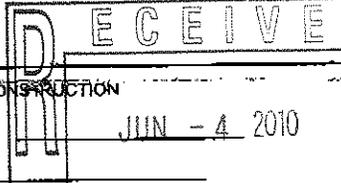


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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/22/2010
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NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Southern Enforcement Branch 106 GOVER STREET, P O BOX 1121 SOMERSET, KY 42502
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F 000	INITIAL COMMENTS A standard health survey was conducted on April 20-22, 2010. Deficient practice was identified with the highest scope and severity being at an "E" level. An abbreviated standard survey (KY14687 and KY14674) was also conducted at this time. Intake #KY14687 was unsubstantiated with no deficient practice identified; however, #KY14674 was substantiated with deficient practice identified related to Physical Environment.	F 000	Somerset Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	Somerset Nursing and 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 assert 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: Cynthia H. [Signature] TITLE: Administrator (X5) DATE: 6/4/10

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 1</p> <p>Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct an accurate comprehensive assessment for one (1) of twenty-eight (28) sampled residents (resident #11).</p> <p>The findings include:</p> <p>A review of resident #11's medical record revealed the resident was admitted to the facility on May 13, 2009, with diagnoses including Dementia, History of Colon Cancer, and Status Post Colostomy Placement.</p> <p>A review of resident #11's Minimum Data Set (MDS) assessments revealed a quarterly MDS assessment had been completed on November 25, 2009. The quarterly assessment indicated that resident #11 had fallen in the last 30 days and in the last 31 to 180 days. The assessment also revealed resident #11 weighed 88. pounds, and had experienced a significant weight gain.</p> <p>A review of resident #11's most recent MDS quarterly assessment dated February 10, 2010, revealed the assessment contained the same data that was included on the November 25, 2009 assessment to include that resident #11 had fallen in the last 30 days and in the last 31 to 180 days. The quarterly assessment dated February</p>	F 272	<p>F272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <ol style="list-style-type: none"> 1. Resident #11's assessments have been reviewed and revised for accuracy relating to her weight and history of falls by the interdisciplinary care plan team to ensure that all future MDS assessments will be correct. 2. All resident's assessments have been reviewed by the interdisciplinary care plan for accuracy. All residents' assessments will be reviewed and revised weekly by the interdisciplinary care plan team to ensure that accurate data is coded on the MDS quarterly, annually and as needed. 3. MDS nurses have been re-educated regarding coding criteria by the corporate 	

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F 272	<p>Continued From page 2</p> <p>10, 2010, also stated that resident #11's weight was 88 pounds, and the resident had experienced a significant weight gain. However, a review of resident #11's Weekly Weight Sheet dated 2010, and an interview on April 21, 2010, at 1:45 p.m., with the Registered Dietician (RD) revealed resident #11's weight on February 3, 2010, was 79 pounds and 78 pounds on February 11, 2010. Further review of a Falls Progress Note Summary from May 30, 2009 thru February 25, 2010, revealed resident #11's last fall at the facility occurred on November 23, 2009.</p> <p>An interview with the MDS Coordinator was conducted on April 21, 2010, at 2:40 p.m. The MDS Coordinator stated the information related to resident #11's weight and falls was incorrect on the February 11, 2010 assessment. The MDS Coordinator stated resident #11's weight should have been entered as 79 pounds on the assessment, which was a significant weight loss, and the resident should not have been coded to have sustained falls in the last 30 days on the February 11, 2010 assessment. The MDS Coordinator was unable to state why the assessment was inaccurate, and had been unaware of the error until brought to the facility's attention by the surveyor.</p>	F 272	<p>Director of Nursing will review all assessments scheduled for the week during the weekly care plan meeting to ensure the assessments accurately reflect the resident. This will be an on-going audit.</p> <p>4. The Director of Nursing will audit at least 10% of the resident charts monthly for the next six months to ensure the assessments are accurate. If assessments are found to be inaccurate a significant correction to prior assessments will be completed as directed by the RAI manual.</p> <p>5. May 28, 2010</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial</p>	F 279	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to assure that the results of assessments are used to develop, review, and revise the resident's comprehensive plan of care.</p> <p>1. Resident #4 and Resident #7's comprehensive care</p>	

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F 279	<p>Continued From page 3</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to utilize the results of the comprehensive assessment to develop individual comprehensive plans of care for two (2) of twenty-eight (28) sampled residents. Resident #4 and resident #7 were assessed to be at risk for dehydration related to the use of diuretics; however, the facility failed to develop a comprehensive care plan to address the residents' potential for dehydration.</p> <p>The findings include:</p> <p>1. Review of the medical record revealed resident #4 was admitted to the facility on March 11, 2009, with diagnoses of Muscle Weakness, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Atypical Psychosis.</p> <p>Review of the April 2010 monthly physician's orders revealed resident #4 required Lasix (a medication that removes excessive fluid from the body) 40 milligrams once daily. Review of the</p>	F 279	<p>plan has been reviewed and revised to include the risk for dehydration related to the use of diuretic treatment.</p> <p>2. All residents' comprehensive care plans have been reviewed and revised based on the resident's comprehensive assessments by the interdisciplinary care plan team to ensure that all risk areas to include but not be limited to risk for dehydration has been addressed on the comprehensive care plan.</p> <p>3. Weekly audits of all comprehensive care plans scheduled to be care planned that week will be performed by the Director of Nursing to ensure they are accurate and reflective of the care being provided. This audit will be on-going. An in-service was conducted with MDS staff on April 25, 2010 to reinforce that the care plan should reflect the care being provided to each resident by the corporate nurse consultant. An in-service was conducted with all licensed staff by the Director of Nursing on May 21, 2010, to reinforce the above.</p> <p>4. The Director of Nursing will audit at least 10% of resident charts monthly for six</p>	

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F 279	<p>Continued From page 4</p> <p>Resident Assessment Protocol Summary (RAPS) dated June 17, 2009, revealed resident #4 triggered for further assessment for dehydration/fluid maintenance due to the use of diuretics. Review of the RAP narrative revealed resident #4 had an estimated fluid need of 1400-1800 milliliters every day and the Dietary Manager (DM) recorded resident #4's average fluid intake exceeded the estimated daily fluid need (the resident averaged 2528 milliliters of fluid intake per day). The RAP indicated a care plan would be developed for resident #4's potential for dehydration/fluid maintenance.</p> <p>Review of the Comprehensive Care Plan for resident #4 revealed the facility failed to develop a care plan that addressed resident #4's potential for dehydration/fluid maintenance.</p> <p>Interview with the MDS Coordinator on April 22, 2010, at 2:20 p.m., revealed the MDS staff that was responsible for developing/revising residents' care plans failed to develop a care plan for resident #4 regarding the resident's potential for dehydration.</p> <p>2. Resident #7 was admitted to the facility on March 27, 2006, and had diagnoses including Diabetes Mellitus and Congestive Heart failure.</p> <p>A review of resident #7's most recent comprehensive MDS assessment dated February 17, 2010, revealed the resident had received a diuretic daily during the assessment period. A review of resident #7's RAP for dehydration/fluid maintenance dated February 17, 2010, revealed the resident received a routine daily diuretic, which placed resident #7 at an increased risk for dehydration. Additionally, the RAP revealed a</p>	F 279	<p>months to ensure all risk areas have been identified.</p> <p>5. May 28, 2010</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 5 care plan for the problem area was required and would be developed. However, a review of resident #7's comprehensive care plan with a review date of February 23, 2010, revealed the facility failed to develop a plan of care related to resident #7's increased risk for dehydration. Interview on April 22, 2010, at 1:50 p.m., with the DM revealed the DM was responsible for the nutrition and dehydration/fluid maintenance RAP narrative. The DM stated the DM attended the care plan meetings; however, the care plan was required to be developed by the staff responsible for the MDS. The DM stated any resident that required diuretics should have a care plan to address the potential for dehydration. Interview on April 22, 2010, at 2:20 p.m., with the MDS Coordinator revealed the MDS staff was responsible for developing and revising the residents' care plans. The MDS Coordinator stated residents that required diuretics should have a care plan developed to address the resident's potential for dehydration. Upon review of the comprehensive care plan for resident #7, the MDS Coordinator stated the MDS Coordinator had missed developing a care plan to address the resident's potential for dehydration.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS. The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility failed to provide services to residents that meet professional standards of quality. The	F 281	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to provide or arrange services that meet professional standards of quality.	

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F 281	<p>Continued From page 8</p> <p>facility failed to provide services as ordered by the resident's physician for two (2) of twenty-three (23) sampled residents. The facility failed to obtain laboratory blood work for resident #2 and failed to utilize Geri-leg protective coverings for resident #12 as ordered by the residents' physician.</p> <p>The findings include:</p> <p>1. A review of resident #2's medical record revealed the resident was admitted to the facility on February 11, 2010, with diagnoses of Alzheimer's Disease, Chronic B12 Deficiency, Chronic Anemia, Hypothyroidism, Diabetes, Chronic Respiratory Failure, and Chronic Obstructive Pulmonary Disease. Medical record review for resident #2 revealed the resident had admission physician's orders for laboratory blood work consisting of a Hemoglobin A1c (HGBA1c), a Complete Blood Count (CBC), a Comprehensive Metabolic Panel (CMP), a Thyroid Stimulating Hormone (TSH), and a Vitamin B12 to be obtained every three months. Review of resident #2's laboratory blood work results revealed the resident had a CBC and a TSH obtained on March 11, 2010. Further review of resident #2's record revealed a copy of hospital records which included a CBC dated February 7, 2010. There was no documentation in the medical record that additional laboratory results had been obtained for resident #2. After questioning facility staff concerning the missing laboratory blood work the facility obtained a copy of extra laboratory results from the resident's hospital stay prior to admission. The hospital documentation revealed resident #2 had a BMP and a Vitamin B12 level obtained on February 8, 2010; however, there was no evidence that a</p>	F 281	<ol style="list-style-type: none"> 1. All labs ordered for resident #2 have been obtained and results reported to physician. All treatment ordered for resident #12 has been accurately transcribed to the treatment record. 2. All residents' labs and Treatment records have been reviewed and audited for accuracy by Director of Nursing or Quality Assurance Nurse. 3. All licensed nursing staff were in-serviced on May 21, 2010, related to proper policy regarding lab draws and treatment regimens. All lab draw book is being utilized to track all ordered labs. 4. For the next six months, Medical Records will daily ensure that all labs have been drawn and reported to the physician. During the morning meeting all orders from the previous day are reviewed and ensure that treatments are transcribed to the treatment administration record. 5. May 28, 2010 	

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F 281	<p>Continued From page 7</p> <p>HGBA1c or a CMP had been obtained for resident #2 as ordered by the physician.</p> <p>An interview conducted on April 21, 2010, at 9:40 a.m., with station 1's Licensed Practical Nurse (LPN) revealed upon a resident's admission to the facility, the nursing staff transcribing the new admissions' physician's orders was required to complete a laboratory blood work requisition to have all laboratory blood work obtained the following day unless the physician specifically ordered that the labs be obtained on a specific date. The LPN stated the resident's laboratory blood work orders would then be documented in the laboratory blood work book for whatever timeframe the physician's orders specified, such as every three months. Further interview conducted on April 12, 2010, at 12:45 p.m., with the LPN revealed nursing staff may use the recent hospital laboratory blood work results for the resident and would not be required to obtain the initial baseline blood work. The LPN confirmed there was no evidence in resident #2's medical record or hospital record that an HGBA1c or CMP had been obtained for this resident as ordered by the physician.</p> <p>An interview conducted on April 22, 2010, at 9:40 a.m., with station 2's Licensed Practical Nurse (LPN) revealed upon a resident's admission to the facility, the nursing staff transcribing the new admissions' physician's orders was required to complete a laboratory blood work requisition to have the laboratory blood work obtained the following day unless the hospital had recently performed the laboratory blood work.</p> <p>Review of the facility's policy regarding the "Lab Monitoring System" revealed the following: (1)</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>Upon admission of a resident, the nurse should review the medications ordered for the need for lab orders. (2) Labs ordered were required to be placed on the lab calendar by the admitting nurse or the nurse who received the phone order. (3) Medical Records was required to check the calendar daily and complete a lab requisition for the labs that needed to be drawn the next morning. (4) A copy of the lab requisition was required to be maintained in a notebook at the nurses' station until the lab results were returned to the facility and reported to the attending physician. The copy would then be removed from the notebook by the nurse after the nurse reported the results to the physician. (5) Weekly, during the interdisciplinary care conference, medical records staff was required to audit the charts of those residents scheduled for care plans to ensure labs had been ordered/obtained. (6) As part of the QA audit, the DON was required to audit a sampling of resident charts for lab orders, lab results, and physician notification of lab results. (7) The nurse who completed the "Change Over" form was required to check lab orders to ensure no labs had been missed.</p> <p>No staff had identified that resident #2's physician-ordered laboratory test had not been performed as ordered.</p> <p>2. Review of the medical record for resident #12 revealed the resident was readmitted to the facility on May 24, 2008, with the diagnoses of Seizure Disorder, Sinus Node Dysfunction, Dementia, Anxiety, and Lumbar Disc/Spinal Stenosis. Review of the Quarterly Minimum Data Set (MDS) dated January 26, 2010, revealed the facility assessed resident #12 as being severely impaired in daily decision-making and resident</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>#12 was dependent on staff for all activities of daily living.</p> <p>Further review revealed on March 11, 2010, resident #12 had developed blisters to the palms of both hands and on the soles of the resident's feet. Resident #12 was evaluated by a dermatologist on March 17, 2010. Resident #12 was diagnosed with Bullous Pemphigoid (an autoimmune skin disorder characterized by large blisters).</p> <p>Review of the physician's orders revealed an order dated September 26, 2008, directing staff to apply geri-legs to resident #12's lower extremities to aid in preventing bruising and skin tears related to thin fragile skin. Further review of the April 2010 monthly physician's orders included the order for staff to apply geri-legs on resident #12's lower extremities.</p> <p>Observations on April 20, 2010, at 9:00 a.m., 9:30 a.m., 12:05 p.m., 1:30 p.m., 2:30 p.m., and 3:30 p.m., revealed resident #12 was not wearing geri-leg protectors. Further observations on April 21, 2010, at 9:30 a.m. and 10:30 a.m., revealed resident #12 did not have the geri-leg protectors applied to the lower extremities.</p> <p>Review of the April 2010 Treatment Administration Record (TAR) revealed the treatment for resident #12 to have geri-leg protectors applied to the resident's lower extremities was not included on the TAR.</p> <p>Interview on April 21, 2010, at 3:00 p.m., with Charge Nurse #1 revealed the floor nurses were responsible for the residents' treatments. Charge Nurse #1 stated a staff member would compare</p>	F 281		

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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 C 04/22/2010	
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 281	Continued From page 10 the TARs and physician's orders each month to ensure the physician's orders were followed. The staff person would then sign the monthly physician's orders, indicating the treatment orders were correctly transcribed on the TARs. Interview on April 21, 2010, at 3:05 p.m., with Certified Medication Technician (CMT) #1 revealed CMT #1 was responsible for checking the Medication Administration Record (MAR) and TAR each month to ensure the physician's orders were transcribed correctly. CMT #1 stated if a medication or treatment was not listed on the resident's preprinted MAR or TAR, CMT #1 would handwrite the order on the MAR or TAR. Upon review of resident #12's TAR, CMT #1 stated the order for the geri-legs was just missed and that CMT #1 should have handwritten the treatment on the TAR.	F 281		
F 364 SS-E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide food that was palatable and at the proper temperature to residents on station 1 and station 2 units at the breakfast meal on April 20, 2010. Test tray temperatures and palatability observations conducted for resident breakfast trays on the station 1 and station 2 halls revealed the	F 364	F364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and that the food is palatable, attractive, and at the proper temperature. 1. There were no residents negatively affected by this practice. 2. Meal temperatures were taken and all other residents' meals were palatable and at the proper temperature. On	

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

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OMB NO. 0938-0391

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F 364	<p>Continued From page 11</p> <p>breakfast items were not at the proper temperature and were unpalatable.</p> <p>The findings include:</p> <p>Observations of the breakfast tray delivery to the station 1 unit on April 20, 2010, revealed four breakfast trays were delivered to the unit at 7:40 a.m., and were served to the residents at 8:14 a.m., 34 minutes after the trays were delivered to the unit. The last tray was intercepted for temperature and palatability testing. At 8:14 a.m., the temperature test revealed the eggs were at 88 degrees Fahrenheit, gravy and biscuit was at 98 degrees Fahrenheit, ham was at 100 degrees Fahrenheit, and the juice was observed to be at 60 degrees Fahrenheit.</p> <p>Observations on April 20, 2010, during the breakfast meal revealed that cart 2 was delivered to station 2 hall on April 20, 2010, at 7:29 a.m. Further observation revealed a Certified Nursing Assistant (CNA) removed the last tray from cart 2 at 8:00 a.m. on April 20, 2010, and proceeded to deliver the tray to resident #27. However, the tray was intercepted by the surveyor prior to the point of service, and resident #27 was provided another breakfast tray.</p> <p>Food temperatures obtained on April 20, 2010, at 8:01 a.m., from resident #27's original breakfast tray revealed the following food temperatures: the scrambled eggs were at 94 degrees Fahrenheit, pureed ham was at 92 degrees Fahrenheit, pureed biscuit and gravy was at 80 degrees Fahrenheit, and the milk was at 50 degrees Fahrenheit.</p> <p>An interview conducted on April 20, 2010, at 8:25</p>	F 364	<p>May 21, 2010, all nursing staff has been in-serviced and re-educated regarding the proper procedure and importance of timely distribution of trays.</p> <ol style="list-style-type: none"> 3. All employees will be provided training in orientation regarding correct meal service policy and quarterly in-servicing will be provided for nursing staff by the Dietary Manager. 4. Breakfast trays will be monitored daily for the next six months by Dietary Manager to ensure that food is palatable, attractive and at the proper temperature Monday - Friday. 5. May 28, 2010. 	

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

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F 364	Continued From page 12 a.m., with a CNA revealed the CNA was not aware of how long a resident tray could sit on the hallway before the resident was to receive another tray. An interview conducted with the Dietary Manager on April 21, 2010, at 2:10 p.m., revealed the Dietary Manager was not aware of resident trays not being served timely or of food items being served cold and unpalatable. Further interview revealed the Dietary Manager monitored meals daily except breakfast, which was monitored weekly. Additionally, the Dietary Manager stated that trays should be delivered to residents within 20 minutes after arriving to the floor and if not staff was required to obtain another tray for the residents. A review of the Facility Minimum Temperature at Point of Service to Resident Policy, which was undated, revealed the temperature for hot food items at point of service was required to be 115 degrees Fahrenheit or greater when served to residents. Further review of the policy revealed juice was to be served at 55 degrees Fahrenheit or less and milk was to be served at less than 45 degrees Fahrenheit.	F 364			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to provide a safe, functional,		

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

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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 1124 SOMERSET, KY 42502		
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F 465	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Hot water temperatures were not maintained within the required range in the station 3 shower room. Chipped/broken tile was observed in a resident room, and loose baseboards were observed in the front hallway.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of hot water temperatures conducted on the station 3 unit men's shower room conducted on April 20, 2010, at 9:20 a.m., during a shower for resident #25, revealed the hot water temperature was 96 degrees Fahrenheit. <p>An interview conducted with resident #25 after the shower was completed on April 20, 2010, at 9:35 a.m., revealed the water in the shower was cold "like wintertime." The resident also stated the water was often cold during showers.</p> <p>Observations on April 21, 2010, at 3:25 p.m., of a shower in the station 3 women's shower room for resident #20 revealed the hot water temperature was 96 degrees Fahrenheit.</p> <p>An interview conducted with resident #20 on April 21, 2010, at 3:25 p.m., during the shower revealed the water in the shower was cold.</p> <p>An interview conducted with resident #8 on April 20, 2010, at 9:25 a.m., revealed the water in the showers can be cold at times.</p>	F 465	<p>sanitary, and comfortable environment for residents, staff and the public.</p> <ol style="list-style-type: none"> 1. A new regulator valve has been installed in the men and women's station 3 shower rooms which will maintain the water temperature between 100 – 110 degrees Fahrenheit. The tile and the sink in resident room 39 have been replaced. 2. All areas of the facility will be audited monthly for needed repairs by Administrative personnel. Water temperatures will be taken by Maintenance every week and as needed to ensure proper water temperatures are being maintained. 3. All nursing staff has been in-serviced to consult the gauge in the shower rooms to ensure proper water temperatures prior to giving a shower. This is a color coded gauge which registers proper water temperature within the green zone. If there is an issue, Nursing is to submit a written maintenance request form for repairs with a copy to administration for follow up. 	

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

PRINTED: 05/04/2010
FORM APPROVED
OMB NO. 0938-0391

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F 465	Continued From page 14 Interviews conducted with three CNAs on April 20, 2010, at 9:30 a.m., revealed that Maintenance had worked on the water, that only the middle shower stall had hot water, and that residents had complained that the water would often get cold during showers. Observations of shower room water temperatures conducted on April 22, 2010, at 10:10 a.m., during an environmental tour revealed the hot water temperatures of the station 3 shower rooms were at 96 degrees Fahrenheit. An interview conducted with maintenance personnel on April 22, 2010, at 10:20 a.m., revealed that Maintenance had replaced the shower valves in the station 1 shower, however, was not aware of the water in the showers being cold on station 3. Further interviews revealed the water temperatures were checked weekly by maintenance staff and the mixing valve was adjusted if necessary. A review of the recent maintenance requests revealed no evidence of any request regarding water temperatures being cold in the showers. A review of the water temperature monitoring log from January 2010 to April 2010 revealed that water temperatures for the station 3 shower rooms was often less than the required 100 degrees Fahrenheit. 2. Environmental observations conducted on April 20, 2010, at 8:10 a.m., revealed chipped/broken tile on the floor by the resident's bed and chipped formica on the resident's sink in resident room 39.	F 465	4. Compliance rounds will be conducted weekly by Maintenance Director for the next six months to monitor for required water temperatures and needed repairs. 5. May 28, 2010	

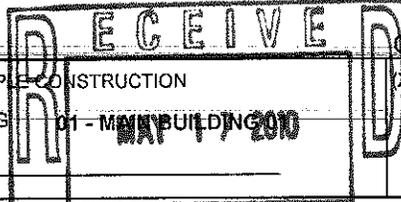
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 465	<p>Continued From page 15</p> <p>Observations conducted during the environmental tour conducted on April 22, 2010, at 10:10 a.m., revealed loose baseboards on the front hallway by the kitchen.</p> <p>An interview conducted with facility maintenance personnel on April 22, 2010, at 10:20 a.m., revealed a wall had to be accessed to fix a water leak by the kitchen and no maintenance request had been submitted for broken tile or formica in room 39. Further interview revealed the problems had not been identified during daily rounds conducted by the maintenance personnel.</p>	F 465		

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

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NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 100 COVER STREET, PO BOX 121 SOMERSET, KY 42502
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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on April 27, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=F	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, the facility failed to maintain the fire/smoke resistance rating of the fire/smoke barrier walls in the attic area in three (3) areas of the facility. The findings include: The Life Safety Code survey on April 27, 2010, at 10:55 a.m., with the Director of Maintenance, revealed an unapproved makeshift door in the fire/smoke barrier wall in the attic above the cross corridor doors at the nurses' station. This type of	K 025	K 025 LIFE SAETY CODE STANDARD It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to maintain the fire/smoke resistance rating of the fire/smoke barrier walls in the attic area in three (3) areas of the facility. 1. The unapproved doors in the fire/smoke barrier wall in the attic above the cross corridor doors at the nurses' station have been sealed off. 2. All areas in the facility which require fire/smoke barriers, sealed penetrations, and fire dampers have been checked by Maintenance to ensure compliance in this area. 3. As part of the facility's preventative maintenance program, the maintenance supervisor will conduct monthly audits to ensure compliance. 4. As part of the facility's on-going CQI program, these areas will monitored to ensure proper fire/smoke barriers, sealed penetrations and fire dampers are in compliance. 5. May 21, 2010	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela Hodge</i>	TITLE <i>Administrator</i>	(X8) DATE <i>5/14/10</i>
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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.

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

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K 025	<p>Continued From page 1</p> <p>access door is required to be of an approved design and rating. Unsealed penetrations of wiring, conduit, and sprinkler piping were also noted in the fire/smoke barrier wall. These areas must be filled with a suitable material to prevent the passage of fire and smoke in a fire situation. The fire/smoke barrier wall was also noted to have ductwork that contained a fire damper. A fire damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview revealed the Director of Maintenance was unaware the door needed to be of an approved design and rating. The Director of Maintenance stated penetrations have been sealed properly in the past but these areas observed during the survey must have been missed. The Director of Maintenance was unaware of the requirements pertaining to fire dampers. During the survey two other fire/smoke barrier walls were noted to have unapproved doors, unsealed penetrations, and fire dampers.</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> <ol style="list-style-type: none"> 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. <p>(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</p>	K 025			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 025	<p>Continued From page 2</p> <p>between the item and the sleeve shall</p> <ol style="list-style-type: none"> 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. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>8.2.3.2.1</p> <p>Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following.</p> <p>(a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>11-1.2 Components.</p> <p>An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads "Frame and Fire Door Assembly."</p> <p>Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1.</p> <p>11-1.2.1</p> <p>Access doors shall be self-closing.</p> <p>11-1.2.2</p> <p>Access doors shall be self-latching.</p>	K 025			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 025	<p>Continued From page 3</p> <p>Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m²) is applied over the entire exposed surface of the door shall not be required to be self-latching.</p> <p>11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool.</p> <p>11-1.2.4 Access doors shall be installed in accordance with their listing.</p> <p>11-2 Types of Doors. 11-2.1 Horizontal Access Doors. 11-2.1.1 Door assemblies used in fire-rated floors or floor-ceiling or roof-ceiling assemblies shall be tested in the horizontal position in accordance with the procedures described in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, and shall be labeled as horizontal access doors. 11-2.1.2 A horizontal access door shall bear a label that includes the additional wording "For Horizontal Installation." 11-2.1.3 A horizontal access door shall be used in a fire-rated floor or floor-ceiling or roof-ceiling assembly only where it has been tested and listed for use as a component of the assembly. 11-2.1.4 Horizontal access doors shall not be required to be subject to the hose stream test. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection</p>	K 025		
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K 025 Continued From page 4
rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.)
11-2.2.2
Vertical access doors shall be used only in walls.
Reference: NFPA 90a (1999 Edition).

K 025

3-4.7 Maintenance.
At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

K 076 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 076

Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.

(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.

(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards in a room next to the nurses' station.

The findings include:

K076 NFPA 101 LIFE SAFETY CODE STANDARD
It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to store oxygen cylinders according to NFPA standards.

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

PRINTED: 05/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
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
K 076	<p>Continued From page 5</p> <p>During the Life Safety Code tour on April 27, 2010, at 11:40 a.m., with the Director of Maintenance, 32 E size oxygen cylinder tanks and 11 smaller oxygen tanks were noted to be stored in a room next to the nurses' station. These tanks were within five feet of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five feet from combustibles. An interview revealed the Director of Maintenance was not aware of this requirement. Quantities of 300 cubic feet and less may follow the requirements of S&C-07-10.</p> <p>Reference: S&C-07-10</p> <p>Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse ' s station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use.</p>	K 076	<ol style="list-style-type: none"> 1. There were no residents negatively affected by this practice. 2. All oxygen cylinders in quantities greater than 300 cu feet have been stored in an area that is five feet from all combustibles. 3. All staff has been in-serviced and educated regarding keeping all oxygen cylinders greater than 300 cu feet stored in an area that is five feet from all combustibles. 4. Director of Nursing will do weekly audits to ensure this policy is being maintained. As part of our on-going CQI program, Maintenance will report on our compliance in this area. 5. May 14, 2010. 	

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K 076	<p>Continued From page 6</p> <p>It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.</p> <p>Reference: NFPA 99 (1999 Edition), 8-3.1.11.2</p> <p>Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³)</p> <p>(A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>8-3.1.11.3 Signs.</p> <p>A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:</p>	K 076			

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K 076	Continued From page 7 CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		