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

PRINTED: 09/08/2020 FORM APPROVED OMB NO. 0938-0391

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185218 B. WNG	09/02/2020					
NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY SOMERSET, KY 42501	106 GOVER STREET					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	BE COMPLETION					
F 000 INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 09/02/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicald 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 99.	(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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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			09	09/02/2020	
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	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(XS) COMPLETION DATE	
E 000	survey was conduct	ed Emergency Preparedness ed on 09/02/2020. The	E	000				
	CFR 483.73 Emerge	be in compliance with 42 ency Preparedness related to t practice was identified.	ļ					
						Na.		
			V.					
2					9			
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNAT	rure		TITLE		(X6) DATE	

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PRINTED: 09/08/2020 FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B; WNG_ 100524 09/02/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **106 GOVER STREET** SOMERSET NURSING AND REHABILITATION FACILIT SOMERSET, KY 42501 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 09/02/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE