

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

PRINTED: 03/17/2011
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 03/03/2011
NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 106 GOVER STREET, P O BOX 1121 SOMERSET, KY 42502	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Somerset Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
F 225 SS=D	<p>A standard health survey was conducted on February 28, 2011 to March 3, 2011. Deficient practice was identified with the highest scope and severity being at an "E" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225	<p>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.</p> <p>F225 483.13(c)(1)(ii)-(iii),(c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS.</p> <p>It is and was on the date of the survey, the policy of Somerset Nursing and Rehabilitation to ensure that injuries of unknown source are thoroughly investigated and reported immediately to the required state</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Angela Hood

TITLE

Administrative

(X6) DATE

3/30/11

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

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F 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to thoroughly investigate and report injuries of unknown origin immediately to the required State Agencies for two of twenty-six sampled residents (residents #3 and #18). Resident #18 was diagnosed with a fracture of the right tibia and fibula on August 26, 2010. The facility failed to conduct an investigation and report the injury of unknown origin to the required State Agencies. Resident #3 was diagnosed with a fracture of the left ankle on January 24, 2011, however, the facility failed to thoroughly investigate the fracture and report the injury of unknown origin to the required state agencies.</p> <p>The findings include:</p> <p>Review of the facility's accidents/incidents policy, not dated, revealed regardless of how minor an accident or incident may be an accident/incident report form must be completed on the shift that the accident or incident occurred. The Charge Nurse and/or the Department Supervisor shall conduct an immediate investigation of the accident or incident; the investigation report must be submitted to the Director of Nursing (DON) no later than 12 hours after the occurrence of the accident/incident. The Charge Nurse and/or Department Supervisor shall complete an accident/incident report form and submit to the</p>	F 225	<p>agencies or conduct an investigation into the cause of the resident's injury.</p> <ol style="list-style-type: none"> 1. Resident #3 is no longer a resident of the facility. Resident # 18 has had no further injuries. 2. Each week day morning the Director of Nursing and interdisciplinary team to include Administrator, Quality Assurance Nurse, and MDS nurses will review all incident reports and injuries, regardless of cause, to determine if incident meets criteria of unknown origin and needs to be investigated and abuse protocol implemented to protect residents. This will be on-going. All parties have been trained utilizing the facility's policy and procedure. 3. All RN, LPN, C.N.A and CMT staff will be in-serviced on Abuse protocol specific to injuries of unknown etiology by the Administrator. Abuse investigation system consists of considering environmental factors of situation, interviewing all involved including employees, visitors and 	

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F 225	<p>Continued From page 2</p> <p>DON along with the investigation report form and submit the original copy of the investigation report and the accident/incident report to the Administrator no later than 24 hours after the occurrence of the accident/incident.</p> <p>Review of the facility's abuse reporting policy, not dated, revealed, "It is the policy of this facility that all personnel promptly report any incident or suspected incident of resident abuse, including injuries of unknown source." The policy went on to state, "Upon receiving reports of mistreatment, abuse, misappropriation of property, or neglect, the Administrator or DON will immediately report the incident to the Division of Licensing and Regulation."</p> <p>1. Review of resident #18's medical record revealed the resident was admitted to the facility on April 20, 2004, with diagnoses of Rheumatoid Arthritis, Diaphragmatic Hernia, Esophageal Reflux, Congestive Heart Failure, and Convulsions.</p> <p>Observation of resident #18 on March 3, 2011, at 2:30 p.m., revealed the resident was in his/her room sitting in the recliner with feet up. A large bruise was observed to resident #18's right forehead; the resident stated the bruise was the result of a fall from the toilet. Observation later that same day at 6:00 p.m., revealed resident #18 sitting in the wheelchair, propelling self out of the resident's room, a self-releasing Velcro belt observed around resident #18.</p> <p>Review of resident #18's nursing notes dated August 25, 2010, at 12:30 p.m., revealed a nursing note which stated resident #18 was complaining of tenderness and pain to the right</p>	F 225	<p>families and a thorough review of all clinical records, considering diagnosis, medications, labs and other contributing factors and reporting any injury of unknown etiology to the appropriate state agencies.</p> <p>4. The Social Service Director will review all incident reports for the week regardless of type of incident. Social Service Director will evaluate if appropriate determination was made by the Director of Nursing and interdisciplinary team to treat incident of unknown etiology and therefore initiate abuse protocol. All injuries of unknown origin will be immediately reported to the required state agencies. Social Service Director has been trained utilizing the facility's abuse policy. This will be an on-going.</p> <p>5. March 24, 2011.</p>

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F 225	<p>Continued From page 3</p> <p>foot, the physician was notified, and an order was obtained to send resident #18 for an x-ray the next day. Nursing notes for August 26, 2010, at 8:30 a.m., revealed the resident was out of the facility for an x-ray. Review of nursing notes dated August 26, 2010, at 1:45 p.m., revealed the resident was back at the facility with a boot-cast to the right lower extremity which was to be on at all times and could be removed for showers and skin assessments. The same nursing note went on to state resident #18 was non-weightbearing on right extremity and the resident required the use of a Hoyer lift for transfers.</p> <p>Review of an x-ray report dated August 26, 2010, revealed an x-ray of the right ankle. The x-ray report findings revealed a mildly displaced oblique fracture of the distal fibula and tibia (two bones in the lower leg).</p> <p>Interview with the Nurse Consultant (NC) on March 2, 2011, at 6:18 p.m., revealed no incident report and no investigation report could be found related to resident #18's fractured bones.</p> <p>Interview on March 3, 2011, at 12:13 p.m., with Certified Nursing Assistant (CNA) #4, who was providing care for resident #18 on March 3, 2011, revealed the CNA did not know how resident #18 had fractured the bones in the lower leg. CNA #4 stated he/she was off work for a few days and upon return to work resident #18 voiced complaints of pain in the right foot. CNA #4 stated he/she was not aware of any falls resident #18 had sustained in the days previous, and resident #18 was not wearing a boot-cast at the time of the resident complaining of the pain. CNA #4 stated resident #18's foot was swollen and red, and that the CNA reported this to staff and was</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>told resident #18's foot had been evaluated and there was nothing wrong with it.</p> <p>Interview on March 3, 2011, at 1:30 p.m., with the Infection Control Nurse (ICN), who was responsible for all fall related incidents and injuries, revealed the facility had no record of resident #18 having fallen in the days prior to the diagnosis of a fracture. Interview with the ICN further revealed an incident report related to resident #18's fracture of the lower leg should have been filled out and an investigation should have been conducted regarding the injury of unknown origin. Interview further revealed the ICN did not remember filling out an incident report, did not conduct an investigation regarding resident #18's fractured bones, and did not know how resident #18 sustained the fractured bones. The ICN went on to state that he/she had no information related to the fractured bones.</p> <p>Interview with the Director of Nursing (DON) on March 3, 2011, at 3:01 p.m., revealed when a resident has an injury of unknown origin the chart and incident reports are reviewed to see if the resident had a fall prior to the injury. Then staff that had provided care for the resident would be interviewed to see if anything had been observed which could have caused the injury. The DON went on to state that if a resident had an injury and had not had a fall prior to the injury then the staff would call the DON and inform her/him of the injury. The DON stated he/she was not aware of how resident #18 received the fractured bones and did not remember getting a call related to resident #18's fracture. The DON stated he/she did not know if an incident report and investigation had been conducted, further the DON could not provide an incident report or an</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>investigation report related to resident #18's injury of unknown origin. The DON also stated the injury of unknown origin had not been reported to the appropriate state agencies.</p> <p>Interview with the Administrator on March 3, 2011, at 4:37 p.m., revealed an incident report along with an investigation was to be conducted on any fracture in the building to determine the exact nature of the fracture. The Administrator went on to say that any injury of unknown origin was to be reported to the appropriate state agencies. Further interview revealed the Administrator could not provide an incident report, an investigation, or information that resident #18's fractured lower leg bones had been reported to the appropriate state agencies. The Administrator stated he/she did not know how resident #18 fractured the bones, and did not remember conducting an investigation related to the fractures.</p> <p>2. Review of resident #3's medical record revealed the resident was admitted to the facility on October 5, 2006, with the following diagnoses: Mental Disorder, Urinary Tract Infection, Advance Dementia, Status Post Right Knee Replacement, Hypothyroidism, Anemia, and Degenerative Joint Disease. Further review of the Consultation Report for January 26, 2011, revealed a left ankle fracture on January 24, 2011, of unknown origin.</p> <p>Observation of resident #3 on February 28, 2011, on initial tour at 10:00 a.m., revealed the resident up in a geri-chair with bilateral lower extremities elevated and covered with a sheet. The resident's call light was attached to the sheet and the alarm sensor pad was in the chair behind the resident.</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>A review of the nurse's notes for January 24, 2011, revealed at 8:45 p.m., while providing care the Certified Nurse Aide (CNA) noted the left lower extremity swollen and discolored. The resident voiced complaints of pain when touched. The nurse contacted the physician and received an order to send the resident to the Emergency Room for evaluation and treatment. The resident returned to the facility at 11:45 p.m., with a new diagnosis of fracture to the tibia and fibula. The resident had an equalizer boot to the left lower extremity and an order for a consultation with an Orthopedic Specialist on January 28, 2011.</p> <p>A review of the nurse's notes for January 26, 2011, revealed at 2:00 p.m., the Orthopedist's office called related to admitting the resident to the hospital for an Open Reduction Internal Fixation of the Left Ankle.</p> <p>A review of the nurse's notes for January 29, 2011, revealed the resident was readmitted to the facility with a Fair rehab potential and physician's orders of non-weightbearing to the left lower extremity.</p> <p>A review of the Resident Incident/Accident Follow-Up Assessment Form for resident #3 for January 24, 2011, at 8:45 p.m., revealed no causative factor was evaluated specifically for the resident such as resident needing to go to restroom, or evaluation of the resident's pain. Recommendation/action taken revealed: sent to Emergency Room. There were no specific interventions or recommendations for this resident.</p> <p>Interview on March 3, 2011, at 6:15 a.m., with</p>	F 225		

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F 225	<p>Continued From page 7</p> <p>State Registered Nurse Aide (SRNA) #1 caring for resident #3 on January 24, 2011, when injury of unknown origin was noted, revealed the resident's leg was swollen. SRNA #1 stated the aide on the prior shift did not report any swelling of the resident's leg. The aide revealed the swollen leg was reported to the Charge Nurse as soon as it was noted. The aide revealed the side rails were used by the resident for bed mobility. The aide further revealed to prevent falls a bed alarm was utilized, and resident #3 was observed every two hours by the SRNAs and/or a wanderguard employee (the facility employed staff called wander guards whose job was to observe at set times all residents with alarms, who were at risk for elopement, and who were at risk for falls).</p> <p>Interview on March 3, 2011, at 6:10 a.m., with the Licensed Practical Nurse (LPN) caring for resident #3 on January 24, 2011, when the injury of unknown origin was observed, revealed she just found the resident that way, and she honestly did not know what had happened to cause the injury.</p> <p>Interview on March 3, 2011, at 1:30 p.m., with the Infectious Disease Nurse and the nurse responsible for incident reports revealed when an injury of unknown origin is discovered in the facility the report was given directly to the Director of Nursing and the Administrator for follow-up.</p> <p>Interview on March 3, 2011, at 3:00 p.m., with the Director of Nursing (DON) revealed the facility policy is to report unknown injury to state agencies. The (DON) revealed that resident #3 had a diagnosis and was sent to the hospital for the fracture, but it was still unknown how the</p>	F 225		

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F 225	Continued From page 8 fracture occurred. Interview with the Administrator on March 3, 2011, at 4:40 p.m., revealed incidents reportable to state agencies are abuse situations and injury of unknown origin which would cause negative outcomes. The Administrator stated that resident #3's hospital report of the fracture on January 24, 2011, revealed Osteopenia and this could be the cause of the fracture. The Administrator further revealed she did interview the staff because there was an injury and she should have reported it to the state agencies.	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to assure that all residents' care plans are reviewed and revised by a team of qualified persons. 1. The care plan of Resident #14 has been reviewed and revised regarding change in behaviors. Individualized interventions were added to address resident #14's drinking a potentially harmful substance and her threats of wanting to die.	

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F 280	<p>Continued From page 9</p> <p>by: Based on observation, interview, and record review, the facility failed to periodically review and revise the Comprehensive Care Plan (CCP) for one of twenty-six sampled residents (resident #14). Resident #14 was exhibiting new behaviors, however, the CCP was not updated to address the behaviors.</p> <p>The findings include:</p> <p>Review of resident #14's medical record revealed resident #14 was admitted to the facility on May 19, 2009, with diagnoses of Symbolic Dysfunction, Depression, Delusional Nocturnal Delirium, and Anemia. Review of the Resident Assessment Protocols (RAPs) dated September 29, 2010, revealed resident #14 made negative statements, persistent anger with self or others, increased confusion, agitation, and threatened to harm staff on September 16, 2010. Review of resident #14's quarterly Minimum Data Set (MDS) dated December 14, 2010, revealed resident #14 exhibited no behaviors.</p> <p>Review of resident #14's behavior/intervention flow chart record for December 2010 revealed resident #14 exhibited no behaviors during the month of December 2010, however, in February 2011, resident #14's monthly behavior/intervention flow chart revealed resident #14 exhibited inappropriate behaviors five days. Facility staff listed on the behavior flow chart that resident #14 had resisted care on February 5, 6, 15, and 16, 2011. Review of resident #14's monthly mood (staff assessment) record revealed on February 5, 6, and 15, 2011, that the resident was short-tempered and easily annoyed. The documentation revealed on February 16, 2011,</p>	F 280	<ol style="list-style-type: none"> 2. All residents' care plans will be reviewed and revised by the interdisciplinary care plan team to capture any change in a resident's condition, quarterly, annually and as needed. 3. Weekly the Director of Nursing will attend care plan meeting to ensure all areas of concern are addressed. 4. As part of the facility's on-going quality assurance program, the Director of Nursing will audit 10% of care plans monthly to ensure the care plan accurately reflects the residents care has been provided. 5. March 24, 2011. 		

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F 280	<p>Continued From page 10</p> <p>resident #14 felt or appeared down, depressed, and hopeless. The monthly mood record also indicated the resident felt bad about his/herself, felt like a failure, and that he/she had let his/herself or family down. In addition, on February 16, 2011, according to the mood (staff assessment) record, resident #14 stated that life was not worth living, wished for death, wanted to harm him/herself, and appeared to be short-tempered and easily annoyed. Review of the behavior flow chart revealed on February 18, 2011, resident #14 exhibited verbally abusive behavior.</p> <p>Review of resident #14's nursing notes dated February 2, 2011, at 8:30, revealed resident #14 reported to staff that he/she drank a small amount of body spray and asked staff if it was poison. A nursing note on February 6, 2011, revealed the resident exhibited increased agitation and anxiety, resisted care, and yelled at staff and his/her roommate. Review of nursing notes dated February 16, 2011, revealed resident #14 was at the nurses' station yelling and cursing and stated "just wanted to kill herself," "I should shoot myself," and "give me some pills to take." Further review revealed resident #14 stated he/she was going to leave the facility, and stated, "I just want to die." In addition, nursing notes dated February 18, 2011, revealed resident #14 became very agitated with another resident and threatened to hit the other resident.</p> <p>Review of resident #14's CCP dated June 1, 2009, revealed resident #14 had a potential for altered mood/behavior related to diagnoses of depression, confusion, dementia with agitation, and insomnia, and a history of negative statements. Interventions listed on the plan dated</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>June 1, 2009, included staff to monitor the resident's mood/behaviors every shift, consult Social Services as needed, psychiatric evaluation as needed, administer medications as ordered, and to notify the doctor as needed if the resident exhibited increased mood or behaviors. Record review revealed these interventions were being provided for resident #14, however, no documentation was provided to show that the interventions had been reassessed for effectiveness for resident #14 related to the new behaviors. The CCP was updated on February 16, 2011, and included for staff to administer 1 milligram (mg) of Ativan, on a one-time basis if the resident's agitation increased. No individualized interventions were added to resident #14's plan to address the resident drinking the poisonous substance, threats of wanting to die, and threats of wanting to commit suicide.</p> <p>Interview with the MDS Coordinator on March 3, 2011, at 1:15 p.m., revealed resident care plans were updated daily when physician's orders were reviewed. The MDS Coordinator stated a nursing staff meeting was held every morning and all department heads were required to attend the meeting. In the meeting staff review physician's orders and nursing documentation for the previous 24 hours. The MDS Coordinator stated the notes consisted of physician's orders, labs, and residents who had been sick. The MDS Coordinator stated nursing staff who worked with resident #14 was responsible to add changes in the resident's behaviors to the 24-hour nursing report. In addition, nursing staff was to update MDS staff of any new or increased behaviors so that the resident's behaviors could be added and addressed in resident #14's CCP. The MDS</p>	F 280			

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F 280	Continued From page 12 Coordinator went on to say that the resident's behaviors of drinking body spray, making negative statements, and threats of suicide should have been added to resident #14's CCP; however, the MDS Coordinator was unaware of the behaviors. Interview with the Director of Nursing (DON) on March 3, 2011, at 3:59 p.m., revealed a department head meeting was held every morning to discuss residents of the facility, and any issues in the facility that needed to be addressed concerning the residents. The DON stated the change in resident #14's behaviors was discussed during the morning meeting on February 16, 2011. The DON provided a copy of a 24-hour nursing report, dated February 16, 2011, for review. The report, completed by nursing staff, included changes in medications, lab reports, physician appointments, and special treatments a resident had received during the previous 24 hours. A review of the report revealed resident #14 had increased behaviors and had been sent to the Emergency Department due to the change in behaviors. However, there was no documentation provided to indicate that resident #14's behaviors had been assessed upon the resident's return from the hospital in order for the nursing staff to update the CCP.	F 280			
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.	F 323	F223 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to ensure a safe environment to include adequate supervision to prevent		

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F 323	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a safe environment to include adequate supervision to prevent accidents for one of twenty-six sampled residents (resident #18). Resident #18 was identified at risk for falls; however, the facility failed to evaluate and analyze the risk factors, identify the causative factors, and develop/implement resident specific interventions, in an attempt to reduce the likelihood of accidents for each resident. Resident #18 sustained twelve falls from May 2010 to February 2011.</p> <p>The findings include:</p> <p>Resident #18 was admitted to the facility on April 20, 2004, with diagnoses including Congestive Heart Failure, Esophageal Reflux, Diaphragmatic Hernia, and Convulsions.</p> <p>Review of the annual Minimum Data Set (MDS) assessment for resident #18 dated June 3, 2010, revealed the facility assessed resident #18 to require limited assistance of one staff person for transfer and ambulation in the room. Resident #18 required extensive assistance of one staff person for ambulation in the halls, and bathing. According to the MDS resident #18 was continent of bowel and occasionally incontinent of bladder. A significant change MDS dated September 6, 2010, revealed the facility assessed resident #18 to require total dependence of two staff persons for transfer, and was assessed as continent of bowel and occasionally incontinent of bladder. The assessment revealed resident #18 had a</p>	F 323	<p>accidents and to evaluate and analyze risk factors, identify causative factors and develop specific interventions to reduce the likelihood of accidents for each resident.</p> <ol style="list-style-type: none"> 1. Resident #18 risk factors have been evaluated and analyzed, causative factors have been identified and specific interventions have been put into place to reduce the likelihood of future accidents. 2. All residents will be evaluated and analyzed upon admission for falls risk factors by the Quality Assurance Nurse and interdisciplinary care plan team. Additionally, all current residents will be evaluated and analyzed with a change in condition, quarterly, annually or as needed for falls risk factors by the interdisciplinary care plan team and Quality Assurance nurse. Individual interventions will be implemented and assessed for effectiveness by the Quality Control Nurse to reduce the likelihood of accidents. 	

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F 323	<p>Continued From page 14</p> <p>history of falls and required the use of a restraint. Review of resident #18's Resident Assessment Protocol (RAP) dated September 6, 2010, revealed the facility assessed resident #18 to have had several falls because the resident thought that he/she could transfer self without help and did not ring for assistance. The RAP went on to say resident #18 had a personal alarm but removed it, had a bed alarm, was on the falling star program, and Therapy was evaluating the resident for the safest device.</p> <p>Review of resident #18's fall risk assessment revealed the facility assessed resident #18 on May, 6, 14, and 25, June 14, August 10 and 16, September 2 and 24, October 30, November 19 and 30, December 12, 2010, and again on January 19, and February 21, 2011, to be at risk for falls. According to the fall risk assessment on each date listed above, resident #18 was assessed to have intermittent confusion, three or more falls in the past three months, was ambulatory/incontinent, poor vision, not able to perform a gait/balance, took three to four antihypertensives (high blood pressure medication), anti-seizure, and narcotics, and had a predisposing disease.</p> <p>Review of resident #18's Comprehensive Care Plan (CCP) dated April 21, 2004, revealed the facility assessed resident #18 to be at risk for falls related to a history of falls, attempted to get up unassisted, had a slow unsteady gait, tired easily, and refused to ring for assistance. Examples of interventions implemented included: keep corridors and rooms well lit; falls assessment quarterly and as needed; frequent staff monitoring with cues and prompting for use of bathroom; remind resident of safety risks on a daily basis if</p>	F 323	<p>3. All LPNs and RNs were in-serviced on March 16, 2011, by the Administrator regarding the correct investigative protocol for falls and incidents. Investigative protocol includes identifying risk factors, environmental factors, changes in conditions, assessing medications and medical diagnosis and identifying accurate causative factors. This investigation will occur immediately after a fall and all appropriate notifications will be made timely. Individualized interventions based on this investigation will be implemented immediately. The incident will be reviewed each week day morning by the interdisciplinary team to include Administrator, Director of Nursing, Quality Assurance Nurse and MDS Nurses to assist in tracking and trending. This will be on-going.</p> <p>4. As part of the facility's on-going CQI process, 10 % of all falls will be audited monthly to ensure the</p>	

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F 323	<p>Continued From page 15</p> <p>he/she doesn't allow someone to help; falling star program, bed alarm, and bilateral full padded side rails to aid in turning and positioning.</p> <p>Review of resident #18's incident report forms revealed resident #18 had a total of 12 falls from May 13, 2010 to February 18, 2011. Five falls occurred when the resident was attempting to go to the restroom. Resident #18 fell on June 11, 2010, August 15, 2010, November 4, 2010, November 21, 2010, December 9, 2010, and January 18, 2011, while attempting to go to the restroom. However, the facility only addressed resident #18's toileting needs on November 5, 2010, when the care plan was updated to include toileting every three hours. Resident #18 had three falls after November 5, 2010, attempting to toilet self, however, the facility did not reassess the intervention of every three-hour toileting to evaluate its effectiveness. Although the facility listed causative factors of resident #18's falls as getting up and toileting self unassisted, the facility failed to determine the potential cause of these behaviors and/or the resident falls.</p> <p>Review of the falls progress notes dated November 19, 2010, November 22, 2010, and December 22, 2010, revealed notes related to resident #18's falls regarding toileting, and the every three-hour toileting program, however, the progress notes stated to continue the toileting program of every three hours without evidence that the every three hours had been reassessed for effectiveness.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on March 3, 2011, at 12:13 p.m., revealed resident #18 was an assist of two staff persons for toileting. SRNA #4 stated that at</p>	F 323	<p>facility is evaluating and analyzing risk factors, identifying causative factors and implementing resident specific interventions to reduce the likelihood of accidents. This will be on going.</p> <p>5. March 24, 2011</p>	

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F 323	Continued From page 16 times he/she would be in another resident's room assisting that resident and unable to hear resident #18's body and Velcro alarms going off. SRNA #4 stated that when he/she would get to resident #18's room resident #18 would have already fallen and the alarm would be going off. Interview with the Infection Control nurse (ICN) on March 2, 2011, at 5:14 p.m., revealed the ICN was responsible for investigating, assessing, interviewing staff, and implementing interventions for all the falls in the facility. The ICN stated that all incident reports for falls come to her/his office and it was his/her responsibility to look at the incident report, assess the resident, interview staff, update the CCP, and assess what interventions need to be made for the resident. The ICN said the facility had a weekly interdisciplinary team (IDT) meeting that consisted of the Administrator, MDS staff, Therapy Department staff, Director of Nursing (DON), and Social Services staff. According to the ICN, all falls for the week were discussed at the weekly IDT meeting. Further interview revealed the IDT team reviewed all interventions that had been put into place for each fall and looked for trends regarding the falls. The ICN stated the IDT had not evaluated the effectiveness of the every three-hour toileting schedule, nor had the IDT assessed for the effectiveness of the Velcro alarm safety belt for resident #18. Interview further revealed interventions developed for resident #18 were not specific and the causative factors for each fall did not address the actual reason resident #18 fell. The ICN stated that notes from the IDT meetings were recorded, however, none were provided. Interview with the DON on March 3, 2011, at 3:01	F 323		

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F 323	Continued From page 17 p.m., revealed the ICN received the incident reports from all falls, that the ICN performed the follow-up assessment on the resident, reviewed the resident's chart, made sure all notifications were made to the physician and family, and reviewed each fall to assess if further interventions needed to be added for that resident. The DON stated all incident reports and interventions were reviewed weekly at the IDT meetings. Interview further revealed that resident #18's interventions were not resident specific for each fall. The DON further stated that the causative factors listed for each fall were not always the reason for the fall, that staff did not understand what causative factors were and just listed what the resident was doing at the time.	F 323	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	F431 483.60(b),(d),(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to date all drugs and biological in accordance with currently accepted professional principles. 1. There were no residents negatively affected by this practice. 2. All RNs and LPNs nursing staff have been in-serviced by the Director of Nursing on March 23, 2011, regarding the facility policy of dating all drugs and

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F 431	<p>Continued From page 18 have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to date all drugs and biologicals in accordance with currently accepted professional principles. One vial of Novolog Mix 70/30 Insulin intended for multi-dose use had been opened and was available for use; however, the medication had not been dated to indicate the date the bottle was opened.</p> <p>The findings include:</p> <p>Observation on March 2, 2011, at 1:10 p.m., of the facility's medication rooms/carts revealed a vial of Novolog Mix 70/30 Insulin in the medication room at Nurse Station #1 had been opened and remained available for resident use. Further observation revealed the vial failed to indicate the date the vial was opened.</p> <p>An interview was conducted with the Director of Nursing (DON) on March 3, 2011, at 12:05 p.m. The DON stated the medication should have</p>	F 431	<p>biological in accordance with the facility policy.</p> <p>3. The Charge Nurse on each station will daily (M-F) audit her nurses station to ensure biological are labeled properly.</p> <p>4. As part of the facility's on-going quality assurance plan, the Director of Nursing will audit biologicals weekly to ensure they are labeled properly.</p> <p>5. March 24, 2011</p>		

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F 431	Continued From page 19 been labeled and dated at the time the medication was opened. The DON further stated he/she felt the medication had probably been opened on the previous shift. The DON stated all medications were currently being spot checked three times per week to ensure all medications opened had been labeled and dated. The DON further stated the DON had been doing the spot checks, and had done the checks on February 28, 2011.	F 431			
F 441 SS=D	A review of the facility policy titled Vials and Ampules of Injectable Medications, containing no date, revealed the date opened and the initials of the first person to use the vial are to be recorded on multi-dose vials, on the vial label, or an accessory label affixed for that purpose. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is and was on the dates of the survey, the policy of Somerset Nursing and Rehabilitation to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections. 1. The Wound Care Nurse involved was promptly educated and in-serviced on standard precautions, prevention of spreading infection and on appropriate hand washing during wound care treatments by the Director of Nursing. 2. All facility LPN and RN staff have been in-serviced on March 23, 2011, by the		

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F 441	<p>Continued From page 20</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to help prevent the development and transmissions of disease and infections for two of twenty-six sampled residents. During wound care observation the facility wound care nurse failed to perform handwashing when performing wound care for residents #1 and #3 on March 1, 2011.</p> <p>The findings include:</p> <p>1. A review of the medical record revealed resident #3 had a diagnosis of left heel decubitus and history of venous stasis disease of the bilateral lower legs.</p> <p>A review of the physician's orders for March 2011</p>	F 441	<p>Director of Nursing on standard precautions, prevention of spreading infections and on appropriate hand washing during wound care as well as in general care.</p> <p>3. The Director of Nursing and the Infection Control Nurse will do weekly audits of both wound care treatments and general resident care observing for appropriate hand washing technique for the next 6 months.</p> <p>4. As part of the facility's on-going CQI program, the above mentioned audits will be made part of our CQI process and reviewed monthly.</p> <p>5. March 24, 2011.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2011
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 441	<p>Continued From page 21</p> <p>revealed the physician requested staff to cleanse resident #3's left heel decubitus with normal saline, apply a Xeroform gauze dressing, and cover the Xeroform dressing with gauze on a daily basis. In addition, the physician requested for the resident to wear a Buck-Boot and indicated the Buck-Boot could be removed for personal care and showers.</p> <p>Observation of wound care provided on March 1, 2011, at 1:30 p.m., to resident #3's left heel pressure sore revealed the wound care nurse donned clean gloves and removed and disposed of the old dressing. The Wound Care Nurse (WCN) then cleansed the wound, changed gloves, applied Xeroform, and covered the wound with gauze. The WCN did not wash his/her hands prior to performing the wound care or between changing the dirty gloves and donning clean gloves.</p> <p>An interview on March 1, 2011, at 2:00 p.m., with the facility's WCN and the Unit Manager concerning handwashing between changing gloves and going from dirty to clean revealed they had never been told by facility to wash hands between changing gloves from dirty to clean. They further revealed they had just been told to wash between residents.</p> <p>The facility's policy, Hand Hygiene, Infection Control Manual for Longterm Care, dated 2007, revealed the purpose: To decrease the risk of transmission of infection by appropriate hand hygiene. Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections.</p> <p>2. A review of the medical record for resident #1</p>	F 441		

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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 03/03/2011 -
NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 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 441	<p>Continued From page 22</p> <p>revealed the resident was admitted to the facility on November 29, 2010, with diagnoses to include Chronic Renal Failure, Diabetes Mellitus, Peripheral Neuropathy, and Peripheral Artery Disease. A review of the Wound Care Summary on admission revealed the resident had a Stage 2 pressure ulcer, located on the coccyx area. A review of the current physician's wound care orders dated March 1, 2011, revealed staff was to cleanse the area to the coccyx with Normal Saline, apply an Aquacel AG dressing, and cover with a Versa dressing. The wound care was ordered to be done every three days and as needed.</p> <p>Observation of wound care for resident # 1 was observed on March 1, 2011, at 1:30 p.m. The WCN was observed to remove the soiled dressing, and discard the dirty dressing and gloves in the trash. The dressing was observed to contain dark brown drainage. The WCN failed to wash her hands before applying clean gloves to continue with the wound care.</p> <p>An interview conducted with the WCN for the facility on March 1, 2011, at 1:55 p.m., revealed the WCN felt changing his/her gloves before going from a soiled area to a clean area was sufficient and was not aware he/she should have washed his/her hands prior to donning clean gloves.</p> <p>A review of the facility's policy titled Hand Hygiene, dated 2007, revealed hands are to be washed when hands are visibly soiled or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids. Hand hygiene is to be used with either a non-antimicrobial soap and water, or an</p>	F 441			

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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 03/03/2011
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 441 F 465 SS=E	Continued From page 23 antimicrobial soap and water. 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Eleven resident rooms had wood chipped on the doors, four resident rooms were observed with loose or cracked baseboards, three resident rooms were observed to have holes in the walls and/or bathroom door, and two different areas were observed with cracked tile. The findings include: During the environmental tour of the facility on March 3, 2011, at 12:30 p.m., the following items were observed to be in need of repair: -Chipped wood on resident room doors were observed in resident rooms 2, 8, 10, 12, 14, 15, 16, 20, 22, 26, and 27. -The baseboard was observed loose under the air conditioner in resident room 19. -A hole was observed in the bathroom door in resident room 17. -The baseboards were observed cracked under the window in resident room 8, beside the window in resident room 12, and beside the air	F 441 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 an effective housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1. The areas of concern have been repaired to ensure the safety of all residents. 2. All resident doors have been evaluated for chipped surfaces and a protective covering is being applied. All baseboards have been checked for cracks and proper sealing and corrected accordingly. All walls have been checked and repaired for any holes and all tiles have been checked for cracking and have been replaced. 3. Maintenance will conduct monthly rounds with documentation to ensure all areas are safe and orderly.	

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

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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 03/03/2011
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 465	<p>Continued From page 24 conditioner in resident room 14. -A hole in the wall was observed in resident room 2 around the air conditioner, and in resident room 14 below the heater. -Cracked tile was observed in resident room 10 in front of the closet. -Cracked tile was observed in the hallway in front of the Conference Room.</p> <p>Interview on March 3, 2011, at 12:50 p.m., with the Maintenance Supervisor (MS) revealed the facility utilized a work order system. The MS stated any staff member could obtain a work order at the nurses' stations to inform the Maintenance Department of anything that needed repair. The MS stated the MS made rounds several times a day to look for items in need of repair and to check the nurses' station for work orders; however, the MS was not aware of the identified areas.</p>	F 465	<p>The Administrator and Director of Nursing will make daily rounds to ensure a safe environment. These rounds will be on-going.</p> <p>4. Maintenance staff will provide the Administrator a monthly checklist noting any necessary repairs and the date the repair was complete.</p> <p>5. March 24, 2011.</p>		

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

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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 03/01/2011
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 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on March 1, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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