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

PRINTED: 06/08/2020 FORM APPROVED OMB NO 0938-0391

CENTEROT OR MEDICARE & MEDICARD SERVICES		_		_CIVID IVO. 0936-0391				
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		C			
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	06/03/2020			
SOMERSET NURSING AND REHABILITATION FACILITY				SOMERSET, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION			
F 000	An abbreviated stand KY31771) and a CON control survey was in concluded on 06/03/2 unsubstantiated and identified. The facility compliance with 42 CO	dard survey (KY31514, /ID-19 focused infection itiated on 06/01/2020 and 2020. The complaints were no deficient practice was y was found to be in EFR 483.80 Infection Control of the Centers for Medicare & EMS) and Centers for Prevention (CDC) ces to prepare for	F 000	DEFICIENCY)				
				W.				
		4			527			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	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.

PRINTED: 06/08/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ С B. WNG\_ 100524 06/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **106 GOVER STREET** SOMERSET NURSING AND REHABILITATION FACILIT SOMERSET, KY 42501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 000 **Initial Comments** N 000 A complaint investigation (KY31514, KY31771) and a COVID-19 focused infection control survey was initiated on 06/01/2020 and concluded on 06/03/2020. The complaints were unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		185218	B. WING	·		03/2020	
NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY				STREET ADDRESS. CITY, STATE, ZIP CODE 106 GOVER STREET SOMERSET, KY 42501	,		
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
E 000	survey was initiated of concluded on 06/03/2 to be in compliance w	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	E 00				
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATURE	:	TITLE		(X6) DATE	

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