard health survey was conducted on 04/10-12/12. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	Somerset Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and a review of the facility's Restraint policy, the facility failed to ensure one of twenty-three sampled residents was free from physical restraints (Resident #7). Resident #7 was observed to be in a wheelchair with a safety belt during the survey conducted on 04/10-12/12. Resident #7 was also assessed to require full bilateral side rails while the resident was in bed. There was no evidence the facility had identified the presence of a medical symptom for Resident #7 that required the use of full side rails and safety belt as a physical restraint. In addition, the facility failed to evaluate the use of the bed rails and safety belt in a systematic process of evaluation to attempt to reduce or eliminate the use of the safety belt and full side rails for the resident. The findings include: A review of the facility's Restraint policy (dated 01/09/03) revealed physical restraints were to be	F 221	Somerset Nursing & 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. Somerset Nursing and Rehabilitation strives to provide the highest quality care while ensuring the rights and safety of all residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Davis, Administrator | TITLE | (X6) DATE: 5/4/12

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 221	Continued From page 1 used after alternatives had been tried unsuccessfully. The policy stated physician's orders would indicate the specific reason for the device and the need for the restraints would be re-evaluated at least quarterly to determine their continued need. The policy/procedure noted "every effort will be made to eliminate their use." The policy failed to include a definition for a restraint. A review of the medical record revealed Resident #7 was admitted to the facility on 10/05/05, with diagnoses including Senile Dementia, Hypertension, Cerebrovascular Disease, Osteoarthritis, Macular Degeneration, and Arthropathy. A review of the annual comprehensive Minimum Data Set (MDS) assessment with a reference date of 02/07/12, revealed Resident #7 was assessed to require extensive assistance of one staff person for bed mobility and toileting. The resident was assessed to require limited assistance of one staff person for transfers and ambulation. The resident was assessed to require side rails and a chair to prevent rising, both of which were coded as a restraint device. Resident #7 was assessed to have had no falls since the prior assessment dated 11/15/11. A review of the Care Area Assessment (CAA) Summary for restraints dated 02/08/12, revealed the resident had a history of falls and attempting to self-transfer and ambulate without help. The CAA noted Resident #7 would frequently ask residents/visitors to remove the belt restraint. The CAA further stated restraint reduction and physical therapy (PT) screening would be conducted quarterly and as needed. Review of the comprehensive care plan for	F 221	F221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation for physical restraints to be used after other alternatives have been tried unsuccessfully, for physician's orders to indicate the specific reasons for the device. The needs for the restraints are re-evaluated at least quarterly to determine their continued need and every effort is made to eliminate their use. 1. Resident # 7 is currently on a restraint reduction trial. On 5/2/12 a physician's order was received indicating the specific medical reasons for her devices. 2. All other residents with physical restraints were reviewed to determine if they were appropriate candidates for a restraint reduction/elimination. These reviews were done by the Unit Coordinators. This was completed on 4/30/12. 3. Administrator and DON provided Unit Coordinators re-education on the process of referring a resident with a physical restraint to therapy if their assessment reveals that the resident is a candidate for a reduction/elimination. This occurred on 5/3/12.	

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F 221	Continued From page 2 Resident #7 revealed the facility had developed a restraint plan of care to include the use of the seat belt and side rails. Interventions included releasing the restraint every two hours and performing range of motion (ROM) exercises, keeping the call light in reach, and conducting PT screening quarterly. A review of the current physician's orders dated April 2012 revealed a seat belt was to be used when the resident was in a wheelchair for positioning and safety and bilateral full side rails were to be used to assist the resident with bed mobility, positioning, and to define bed parameters. However, there was no evidence the facility had determined the presence of a specific medical symptom that would require the use of these restraint devices. A review of the Physical Restraint Evaluation conducted on 06/01/10, revealed Resident #7 had a history of falls, osteoarthritis, and dementia. The assessment noted the seat belt and side rails were to be considered as restraint devices for the resident and were to be used to protect the resident from falls. A review of the fall record for Resident #7 revealed the resident had sustained two falls from 03/23/11 to 02/22/12 (a timeframe of eleven months), when the resident attempted to self-transfer. Review of the Physical Restraint Elimination Assessment revealed the seat belt and side rails had been reviewed on 08/30/11, 11/12/11, and 02/07/12. On both of these assessments, the resident's score for restraint reduction was noted to be "14" which indicated the resident was a "priority candidate" for restraint reduction.	F 221	4. Unit Coordinators will assess all residents with physical restraints quarterly to determine if the resident is a candidate for a restraint reduction/elimination and make the appropriate referrals to therapy in order for a restraint reduction attempt to be conducted. This will be an on-going measure. 5. May 6, 2012	

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F 221	Continued From page 3 However, there was no evidence the facility had attempted restraint alternatives, restraint free periods, or a reduction since 04/02/11. Resident #7 was observed on 04/10/12, at 2:30 PM, to be sitting in a wheelchair in the doorway of another resident's room. A seat belt attached to the chair was observed to be around the resident's waist and a chair alarm was also noted to be attached to the wheelchair. Resident #7 stated, "I don't know why that is there; they just put it there." On 04/10/12, at 5:25 PM, the resident was observed to be in the wheelchair with the seat belt and chair alarm in place while eating dinner in the facility dining room. The seat belt remained in place during the meal. Resident #7 was again observed on 04/11/12, at 9:35 AM and at 10:50 AM, sitting in a wheelchair with the seat belt in place. During the noon meal on 04/11/12, at 12:15 PM, the resident was observed to consume the meal while sitting in a wheelchair with the seat belt in place. Resident #7 was again observed to be in the wheelchair with the seat belt and chair alarm in use on 04/12/12, at 8:30 AM and 9:35 AM. There were no opportunities for observations of Resident #7 while in the bed; however, full side rails were observed to be in place on the resident's bed during the survey conducted on 04/10/12 through 04/12/12. An interview conducted with Certified Nursing Assistant (CNA) #2 on 04/11/12, at 4:10 PM, revealed Resident #7 required the use of the safety belt and side rails due to a fall risk. The CNA stated she had provided care for Resident #7 for two years and both the safety belt and side rails had been used. CNA #2 stated the resident	F 221		

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F 221	Continued From page 4 reportedly would try to get up, unassisted, without the use of the belt and side rails, but she had not observed the resident making these attempts. An interview conducted with CNA #3 04/12/12, at 10:35 PM, revealed the CNA had been providing care for Resident #7 for approximately three years and the resident had the full side rails and seat belt restraints during that time. CNA #3 stated she had observed the resident attempt to climb out at the foot of the bed unassisted and believed the devices were to keep the resident from falling. CNA #3 stated she could not recall any other alternatives being attempted for Resident #7. Interviews conducted with Restorative Aides (RAs) #1 and #2 on 04/12/12, at 10:10 AM, revealed the RAs were assigned to work in the dining room during meals. The RAs stated restraint devices were to be removed from the residents during meal times and stated staff must have forgotten to remove the seat belt from Resident #7 during meal times. An interview conducted with the Occupational Therapist (OT) on 04/12/12, at 10:15 AM, revealed residents were screened on a quarterly basis to determine if the resident had any significant changes that required a therapy service. The OT stated an evaluation of the restraint was not included as part of the quarterly screening. The OT stated restraint reduction had been attempted for the seat belt for Resident #7 in April 2011, but no further attempts had been tried. The OT was not aware of any attempts to reduce/eliminate the use of the full side rails for Resident #7. The OT further stated she was not	F 221		

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F 221	Continued From page 5 familiar with the Restraint Elimination Assessment completed by the nursing staff. Interview conducted with the Unit Manager (UM) on 04/12/12, at 10:50 AM, revealed the UM had conducted the Restraint Elimination Assessment for Resident #7 on 02/07/12, and had determined the resident was appropriate for restraint reduction. The UM stated when this determination was made a referral was required to be made for Therapy to evaluate; however, the UM stated she did not know if she was responsible to make the referral. The UM stated she had been at the facility since February 2011 and full side rails and a safety belt had been utilized for Resident #7 since that time. An interview conducted with the Infection Control/Quality Assurance (QA) Coordinator on 04/12/12, at 3:35 PM, revealed she had conducted the Restraint Elimination Assessments for Resident #7 on 08/30/11 and on 11/12/11. The QA Coordinator stated the resident's score indicated Resident #7 was a candidate for reduction; however, no further attempts for restraint reduction/elimination had been conducted for Resident #7 after April 2011. Interview conducted with the Director of Nurses (DON) on 04/12/12, at 6:50 PM, revealed a restraint elimination assessment was required to be completed quarterly for residents who needed a restraint device. The DON stated if the assessment revealed the resident was a candidate for reduction/elimination a referral to Therapy was required and restraint reduction attempts were to be conducted. The DON stated the facility failed to appropriately attempt to	F 221		

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F 221	Continued From page 6 reduce/eliminate the use of the seat belt and full side rails for Resident #7.	F 221		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and review of facility policy, it was determined the facility failed to ensure that it was free of medication error rates of five percent or greater. A total of forty opportunities were observed with three medication errors, which affected two unsampled residents (Residents A and B). The facility's medication error rate was five percent. The findings include: Review of the facility policy for Administration of Inhaled Medications (no date) revealed if a second puff of the same medication was prescribed the nurse was required to wait at least one minute between puffs. The review of the policy also revealed the resident would be directed to "rinse and spit" after steroidal inhalants were administered to remove residue from the resident's mouth. Observations of a medication administration on 04/10/12, at 3:15 PM, revealed Certified Medication Technician (CMT) #1 administered one puff of a steroidal inhalant, Advair Diskus	F 332	F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to ensure that the facility is free of medication errors rates of five percent or greater. 1. No residents were adversely affected by the facility practice. 2. All CMTs have been re-educated on administering inhalers. 3. The Director of Nursing has re-educated all Certified Medication Technicians on offering/instructing residents to rinse and spit after a steroidal inhaler has been administered. The DON also re-educated the CMTs on instructing residents to wait at least one minute between puffs of the same inhaler medication. This was completed on 5/3/12. The Consultant Pharmacist will in-service all CMTs on 5/22/12 regarding instructions on administration of inhalers and provide them with training materials, as well as provide the material to new hires.	

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F 332	Continued From page 7 (bronchodilator) 250-50 mcq to Resident A. However, the CMT failed to offer/instruct the resident to rinse and spit after the steroidal inhaler had been administered. A review of Resident A's Medication Administration Record (MAR) for April 2012 revealed directions were provided to rinse the resident's mouth after administering the Advair inhaler. CMT #1 was also observed during the 04/10/12 medication pass to administer two puffs of a steroidal inhaler, Symbicort inhaler (anti-inflammatory steroid) 80-4.5 mcq to Resident #B. The resident was observed to self-administer two puffs of the inhaler medication while the CMT watched. However, the CMT failed to instruct Resident B to wait for at least one minute between puffs and failed to instruct the resident to rinse and spit after the steroid inhaler was administered. A review of Resident B's Medication Administration Record (MAR) for April 2012 revealed directions were provided to rinse the resident's mouth after administering the Symbicort to Resident B. Interview with CMT #1 on 04/10/12, at 3:45 PM, revealed the CMT believed staff was required to wait ten seconds between puffs of an inhaler medication. The CMT stated she had been instructed to ensure the residents rinsed their mouth after an inhaler medication was administered, but was used to the resident self-administering the medication and failed to offer instruction or direction to Residents A and B. Interview conducted with the Consultant Pharmacist on 04/12/12, at 1:15 PM, revealed when two puffs of the same medication were	F 332	4. The DON and Unit Coordinators will monitor medication passes on all CMTs who administer inhaler medications at least one time a month for the next six months to ensure the facility is free of medication error rates of five percent or greater. In addition, for the next six months the pharmacy will do med pass audits at least monthly with CMTs and with any new CMTs within the first month of employment. 5. May 23, 2012.	

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F 332	Continued From page 8 administered staff should wait one minute between puffs. The Pharmacist stated staff was required to rinse the resident's mouth after an inhaler was administered to remove residue. The Pharmacist further stated she had provided a staff in-service regarding instructions for administration of inhalers. Interview with the Director of Nurses (DON) on 04/12/12, at 6:50 PM, confirmed staff was required to wait for one minute between puffs of the same inhaler and to rinse the resident's mouth after an inhaler was administered. The DON stated all staff responsible for medication administration had received direction for proper administration of inhalers during an in-service on 03/21/12. The DON stated all staff had a post-test after the in-service. The DON further stated CMA #1 had attended the in-service.	F 332		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	F334 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation for residents to be counseled on the risks of influenza, efficacy, side effects and contraindications of the immunizations and the resident's consent or declination is to be documented. If the resident gives consent for the influenza vaccine, a physician's order is obtained and the vaccine is administered. In addition, upon admission or at a resident's request the resident's pneumococcal immunization status is assessed. Residents are counseled on the risks of pneumococcal disease	

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F 334	Continued From page 9 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	F 334	and informed of the recommendations of the CDC prior to administration of the vaccine. If consent is given for the pneumococcal vaccine, a physician's order is obtained and the vaccine is administered. 1. Resident # 4 will be offered an influenza immunization for the 2012 influenza season as determined by CDC guidelines, and each year thereafter. Resident # 20 received the pneumococcal immunization on 4/17/12, and Resident #21 is no longer a resident. 2. All residents will be offered an influenza immunization for the 2012 influenza season, as determined by CDC guidelines, and each year thereafter. The Unit Coordinators completed an audit on of all resident's charts to determine that the pneumococcal vaccine was administered to all residents who had signed consent forms to receive the pneumococcal vaccine. This was completed on 4/17/12.	

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F 334	Continued From page 10 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of facility policy/procedure it was determined the facility failed to ensure influenza and pneumococcal vaccines were offered/provided to residents. One of twenty-three sampled residents (Resident #4) had no evidence the influenza vaccine had been offered and/or administered. Two of twenty-three sampled residents (Residents #20 and #21) had signed consent forms to receive the pneumococcal vaccine but there was no documented evidence the vaccine had been administered. The findings include: A review of the facility policy/procedure entitled Immunization Against Influenza (not dated) revealed residents were to be counseled on the risks of influenza, efficacy, side effects and contraindications of the immunizations and the resident's consent or declination was to be documented. If the resident gives consent for the influenza vaccine, a physician's order is obtained and the vaccine is administered. The Centers for Disease Control (CDC) guidelines are used to determine the influenza season. A review of the facility policy/procedure entitled Immunization	F 334	3. The DON as well as the Unit Coordinators will complete chart audits at least one time a month for the next twelve months to ensure the facility is in compliance with influenza and pneumococcal vaccinations. In addition, the MARs will include the due dates for influenza and pneumococcal vaccinations. 4. As part of the ongoing CQI program, these areas will be monitored by the DON to ensure that influenza and pneumococcal vaccinations are up to date. This will be reported at least one time a quarter as a part of our CQI process. 5. May 6, 2012	

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SOMERSET NURSING AND REHABILITATION FACILITY	106 GOVER STREET, P O BOX 1121 SOMERSET, KY 42502

(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 334	Continued From page 11 Against Pneumococcal Disease (not dated) revealed upon admission or at a resident's request the resident's pneumococcal immunization status will be assessed. Residents will then be counseled on the risks of pneumococcal disease and informed of the recommendations of the CDC prior to administration of the vaccine. If consent is given for the pneumococcal vaccine, a physician's order is obtained and the vaccine is administered. 1. Review of the medical record of Resident #4 revealed the facility admitted the resident on 01/25/11, with diagnoses of Arthropathy, Dysphagia, Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, and Dementia. Further review of the medical record revealed the resident had refused the influenza vaccine when admitted in January 2011. There was no evidence the resident had been offered/received the influenza vaccine during the fall of 2011. Interview on 04/12/12, at 5:21 PM, with Registered Nurse (RN) #1 revealed Resident #4 was offered and refused the influenza vaccine three times in the fall of 2011. However, RN #1 was unable to show evidence of the resident's refusal or that the risk and benefits of the vaccine were explained. Interview on 04/12/12, at 6:08 PM, with the Director of Nursing (DON) revealed "staff probably thought" the resident's refusal for consent of the influenza vaccine obtained in January 2011 could be used for the fall 2011 flu season and had not offered the resident the influenza vaccine.	F 334		

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NAME OF PROVIDER OR SUPPLIER: SOMERSET NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE: 106 GOVER STREET, P O BOX 1121 SOMERSET, KY 42502	

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F 334	Continued From page 12 2. Review of the medical record of Resident #21 revealed the facility admitted the resident on 12/20/11, with diagnoses of Dementia, Diabetes Mellitus Type 2, Parkinson's, Hypertension, Coronary Artery Disease, and Degenerative Disc Disease. Further review of the medical record revealed the resident had signed consent to receive the pneumococcal vaccine on 12/20/11. There was no evidence the pneumococcal vaccine had been administered to Resident #21. Interview on 04/12/12, at 6:08 PM, with the DON revealed staff was to assess a resident's immunization status at the time of admission and acknowledged pneumococcal immunizations had been missed due to the failure of staff to follow up on the status of the resident's immunizations. The interview also revealed the facility had worked on a new system for monitoring the administration of the pneumococcal vaccine to ensure all residents were offered and/or received the vaccine for approximately two months. 3. A review of the medical record revealed the facility admitted Resident #20 on 09/14/11, with diagnoses to include Coronary Artery Disease, Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, and Mitral Regurgitation. A review of the Resident Acknowledgment of Influenza Training and Vaccination Decision form revealed consent had been obtained on 09/14/11, for Resident #20 to receive the pneumococcal vaccination. However, a review of the immunization record revealed no evidence the vaccine had been administered to Resident #20. An interview conducted with Quality Assurance Coordinator (QAC) on 04/12/12, at 6:50 PM,	F 334		

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F 334	Continued From page 13 revealed the QAC was responsible to ensure vaccinations were administered by the nursing staff. The QAC stated she was responsible to verbally instruct the nurses regarding consent for the pneumococcal vaccine. The QAC further stated she was responsible to conduct chart audits to monitor the immunization records; however, the QAC failed to identify the pneumococcal vaccine had not been administered to Resident #20. An interview conducted with the Director of Nurses (DON) on 04/12/12, at 7:00 PM, confirmed the QAC was responsible to inform the nursing staff when a vaccine was due to be administered and to conduct a chart audit at the end of each month to identify any concerns. The DON stated no problems had been reported to her concerning the pneumococcal vaccines.	F 334		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	F514 483.75 (l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to ensure that a resident's choice about advance directives be respected. The facility defines advanced directives as preferences regarding treatment options which include Do Not Resuscitate. 1. The nurse aide care plan for Resident # 10 now reflects that she is a DNR. This was corrected on 4/12/12. Those residents who have elected a full code	

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F 514	Continued From page 14 by: Based on facility interview, observation, record review, and a review of facility policy, it was determined the facility failed to maintain accurate clinical records for one of twenty-four sampled residents (Resident #10). The responsible party for Resident #10 signed the Do Not Resuscitate (DNR) order for the resident's code status on 03/09/12. The attending physician signed the DNR order on 04/03/12. However, the facility failed to document the change of the resident's code status to DNR in Resident #10's medical record. The findings include: A review of the Advance Directive policy revealed it was the policy of the facility to ensure that a resident's choice about advance directives be respected. The facility defined advance directives as preferences regarding treatment options which included Do Not Resuscitate. A review of the medical record for Resident #10 revealed the facility admitted the resident on 02/24/10, with diagnoses that included Myasthenia, Hypertension, Gastroesophageal Reflux Disease, Coronary Artery Disease, Degenerative Joint Disease, and Depression. A review of the advance directive form dated 02/24/10, revealed the responsible party for Resident #10 signed the consent form for the resident to be Full Code (provide resuscitative measures). A review of physician's progress notes in the medical record dated 03/08/12, revealed the physician had a conversation with the facility regarding the code status for Resident #10. A review of the DNR orders revealed the	F 514	status will have a heart on their name plate at the door. 2. All nurse aide care plans, doors, and charts are being reviewed by the Unit Coordinators to ensure that each resident's choice about advance directives is reflected and followed by staff. 3. The DON as well as the Unit Coordinators will audit all nurse aide care plans, name plates, and charts at least one time a month for the next twelve months to ensure the facility is in compliance. 4. As part of the ongoing CQI program, this area will be monitored at least one time a quarter by the DON to ensure that code status is accurate. This will be a continuous measure and reported on as part of our CQI process. 5. May 6, 2012	

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F 514	Continued From page 15 responsible party signed the consent form on 03/09/12 for Resident #10 to be DNR. A review of a nurse aide care plan developed by the nurse for Certified Nursing Assistants (CNAs) to use in the provision of care for Resident #10 revealed staff had noted in red print on the nurse aide care plan that Resident #10 was a "full code." Observation of Resident #10 at 2:30 PM on 04/10/12, revealed the resident was in bed sleeping with the call light within reach. An interview was conducted at 2:40 PM on 04/11/12, with CNA #1 and revealed the CNA had been assigned to provide care for Resident #10. The CNA stated "the orange dot on the door by a resident's name was the system the facility had in place to alert staff that a resident was "DNR." The CNA stated a resident's code status was also on the CNA care plan. The CNA further stated if a resident does not have an orange dot by their name on the door that would mean the resident was a Full Code. The CNA accompanied by the surveyor observed Resident #10's name on the door and noted there was not an orange dot by the resident's name. The CNA stated if there was not an orange dot by Resident #10's name, the resident was a Full Code. An interview was conducted at 8:35 AM on 04/12/12, with Registered Nurse (RN) #1 regarding Resident #10's code status. The RN stated if a resident was DNR an orange dot would be on the outside of the chart, on the door by the resident's name, and on the CNA care plan. RN #1 and the surveyor observed Resident #10's	F 514		

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F 514	Continued From page 16 name on the door and observed the outside of the medical record chart. However, there was not an orange dot on the door by Resident #10's name, nor was an orange dot on the outside of the medical record chart. RN #1 reviewed the CNA care plan. Full Code was stamped on the CNA care plan in red. The RN stated the code status for Resident #10 had recently been changed to DNR. However, the RN stated the code status on the door by the resident's name, the outside of the medical record chart, nor the CNA care plan had been changed to reflect Resident #10's current code status of DNR. An interview was conducted with the Director of Nursing (DON) at 5:30 PM on 04/12/12. The DON stated the system the facility had in place to identify residents that had a DNR order was an orange dot by a resident's name. The DON acknowledged the facility failed to follow through with identifying the change in Resident #10's code status to be DNR.	F 514		

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	185218	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/10/2012

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1988 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (000) SMOKE COMPARTMENTS: Six FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II propane generator A life safety code survey was initiated and concluded on 04/10/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

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

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