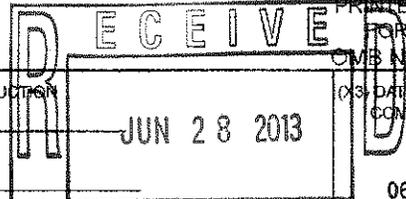


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2013  
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  06/06/2013
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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
F 000	INITIAL COMMENTS	F 000	Somerset Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Somerset Nursing &amp; Rehabilitation reserves all rights to contest the survey findings through the informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Somerset Nursing and Rehabilitation reserves all rights to raise possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Somerset Nursing and Rehabilitation does not waive, and reserves the right to asset in any administrative, civil or criminal claim, action or proceeding. Somerset Nursing and Rehabilitation offers its response, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents.</p> <p>Somerset Nursing and Rehabilitation strives to provide the highest quality care while ensuring the rights and safety of all residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X5) DATE: *06/28/13*

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

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policy it was determined the facility failed to immediately notify the legal representative or interested family member/responsible party for one of nineteen sampled residents when the resident was transferred to the hospital (Resident #1). On 05/26/13 at 5:45 AM, Resident #1 experienced a change in condition and was transferred to the local hospital. The resident's legal representative or interested family member was unaware of the resident's change in condition until the physician in the Emergency Room (ER) at the local hospital contacted the resident's family member.</p> <p>The findings include:</p> <p>A review of the facility's Family Notification Policy dated 01/09/03 revealed the facility was responsible to notify the resident's attending physician of changes in the resident's condition and/or status. The policy further revealed Nursing Services would be responsible for notifying the resident, next-of-kin, or his/her representative (sponsor) as each case may apply, and unless otherwise instructed by the resident, when it was necessary to transfer the resident to a hospital.</p> <p>An interview conducted with the family member of Resident #1 on 06/05/13 at 1:30 PM, revealed Resident #1 had been transferred to the local hospital on 05/26/13 at 6:10 AM after a change in condition. The family member stated Resident</p>	F 157	<p>F157 483.10(b)(11) NOTIFYING OF CHANGES (INJURY/DECLINE/ROOM, ETC.)</p> <p>It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.</p> <ol style="list-style-type: none"> <li>1. The charge nurse who failed to contact Resident # 1's responsible party/family member at the time the resident was transferred to the hospital was re-educated on F157 requirements which includes notification of the resident's legal representative or an interested family member of any changes in condition and/or status.</li> <li>2. Each current resident's record from the past 30 days has been reviewed to determine if any other residents had any changes in condition and/or status that had not been addressed through the notification process required in F157. These reviews were done by the Director.</li> </ol>	

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F 157	<p>Continued From page 2</p> <p>#1's Responsible Party (RP) had not been notified until the physician at the hospital Emergency Room contacted the RP.</p> <p>An interview conducted with the Unit Coordinator on 06/06/13 at 9:30 AM revealed she had provided care to Resident #1 on the day Resident #1 was transported to the Emergency Department on 05/26/13. The Unit Coordinator stated she/he was aware the resident's RP was to be notified immediately prior to transporting a resident to the hospital; however, the Unit Coordinator stated she/he forgot to contact Resident #1's RP immediately prior to transfer.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/06/13 at 4:30 PM revealed the DON had been made aware of the Unit Coordinator's failure to immediately notify Resident #1's responsible party/family member at the time the resident was transported to the Emergency Room on 05/26/13. The DON stated the resident's RP should have been notified immediately at the time of Resident #1's transfer to the hospital.</p>	F 157	<p>of Nursing and Unit Coordinators and were completed on 6/26/13.</p> <p>3. To ensure a similar situation will not occur, all licensed staff were re-educated 6/3/13, and again inserviced on 6/18/13 on F157 requirements of notification by the Director of Nursing.</p> <p>4. Unit Coordinators will evaluate all changes (injury, decline, room, etc.) on a daily basis that occur on their unit Monday through Friday. Manager on Duty will review on weekends. An audit for proper notification of the resident/physician/responsible party will be done at that time. Correction and reinforcement of the process will occur at the time of the audit when any deficient practice is observed.</p> <p>5. June 26, 2013</p>	
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,</p>	F 221	<p>F221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation for physical restraints to be used for a medically related symptom and only after other alternatives have been tried unsuccessfully. 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.</p>	

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F 221	<p>Continued From page 3</p> <p>and a review of the facility's Restraint policy, the facility failed to ensure two of twenty-four sampled residents were free from physical restraints (Residents #8 and #10). Resident #8 was observed during the survey conducted on 06/04/13, 06/05/13, and 06/06/13 to be in a wheelchair with a safety belt (a device that restricts movement) around the resident's waist and wheelchair. Resident #10 was observed on 06/04/13, 06/05/13, and 06/06/13 to be in a wheelchair with an alarm-activated velcro safety belt around the resident's waist and wheelchair. Residents #8 and #10 were observed to be unable to remove the safety belts unassisted and the belts restricted the residents' standing ability. There was no evidence the facility had identified a medical symptom that required the restriction of standing/movement for Resident #8 and Resident #10. In addition, the facility failed to systemically evaluate and/or assess the use of the safety belt to attempt to reduce or eliminate the use of the safety belt for these residents. During the previous survey conducted on 04/10/12, 04/11/12, and 04/12/12, deficient practice was cited related to restraint use for Resident #8. According to the facility's plan of correction (compliance date of 05/06/12), a physician's order was obtained on 05/02/12 to indicate the specific medical symptom for the use of the safety belt and Resident #8 was placed on a restraint reduction trail. However, the facility was unable to provide evidence these corrective actions had been taken for Resident #8 as stated in the plan of correction.</p> <p>The findings include:</p> <p>A review of the facility's Restraint policy (dated 01/09/13) revealed restraints would only be used</p>	F 221	<ol style="list-style-type: none"> <li>1. Resident # 8 and Resident # 10 have been reviewed to determine if a restraint reduction trial is appropriate. On 6/17/13 a physician's order was received indicating the specific medical symptoms for Resident #8s device. A physician's order indicating the specific medical symptoms for Resident #10s device was received on 6/21/13.</li> <li>2. All other residents with physical restraints are being reviewed to determine if they are appropriate candidates for a restraint reduction/elimination. These reviews are being done by the Unit Coordinators. This will be completed by 7/5/13.</li> <li>3. Administrator and DON provided Unit Coordinators re-education on the process of restraint reduction/elimination, restraint alternatives and restraint-free periods. This occurred on 6/21/13.</li> <li>4. Unit Coordinators will assess all residents with physical restraints monthly for the next 12 months 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.</li> <li>5. July 6, 2013</li> </ol>		

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F 221	<p>Continued From page 4</p> <p>for a medically related symptom and only after other alternatives had been tried unsuccessfully. The policy further noted the need for 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."</p> <p>1. A review of the medical record revealed the facility admitted Resident #8 on 10/05/05 with diagnoses that included Senile Dementia, Hypertension, Degenerative Joint Disease, Chronic Obstructive Pulmonary Disease, and Anemia. A review of the annual comprehensive Minimum Data Set (MDS) assessment with a reference date of 11/27/12 revealed Resident #8 was assessed to require limited assistance of one staff person for transfers, ambulation, and toileting. Facility staff also assessed Resident #8 to require a chair to prevent rising and was coded as a restraint device.</p> <p>A review of the Care Area Assessment (CAA) Summary for restraints dated 11/28/12 revealed Resident #8 had a history of falls and the safety belt device was utilized for "positioning and safety." The CAA further revealed restraint reduction and physical therapy (PT) screening would be conducted quarterly and as needed. In addition, the CAA noted Resident #8 would frequently ask residents/visitors to remove his/her belt restraint.</p> <p>Review of the comprehensive care plan revealed the facility had developed a restraint plan of care for Resident #8 on 07/04/06 and had reviewed the plan on 05/01/13 with no "current issue noted." The plan of care included the use of the</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>safety belt. Interventions included releasing the restraint every two hours and performing range of motion (ROM) exercises, keeping the call light within reach, and conducting PT screenings quarterly.</p> <p>A review of the fall record for Resident #8 revealed the resident had sustained three falls with the restraint device in use from 04/20/12 to 01/03/13 (a timeframe of nine months), two when the resident attempted to self-transfer and one when the resident slid from the wheelchair.</p> <p>Review of the Physical Restraint Elimination Assessment revealed facility staff had reviewed the use of the safety belt on 06/19/12, 07/03/12, 08/10/12, 09/11/12, 11/27/12, 12/17/12, 02/25/13, 03/12/13, and 04/20/13. During each 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. Further review of the 11/27/12 assessment revealed the resident was referred to physical therapy (PT) for evaluation for possible restraint reductions. Review of the physical therapist's notes revealed an evaluation was conducted on 11/30/12 and the safety belt was removed to assess the resident's abilities and safety without the belt in place. The therapist noted after the belt was removed for two minutes, Resident #8 attempted to maneuver his/herself to the bathroom without assistance. Review of the 12/17/12 assessment revealed the resident was evaluated on 12/07/12 by the physical therapist and the resident made several attempts to stand after the safety belt was again removed. However, there was no evidence the facility had attempted restraint alternatives or a reduction</p>	F 221			

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F 221	<p>Continued From page 6 since 11/30/12 and 12/07/12.</p> <p>A review of the current physician's orders dated June 2013 revealed a safety belt was to be used when the resident was in a wheelchair for positioning and safety. However, there was no evidence the physician had provided and/or the facility had determined the presence of a specific medical symptom that would require the use of the restraint device.</p> <p>Resident #8 was observed on 06/04/13 at 3:40 PM, to be sitting in a wheelchair in the resident's room and a safety belt was observed around the resident's waist and was attached to the wheelchair. At 5:15 PM, Resident #8 was observed sitting in a wheelchair while eating the dinner meal in the facility dining room. The safety belt was observed to be released during the meal service. On 06/05/13, at 9:35 AM, 10:35 AM, and 1:10 PM, the resident was again observed sitting in the wheelchair with the safety belt in place. The resident was unable to demonstrate how to release the safety belt. A review of an MDS assessment conducted on 11/27/12 revealed facility staff had assessed Resident #8 to have impaired cognition and an interview was not conducted with the resident.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #5 on 06/05/13, at 1:15 PM, revealed Resident #8 required the use of the safety belt to prevent the resident from leaning forward and to "keep the resident safe." The CNA stated the resident would try to get up unassisted in an attempt to go to the bathroom if the safety belt was not in use.</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>An interview conducted with CNA #4 on 06/05/13, at 2:45 PM, revealed she had been assigned to provide direct care for Resident #8 when on duty since August 2012. The CNA stated the safety belt was used to prevent the resident from leaning forward while in the wheelchair and had been used since she had been caring for the resident. CNA #4 stated she could not recall any other alternatives being attempted for Resident #8.</p> <p>Interview conducted with Unit Coordinator (UC) #1 on 06/06/13 at 2:45 PM revealed she was responsible to conduct the quarterly Restraint Elimination Assessment for Resident #8. The UC verified the resident's score of 14 (as noted above) did indicate the resident was a good candidate for reduction attempts. The UC stated she had discussed the assessment results with the therapy staff and believed they had conducted an evaluation for restraint reduction/elimination for Resident #8. The UC further stated she was not aware of any other safety or restraint devices being tried for Resident #8 during the previous year.</p> <p>An interview conducted with Occupational Therapist (OT) #1 on 06/06/13 at 4:05 PM 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 restraint use was not included as part of the quarterly screening unless the physician ordered a restraint reduction trial or attempt. The OT provided documentation related to the previous restraint reduction attempted on 11/30/12 by a previous physical therapist (PT). The OT stated a referral</p>	F 221		

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F 221	<p>Continued From page 8</p> <p>was received for a screening to be conducted on 03/01/13 for restraint reduction, but no reduction attempts had been conducted at that time. The OT confirmed there had not been any additional attempts of restraint reduction, except for the one attempted by PT on 11/30/12, for Resident #8 since the previous survey. The previous physical therapist was no longer employed by the facility and not available for interview.</p> <p>Interview conducted with the Director of Nurses (DON) on 06/06/13 at 5:40 PM confirmed the UM was responsible to conduct the restraint elimination assessment and to refer the resident to Therapy Services as indicated. The DON stated she believed attempts had been made to reduce restraint use for Resident #8; however, the DON could not provide any documentation of any prior attempts.</p> <p>2. A review of the medical record revealed the facility admitted Resident #10 on 04/15/09 with diagnoses including Diabetes Mellitus, Anxiety, Hypertension, Arthropathy, Osteoporosis, Dementia, Depression, and Seizure Disorder.</p> <p>Review of the comprehensive care plan dated 01/19/12 for Resident #10 revealed the facility had developed a restraint plan of care to include the use of a Velcro alarm-activated seatbelt. Interventions included release of the Velcro alarm-activated belt and to provide range of motion (ROM) exercises "as needed." In addition, the care plan indicated PT was to evaluate the resident quarterly and "as needed."</p> <p>A review of the annual comprehensive Minimum Data Set (MDS) assessment with a reference</p>	F 221			

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F 221	<p>Continued From page 9</p> <p>date of 04/16/13 revealed Resident #10 was assessed to require extensive assistance of two staff persons for bed mobility, transfers, and toileting. The resident was assessed to require a chair to prevent rising (Velcro alarm-activated safety belt) which was coded as a restraint device. Resident #10 was assessed to have had no falls since the prior assessment dated 01/29/13.</p> <p>A review of the Physical Restraint Evaluation conducted on 04/16/13 revealed Resident #10 continued to be at risk for falls due to the resident's attempt to stand without assistance. Review of the fall record revealed Resident #10 had not sustained any falls since the placement of the Velcro alarm-activated seatbelt on 10/19/12. However, further review of the Physical Restraint Elimination Assessment revealed the Velcro alarm-activated safety belt had been reviewed on 10/22/12, 11/28/12, 01/29/13, and 03/01/13. According to those four assessments, the resident's score for restraint reduction was noted to be "23" which indicated the resident was a "good candidate" for restraint reduction. There was no evidence the facility had attempted restraint alternatives, restraint free periods, or a reduction since the Velcro alarm-activated seatbelt was applied on 10/19/12.</p> <p>A review of a Physical Therapy (PT) notation dated 03/05/13 revealed Resident #10 was referred to PT by the nursing staff on 03/01/13. PT evaluated Resident #10 and determined PT services were not warranted, and to continue with prior established nursing interventions. However, PT was not available for interview.</p>	F 221		

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F 221	<p>Continued From page 10</p> <p>A review of the Care Area Assessment (CAA) Summary for restraints dated 04/17/13 revealed Resident #10 had a history of falls and attempted to transfer him/her self without assistance. The CAA further revealed Physical Therapy (PT) would screen quarterly and "as needed" to evaluate for restraint reduction.</p> <p>A review of the physician's current orders dated 05/28/13 revealed a Velcro alarm-activated safety belt was to be in place when Resident #10 was sitting up. However, there was no evidence the facility had determined the presence of a specific medical symptom that would require the use of the restraint device.</p> <p>Resident #10 was observed on 06/07/13 at 10:35 AM, 11:15 AM, and 1:50 PM; and on 06/05/13 at 11:30 AM to be sitting in the dining room with the Velcro alarm-activated seatbelt in place.</p> <p>An interview conducted with the Occupational Therapist (OT) at 4:05 PM on 06/06/13 revealed the OT was not aware of any attempts to reduce/eliminate the use of the Velcro alarm-activated seatbelt for Resident #10 until 03/01/13.</p> <p>Interview with the Unit Manager (UM) at 5:00 PM on 06/06/13 revealed the UM had conducted the Restraint Elimination Assessment for Resident #10 on 03/01/13, had referred the resident to PT to screen for possible restraint reduction related to the Velcro alarm-activated belt but had not followed up to ensure the therapist had evaluated the resident. However, there was no evidence any attempts were made by staff to reduce/eliminate the use of the restraint.</p>	F 221			

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F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, sanitary, orderly, and comfortable interior. Observation during the environmental tour on 06/06/13, beginning at 3:20 PM, revealed one resident sink with a chipped countertop with sharp edges; three resident bedrooms with scraped drywall; four resident bedrooms with chipped wooden doors with sharp edges; one resident bedroom with chipped paint; seven resident beds with torn side rail padding; one wheelchair with worn/ragged armrests; and one resident bedroom with a loose baseboard. In addition, Resident #8 was observed to be wearing a heavily soiled lap belt on 06/04/13 and 06/05/13.</p> <p>The findings include:</p> <p>1. A review of the facility policy titled, "Work Orders," dated 01/09/03, revealed the facility utilized a work order system to complete maintenance repairs. The policy revealed a supply of work orders would be maintained at each nurses' station, and in each department head office. The policy also revealed the work orders would be picked up daily.</p>	F 253	<p>F253 483.15(h)(2) HOUSEKEEPING AND MAINTENANCE SERVICES</p> <p>It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <ol style="list-style-type: none"> <li>The sink with a chipped countertop in room 20 has been replaced. The scraped drywall in rooms 8, 28 and 68 has been repaired, trim for the chipped wooden doors with sharp edges in rooms 61, 63, 64, and 69 will be completed by 7/1/13, the chipped paint in room 6 has been repaired, the torn siderail padding on the following resident's beds has been replaced: 8-B, 11-A, 12-A, 27-A, 56-A, 59-A, and 59-B. The worn/ragged wheelchair armrest in room 5 has been replaced. The loose baseboard in room 52 has been repaired. In addition, staff have been instructed to clean all positioning belts daily and prn. This was completed on 6/26/13.</li> <li>Maintenance conducted an environmental round on all other resident's rooms to determine if any other resident rooms had issues that had not been addressed per F253 requirements. This was completed on 6/24/13.</li> <li>Staff have been re-educated by the Administrator on the "work orders"</li> </ol>	

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F 253	<p>Continued From page 12</p> <p>Observation during the environmental tour beginning on 06/06/13, at 3:20 PM, revealed:</p> <ul style="list-style-type: none"> <li>-Resident bedroom 20 was observed to have a sink with a chipped countertop with sharp edges.</li> <li>-Resident bedrooms were observed to have walls with scraped drywall in resident bedroom 8-B behind the chair, bedroom 28 beside the window, and bedroom 68-B at the head of the bed.</li> <li>-Resident bedrooms 61, 63, 64, and 69 were observed to have entrance doors which had chipped wood with sharp edges.</li> <li>-Resident bedroom 6 was observed to have chipped paint on the trim at the head of the residents' beds.</li> <li>-Resident beds in resident bedrooms 8-B, 11-A, 12-A, 27-A, 56-A, 59-A, and 59-B were observed to have side rails with torn foam padding.</li> <li>-Resident bedroom 5 was observed to have a wheelchair with worn/ragged armrests.</li> <li>-Resident bedroom 52 was observed to have a loose baseboard under the air conditioner.</li> </ul> <p>An interview conducted with the Maintenance Supervisor on 06/06/13, at 3:45 PM, revealed he or the maintenance staff completed an environmental round once a month to check for any repairs that might be needed to the facility. The Maintenance Supervisor stated work order requests were kept at every nurses' station and any staff member who found a maintenance issue was required to fill out a work order. According to the Maintenance Supervisor, the work order was to be placed in the tray at the nurses' station and the maintenance staff was to pick up the work orders on a daily basis. The Maintenance Supervisor stated after the repair</p>	F 253	<p>policy. This was completed on 6/25/13.</p> <p>4. As a part of the facility's preventative maintenance program, an environmental round will be conducted by the maintenance department bi-weekly for six months to ensure that a sanitary, orderly and comfortable interior is maintained. This information will be forwarded to the Administrator for review.</p> <p>5. July 2, 2013</p>		

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F 253	<p>Continued From page 13</p> <p>was completed he kept a copy and forwarded a copy to the Administrator. The Maintenance Supervisor stated he had not been aware of the issues identified during the environmental tour.</p> <p>An interview conducted with the Administrator on 06/06/13, at 3:50 PM, revealed she meets with the Maintenance Supervisor in the daily team meetings. The Administrator stated she reviewed the completed work orders and also what the Maintenance Department was currently working on. The Administrator revealed she had not been aware of the issues identified during the environmental tour.</p> <p>2. Review of the facility policy entitled "Cleaning Schedules" (dated 01/09/03) revealed cleaning schedules would be developed and implemented to ensure the facility was maintained in a clean and comfortable manner. However, the policy did not address cleaning of the safety belts used for residents.</p> <p>Resident #8 was observed on 06/04/13 at 3:40 PM, to be sitting in a wheelchair in the resident's room with a safety belt attached to the wheelchair. The safety belt was observed to be heavily soiled/stained. Resident #8 was also observed on 06/05/13, at 9:35 AM, 10:35 AM, and 1:10 PM, to be sitting in the wheelchair with the soiled/stained safety belt in place.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #4 on 06/05/13, at 2:45 PM, revealed she was assigned to provide care to Resident #8 on 06/05/13. The CNA stated the safety belt was to be sent to the laundry when soiled. CNA #4 further stated an extra belt was to be kept in the</p>	F 253			

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F 253	Continued From page 14 resident's room for replacement; however, a search of the resident's room failed to locate the extra belt. CNA #4 stated she should have replaced the safety belt for Resident #8, but had not noticed the belt was soiled.  Interview with the Director of Nurses (DON) on 06/05/13 at 4:10 PM revealed the facility did not have a policy/procedure specifically related to cleaning of the safety belts, but did have policies related to maintaining a sanitary environment. The DON stated an extra safety belt was to be kept in the resident's room and the CNAs were responsible to replace the belt when the belt was soiled.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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 needs that are identified in the comprehensive assessment.  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).	F 279	F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  It is and was on the date 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.  1. Resident # 8's comprehensive care plan has been reviewed and revised to reflect the use of the correct device. 2. All resident's care plans were reviewed for accuracy by the Unit Coordinators and MDS nurses to ensure the care plan reflects the services that are to be furnished, including the use of all devices. This was completed on 6/27/13. 3. MDS nurses were re-educated on 6/26/13 regarding care plans describing		

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F 279	Continued From page 15  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive plan of care for one of twenty-four sampled residents (Resident #8). Resident #8 was observed to have a pommel cushion (a device used to prevent a resident from sliding forward) in place during the survey conducted on 06/04/13, 06/05/13, and 06/06/13. However, there was no evidence the facility had developed a plan of care to address the use of the pommel cushion.  The findings include:  Review of the facility's Comprehensive Care Plan policy (dated 01/09/03) revealed a comprehensive care plan would be developed by the interdisciplinary team for each resident to include measurable objectives and timetable to meet the resident's medical, nursing, and psychological needs.  Resident #8 was observed on 06/04/13 at 3:40 PM to be sitting in a wheelchair in the resident's room with a seatbelt attached to the wheelchair. A pommel cushion was also noted to be in place in the resident's wheelchair. At 5:15 PM, Resident #8 was observed sitting in a wheelchair while eating the dinner meal in the facility dining room. Although the seat belt was observed to be released during the meal service, the pommel cushion continued to be in use. Resident #8 was also observed on 06/05/13 at 9:35 AM, 10:35 AM, and 1:10 PM sitting in the wheelchair with the	F 279	the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being as required under F279. In addition, weekly audits of all comprehensive care plans scheduled for care plan meetings that week will be performed by the Director of Nursing to ensure they are accurate and reflect the correct devices are being used. This audit will be on-going.  4. The DON will audit at least 10% of the resident's charts monthly for the next 6 months to ensure that the care plan describes the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being as required under F279.  5. June 28, 2013		

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F 279	<p>Continued From page 16</p> <p>safety belt and the pommel cushion in place. On 06/06/13 at 2:30 PM, staff released Resident #8's safety belt, the resident was observed to stand up from the wheelchair, and the pommel cushion continued to be in use.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #4 on 06/05/13, at 2:45 PM, revealed she routinely provided care for Resident #8. CNA #4 stated the pommel cushion was used to keep Resident #8 from leaning forward from the wheelchair. The CNA stated the pommel cushion had been in use for Resident #8 since she started working at the facility in August 2012.</p> <p>A review of the annual comprehensive Minimum Data Set (MDS) assessment with a reference date of 11/27/12 revealed Resident #8 was assessed to require limited assistance of one staff person for transfers, ambulation, and toileting. The resident was also assessed to require a chair to prevent rising, which was coded as a restraint device. A review of the Care Area Assessment (CAA) Summary for restraints dated 11/28/12 revealed Resident #8 had a history of falls and the seatbelt device was utilized for positioning and safety; however, continued review of the CAA revealed facility staff had failed to address the use of the pommel cushion.</p> <p>Review of the comprehensive care plan for Resident #8 revealed facility staff had reviewed the care plan on 05/01/13 and had addressed the resident's fall risks, impaired mobility, and restraint use. However, there was no evidence the facility had developed a plan of care to address the use of the pommel cushion for Resident #8.</p>	F 279			

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F 279	Continued From page 17  Interview conducted on 06/06/13, at 5:20 PM, with the MDS nurse, Licensed Practical Nurse (LPN) #1, revealed the pommel cushion was used as a positioning device for Resident #8 when the resident was in a wheelchair. The MDS nurse was unable to recall when the pommel cushion had been initiated for Resident #8. The MDS nurse stated a care plan should have been developed for the use of the pommel cushion.  Interview with the Director of Nurses (DON) on 06/06/13, at 5:40 PM, revealed a care plan should have been developed for the use of the pommel cushion. The DON stated routine audits were conducted by administrative staff to ensure care plans were developed appropriately for each resident. However, the DON stated the audits had not identified a care plan was not developed to address the use of the pommel cushion for Resident #8.	F 279		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F520 483.75(o)(1) QAA COMMITTEE-MEMBERS MEET QUARTERLY/PLANS  It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation for the quality assessment and assurance committee to meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  1. Resident #8, #9 and #10's restraints are being reviewed to determine if they are appropriate candidates for a restraint	

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F 520	<p>Continued From page 18</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies/procedures, and a review of the facility's Plan of Correction (POC) for deficiencies cited during a recertification survey conducted on 04/10/12, 04/11/12, and 04/12/12, it was determined the facility failed to ensure the Quality Improvement (QI) Committee developed, implemented, and monitored appropriate plans of action to correct identified deficiencies. A review of the Census and Conditions Report completed by the facility on 05/04/13 revealed the facility had three residents in the facility that required a restraint device (Residents #8, #9, and #10). Residents #8, #9, and #10 were included in the twenty-four sampled residents selected for review. Deficient practice was identified related to restraint use for Resident #8 (identified as Resident #7 during the previous survey) during the previous survey conducted on 04/10/12, 04/11/12, and 04/12/12 and the facility developed/submitted a POC for the deficient practice. Based on a review of the POC, the</p>	F 520	<p>reduction/elimination. These reviews are being done by the Unit Coordinators. This will be completed on 7/5/13. In addition, a physician's order was received indicating the specific medical symptoms for Resident #8s device on 6/17/13.</p> <ol style="list-style-type: none"> <li>2. All other residents with physical restraints are being reviewed to determine if they are appropriate candidates for a restraint reduction/elimination. These reviews are being done by the Unit Coordinators. This will be completed by 7/5/13.</li> <li>3. The Quality of Care Committee will review all residents who require restraint intervention weekly. This review will ensure that the least restrictive device is being utilized and that the restraint relates to a medical condition.</li> <li>4. As a part of the Continuous Quality Improvement program, the committee will review residents listed on the quality measures report to ensure the restraint relates to a medical condition and is least restrictive.</li> <li>5. July 6, 2013</li> </ol>	

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F 520	Continued From page 19 facility's QI program was to provide ongoing monitoring of restraint use to ensure the deficient practice was corrected. However, the facility failed to provide evidence the POC had been implemented. There was no documentation provided that the QI Committee had monitored the restraint reduction/elimination protocols or ensured Resident #8's physician had been consulted regarding the medical justification for the use of the restraint device as indicated in the POC. In addition, there was no documentation provided that the QI Committee had monitored to ensure attempts had been made to reduce/eliminate the safety belt for Resident #8. Resident #8 was observed on 06/04/13, 06/05/13, and 06/06/13 to have a safety belt in place while sitting in a wheelchair as identified in the previous statement of deficiencies.  Refer to F221.  The findings include:  A review of the Quality Improvement (QI) policy/procedure (no date) revealed the QI process included monitoring, evaluation, and appropriate follow-up action to continually improve and provide excellence in service. The QI policy indicated the sources utilized to obtain information included regulatory surveys. The policy further noted the QI Committee would be responsible for the establishment of indicators thresholds and action teams; for a tracking system for follow-through and monitoring of QI follow-up and improvement; and to ensure QI reports that included dates of meetings, record of attendance, and topics discussed would be available for surveyor review.	F 520		

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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  06/06/2013
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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F 520	Continued From page 20  A review of the facility's POC for deficiencies issued from a survey on 04/10/12, 04/11/12, and 04/12/12 was conducted. The POC revealed Resident #8 had been placed on a restraint reduction trial and a physician's order had been received on 05/02/12 that identified the specific medical symptom for the use of the resident's restraint device. The POC further noted the Administrator and DON would provide re-education for the Unit Coordinators (UC) on the process of restraint assessments and therapy referrals for restraint reduction and/or elimination if the restraint assessment indicated the resident was a candidate. The POC also noted the UC would conduct restraint assessments quarterly to determine if Resident #8 was a candidate for restraint reduction/elimination and to make appropriate referrals to therapy staff. The facility identified 05/06/12 as the date the deficient practice would be corrected and that the overall POC would be ongoing.  A review of physician's orders dated April 2012 revealed an order for a safety belt to be utilized when Resident #8 was up in a wheelchair for positioning and safety. Continued review of physician's orders dated June 2013 revealed Resident #8's physician had continued to request a safety belt to be utilized for positioning and safety when the resident was sitting in a wheelchair.  Resident #8 was observed on 06/04/13 at 3:40 PM, to be sitting in a wheelchair in the resident's room with a seatbelt attached to the wheelchair. The resident was also observed on 06/05/13, at 9:35 AM, 10:35 AM, and 1:10 PM sitting in the	F 520			

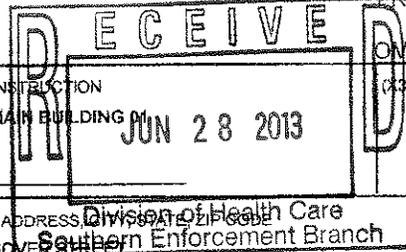
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NAME OF PROVIDER OR SUPPLIER  SOMERSET NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 106 GOVER STREET SOMERSET, KY 42502	
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F 520	<p>Continued From page 21</p> <p>wheelchair with a safety belt in place.</p> <p>Interview with the Occupational Therapist (OT) on 06/06/13, at 4:05 PM, revealed only two attempts had been made to reduce/eliminate the safety belt for Resident #8 since the previous survey. The OT stated that following the previous survey conducted in 2012 she had been told the facility would provide her with restraint referrals based on each residents restraint assessment; however, according to the therapist, the referrals had not been made consistently for Resident #8.</p> <p>Interview conducted with the Unit Coordinator (UC) on 06/06/13, at 5:00 PM, revealed she had received training related to conducting quarterly restraint reduction/elimination assessments. The UC stated she had conducted the quarterly assessments for Resident #8 and made referrals to the therapy staff for screening for restraint reduction/elimination. The UC stated she was not aware the screenings had not been completed for Resident #8 as directed in the POC.</p> <p>Interview conducted with the Administrator on 06/06/13, at 5:50 PM, revealed she was also the QI Coordinator for the facility. The Administrator stated the QI Committee had been reviewing the medical record for Resident #8 to ensure the quarterly restraint assessments had been conducted as directed in the POC. The Administrator stated although quarterly assessments had been conducted, the QI Committee had not reviewed the outcome or result of the assessments to ensure restraint reduction/elimination attempts had been conducted for Resident #8.</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER  SOMERSET NURSING AND REHABILITATION FACILITY	STREET ADDRESS 106 GOVERNOR STREET SOMERSET, KY 42502
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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 06/04/13, 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	K061 NFPA 101 LIFE SAFETY CODE STANDARD  It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation for required automatic sprinkler systems to have valves supervised to that at least a local alarm will sound when the valves are closed.  1. Local electrician to run wiring from the valve in the outside pit to the mechanical room. Anticipated completion date is 7/5/13. 2. Sentry Fire will then install equipment, make all final wiring connections, perform all necessary programming, and test new Sprinkler Supervisory Switches for proper operation and instruct maintenance staff on operation of equipment 3. As part of the facility's preventative maintenance program, the maintenance supervisor will monitor Sprinkler Supervisory Switches monthly to ensure this standard is maintained. This will be an ongoing measure. 4. July 19, 2013	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA	K 061		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jennifer Davis</i>	TITLE Administrator	(X6) DATE 6/28/13
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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.

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K 061	<p>Continued From page 1 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the building sprinkler system was maintained as required by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 123 beds with a census of 117 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 06/04/13, at 2:50 PM, with the Director of Maintenance (DOM) an outside pit that contained a valve that controlled water flow to the sprinkler system was observed to not be electronically supervised as required. This electronic device alerts the facility when the water valve has been turned off. An interview with the DOM on 06/04/13, at 2:50 PM revealed he was not aware the valve should be electronically supervised.</p> <p>The findings were revealed to the Administrator during exit.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>3-8.3.3.3.2* If a valve is installed in the connection between an alarm-initiating device intended to signal activation of a fire suppression system and the</p>	K 061		

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K 061	Continued From page 2 fire suppression system, the valve shall be supervised in accordance with the requirements of Chapter 2.  A-3-8.3.3.3.2 Sealing or locking such a valve in the open position, or removing the handle from the valve, does not meet the intent of the supervision requirement.	K 061		