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

PRINTED: 05/22/2020 FORM APPROVED OMB NO. 0938-0391

MAKE OF PROMISER OR SUPPLIER  SOMERSET NURSING AND REHABILITATION FACILITY  (X4) ID PREPARATION OF LICE IDENTIFYING INFORMATION)  FOR INITIAL COMMENTS  A COVID-19 focused infection control survey was conducted on 04/06/2020. The facility was found to be in compliance with 42 CFR 493.80 Infection Control and has implemented the Centers for Medicare & Medical Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified. The total census was 105.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
SOMERSET NURSING AND REHABILITATION FACILITY  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  A COVID-19 focused infection control survey was conducted on 04/06/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.			185218	B. WING			04/06/2020	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  A COVID-19 focused infection control survey was conducted on 04/06/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.					106 GOVER STREET	CODE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		A COVID-19 focused conducted on 04/06/2 to be in compliance we Control and has imple Medicare & Medicaid Centers for Disease (CDC) recommended COVID-19. No deficit The total census was	I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention I practices to prepare for ent practice was identified. 105.					

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185218	B. WING			04/06/2020	
NAME OF PROVIDER OR SUPPLIER  SOMERSET NURSING AND REHABILITATION FACILITY			·	STREET ADDRESS, CITY, STATE, ZIP C 106 GOVER STREET SOMERSET, KY 42501	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
E 000	survey was conducte facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 04/06/2020. The se in compliance with 42 ncy Preparedness related to practice was identified.	E				
I ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE	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.

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Office of Inspector General

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						3) DATE SURVEY COMPLETED	
100524				B. WING			04/06/2020	
NAME OF PROVIDER OR SUPPLIER  STREET ADD  106 GOVER				DRESS, CITY, STATE, ZIP CODE ER STREET ET, KY 42501				
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 000	A COVID-19 focused conducted on 04/06/2	infection control survey 2020. The facility was foursuant to 42 CFR 483. was identified.	ound	N 000				

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

TITLE (X6) DATE