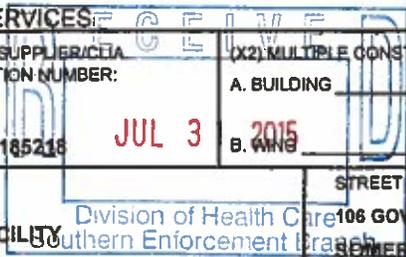


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2015
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
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NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 106 GOVER STREET SOMERSET, KY 42502
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 F 282 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 07/07-09/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of twenty-four (24) sampled residents (Resident #7). Resident #7's Comprehensive Care Plan contained care plan interventions that included Tender Care Pads to side rails; however, observations on 07/07/15, 07/08/15, and 07/09/15 revealed the Tender Care Pads were not in use for Resident #7.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Using the Care Plan," dated 08/01/13, revealed daily care and documentation must be consistent with the resident's care plan. Further review revealed changes in the resident's condition must be reported to the Nurse Assessment Coordinator so that a review of the resident's assessment and care plans can be made.</p>	F 000 F 282	<p>Somerset Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.</p> <p>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.</p> <p>Somerset Nursing and Rehabilitation strives to provide the highest quality care while ensuring the rights and safety of all residents.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 7/21/15

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 282	<p>Continued From page 1</p> <p>Review of Resident #7's medical record revealed the facility admitted Resident #7 with diagnoses of Parkinson's Disease, Hypertension, General Weakness, Osteoarthritis, and Diabetes. Review of the Minimum Data Set (MDS) assessment dated 05/06/15 revealed Resident #7 was on a turning and repositioning program related to his/her Parkinson's Disease.</p> <p>Review of the Comprehensive Care Plan dated 05/02/14 revealed Resident #7 required the use of half side rails for positioning. Further review of the Comprehensive Care Plan revealed the care plan was updated on 04/10/15 for Tender Care Pads to be added to the side rails to provide safety related to the resident's diagnosis of Parkinson's Disease.</p> <p>Observations of Resident #7 on 07/07/15 at 10:50 AM, 12:00 PM, 2:15 PM, 3:40 PM, and 5:40 PM, 07/08/15 at 8:25 AM, and 07/09/15 at 8:10 AM revealed Resident #7 to be in bed with his/her side rails up; however, no Tender Care Pads were on Resident #7's side rails.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 07/09/15 at 1:53 PM revealed the Tender Care Pads should have been on Resident #7's side rails because they were on the care plan. She further revealed sometimes the CNAs forgot to put them back on the side rails after Resident #7 has been transferred back to bed.</p> <p>Interview with the Unit Coordinator on 07/09/15 at 1:58 PM revealed she was responsible for ensuring the CNAs were following the interventions on the care plan. She further revealed the Tender Care Pads were being used to prevent injury/skin tears related to Resident</p>	F 282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's plan of care.</p> <ol style="list-style-type: none"> 1. The charge nurse and SRNAs who were responsible for ensuring that Tender Care Pads were added to Resident #7's side rails were promptly educated and inserviced by the Unit Coordinator on reading and following each resident's plan of care. This took place on July 9, 2015. 2. To ensure a similar situation will not occur, all licensed staff were re-educated on reading and following the care plan by the Director of Nursing. This was completed on 7/10/15. 3. The Continuous Quality Improvement Clinical Team Leader will assign a total of at least fifteen monthly audits to the Clinical Team to ensure that care plans are being read and followed. Audits will be done on all shifts. If problems are identified, staff will be re-instructed immediately. 		

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F 282	Continued From page 2 #7's Parkinson's Disease. She further revealed the CNAs would remove the Tender Care Pads before starting the transfer process with the Hoyer Lift and put them behind Resident #7's bed. The Unit Coordinator stated the CNAs sometimes forgot to put them back on the side rails after Resident #7 was put back into bed. Interview with the Director of Nursing (DON) on 07/09/15 at 2:05 PM revealed the Unit Coordinator and nurses were responsible to ensure the CNAs were following the care plans. She further stated that the staff conducts morning meetings concerning following the care plans, and no problems had been identified concerning following the care plans.	F 282	4. As a part of the ongoing Continuous Quality Improvement Program, the committee will review above mentioned audits and corrective actions monthly for six months to monitor these areas and ensure that correction is achieved. 5. July 31, 2015		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure a safe environment free of accident hazards for Resident #7. Tender Care Pads were ordered to be used with side rails. However, observations revealed the Tender Care Pads were not used from 07/07/15 to 07/09/15.	F 323	F323 483.25(H) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. The charge nurse and SRNAs who were responsible for ensuring that Tender Care Pads were added to Resident #7's side rails were promptly educated and inserviced on the use of assistance devices to prevent accidents. This took place on July 9, 2015.		

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F 323	<p>Continued From page 3</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 07/09/15 at 2:05 PM revealed the facility did not have a policy related to safety concerning the use of padding on side rails.</p> <p>Review of Resident #7's medical record revealed the facility admitted Resident #7 on 09/07/12 with diagnoses of Diabetes, General Weakness, Hypertension, Osteoarthritis, and Parkinson's Disease. Review of the Minimum Data Set (MDS) assessment dated 05/08/15 revealed Resident #7 was on a turning and repositioning program related to his/her diagnosis of Parkinson's Disease.</p> <p>Review of the Comprehensive Care Plan updated on 04/10/15 revealed Resident #7 required the use of half side rails for positioning, along with Tender Care Pads to be on the side rails for safety. Further review of the care plan dated 09/20/12 revealed Resident #7 required the use of a Hoyer Lift to promote safety during transfers.</p> <p>Observations of Resident #7 on 07/07/15 at 10:50 AM, 12:00 PM, 2:15 PM, 3:40 PM, and 5:40 PM, 07/08/15 at 8:25 AM, and 07/09/15 at 8:10 AM revealed Resident #7 to be in bed with his/her side rails raised; however, there were no Tender Care Pads on Resident #7's side rails.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 07/09/15 at 1:53 PM revealed Resident #7 used a Hoyer Lift for transfers and the Tender Care Pads were removed several times during the day for transfers and sometimes the CNAs forgot to put them back on the side rails. She further revealed she had not noticed if the Tender</p>	F 323	<ol style="list-style-type: none"> 2. To ensure a similar situation will not occur, all licensed staff were re-educated on the use of assistance devices to prevent accidents by the Director of Nursing. This was completed on 7/10/15. 3. All other residents with assistance devices are being reviewed to determine if they are in place. These reviews are being done by the Unit Coordinators. This will be completed by 8/14/15. 4. As a part of the ongoing Continuous Quality Improvement Program, the committee will review assistance device audits and corrective actions monthly for six months to monitor these areas and ensure that correction is achieved. 5. 8/15/15 		

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F 323	<p>Continued From page 4</p> <p>Care Pads were on the side rails the last day or two.</p> <p>Interview with the Unit Coordinator on 07/09/15 at 1:58 PM revealed the Tender Care Pads were being used to prevent injury/skin tears related to Resident #7's Parkinson's Disease. She further revealed the CNAs would remove the Tender Care Pads before starting the transfer process with the Hoyer Lift and put them behind Resident #7's bed. The Unit Coordinator stated the CNAs sometimes forgot to put them back on after Resident #7 was transferred back into bed.</p> <p>Interview with the DON on 07/09/15 at 2:05 PM revealed the Unit Coordinator and nurses were responsible to ensure the CNAs were following the care plans. She further stated no problems had been identified concerning following the care plans related to padded side rails. She further stated that the staff conducts morning meetings concerning following the care plans, and no problems had been identified concerning following the care plans.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 106 GOVER STREET SOMERSET, KY 42502
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1988</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 07/07/15, 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000	<p>K 021 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation for any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <ul style="list-style-type: none"> a) The required manual fire alarm system; b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) The automatic sprinkler systems, if installed. <ul style="list-style-type: none"> 1. The latch that was holding open the corridor door leading to the kitchen area was removed on 7/7/15. 2. As a part of the facility's preventative maintenance program, the maintenance supervisor will monitor all corridor doors monthly to ensure this standard is maintained. 3. As part of the facility's continuous Quality Improvement program, the maintenance of all corridor doors will be audited by the Operations Team monthly for the next six months. 4. July 31, 2015 	
K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by</p>	K 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *7/31/15*

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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K 021	<p>Continued From page 1</p> <p>devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that doors to a hazardous area were maintained as required. This deficient practice affected one (1) of six (6) smoke compartments, staff, and approximately thirty-five (35) residents. The facility has the capacity for 123 beds with a census of 119 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/07/15 at 11:30 AM with the Director of Maintenance (DOM), a corridor door leading to the kitchen area was observed to be held open by a latch that connected to a wall in the kitchen. Doors to hazardous areas cannot be held open by devices not connected to the fire alarm system.</p> <p>An interview with the DOM on 07/07/15 at 11:30</p>	K 021			

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K 021	<p>Continued From page 2</p> <p>AM revealed he was not aware of the requirements pertaining to hazardous area doors.</p> <p>The findings were reported to the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p>	K 021			