STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185218	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET NURSING AND REHABILITATION FACILITY	186 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 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 A COVID-19 focused infection control survey was conducted on 12/09/2020. The facility was found to be out of compliance with 42 CFR 483.80 Infection Control. Deficient practice was identified with the highest scope and severity at "E" level. The total census was 94.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	Somerset Nursing and rehabilitation Facility does not believe nor does the facility admit that any deficiencies exists. Somerset Nursing Facility 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 Facility offers its response, credible allegations of compliance and plan of correction as part of its on-going effort to provide the highest quality of care while ensuring the rights and safety of all residents.	01/10/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/8/21

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186218	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET NURSING AND REHABILITATION FACILITY	108 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880	**F880** It is and was on the date of the survey the policy of Somerset Nursing Facility to Maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 1. On 12/9/20 resident #2 and Resident #7 were assessed by the RN unit manager to be afebrile, and without signs and symptoms of acute distress and with stable vital signs. 2. Resident number #2 and #7 were noted to be room- mates. Additionally, Employee #1 and employee #2 were assessed on 12/9/20 by licensed nurse to be afebrile, no cough, without N&V , diarrhea, headaches, loss of taste or smell, shortness of air, body or muscle aches. Chills or fatigue, sore throat, runny nose or congestion . 3. On 12/9/20 Employee #1 and Employee #2 were given immediate education by Licensed Nurse/infection preventionist on transmission based precautions , including as it relates to care with COVID -19 positive resident, appropriate Mask (N-95 usage) including hand hygiene. Competency exam was given by licensed nurse to employee #1 and employee #2 on 12/23/20 with 100% score obtained. Education was initiated on 12/9/20 to all staff on care of COVID positive resident, transmission based precautions including donning of appropriate N-95 mask by licensed Nurse. Additionally, all staff competency exam was given to staff by licensed nurse prior to the next work shift with 100% accuracy expected. On December 28, 2020 127/155 (87%) of staff had been educated with the remaining to be educated before next scheduled shift.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185218	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET NURSING AND REHABILITATION FACILITY	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to prevent the possible spread of COVID-19. On 12/09/2020, two (2) direct care staff (State Registered Nurse Aide [SRNA] #1 and #2) were observed entering the room of Resident #2 and #7 who were both positive for COVID-19 without donning the appropriate Personal Protective Equipment (a N-95 or higher face mask). The findings include: Review of the facility policy titled, "Managing Covid-19 Positive Residents or Residents Under Covid-19 Investigation", undated revealed "The resident should be placed in airborne isolation precautions. All staff who enter the resident's room shall don (put on), and doff (take off) the following Personal Protective Equipment: Respirator (N95), Gown, Gloves, Eye Protection". Review of Resident #2's medical record revealed the facility admitted the resident on 09/04/2015, with diagnoses of Hypothyroidism, Dysphagia, and Hypertension. Further record review revealed Resident #2 tested positive for COVID-19 on 12/08/2020. Review of Resident #7's medical record revealed the facility admitted the resident on 07/10/2020 with diagnoses of Diabetes Mellitus Type II, Cellulitis, and Atrial Fibrillation. Further review revealed Resident #7 also tested positive for COVID-19 on 12/08/2020. Observation on 12/09/2020 at 10:34 AM, revealed signage for droplet precautions posted on Resident #2 and #7's doors. The signage stated	F 880	4.The red cross on the outside of a resident's door will be a visual identification symbol of a resident with COVID-19. Education and a post test was provided by a licensed nurse/administrator for all staff members who are currently working on 1/8/21. Employee #1 and #2 were also immediately educated and post given on 1/8/2021 by licensed nurse/administrator with 100% accuracy. Additionally, education and post test will be provided by a licensed nurse/administrator to all staff members prior to their next worked shift and a post test given with 100% accuracy expected. 5. On 12/28/20 COVID -19 N95 Mask compliance Audit was conducted which included observing 3 random staff members caring for COVID-19 positive resident for wearing N-95 mask. Audit was conducted by licensed nurse and 100% compliance was noted with no concerns being identified. Additionally, while the COVID -19 unit remains open the N-95 compliance audit for employees while caring for COVID-19 positive residents will be conducted by a licensed nurse daily starting 12.28/20 and running through 1/7/20 (scheduled end date of COVID unit) 3 staff members will be observed for compliance by the licensed nurse daily. With no further Concerns, If there are any additional COVID-19 outbreaks , compliance for care for COVID-19 positive residents/PPE usage will be monitored through our QAPI process. 6.On 1/9/2021 3 staff members of random departments were selected and asked what a red cross on a resident's door signifies. The audit was completed on 1/9/2021 by a licensed nurse or administrator with 100% accuracy, no concerns identified. Additionally, 3 staff members from random departments will be selected by a licensed nurse 3x's a week for 8 weeks and asked what a red cross on a resident's door signifies. 100% accuracy is expected and with no concerns the facility will continue to monitor through the QAPI process.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185218	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET NURSING AND REHABILITATION FACILITY	105 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 prior to entry to the room, staff must don a gown, mask, gloves, and face shield. Observation on 12/09/2020 at 10:37 AM, revealed SRNA #1 and SRNA #2 donned a gown, surgical mask, face shield and gloves prior to entering Resident #2 and Resident #7's room (both positive for COVID-19). Interview with SRNA #1, on 12/09/2020 at 10:42 AM, revealed staff were alerted if a resident was on transmission based precautions by the signage posted outside the resident's room door. He stated he was aware that Resident #2 and Resident #7 had tested positive for COVID-19, but was unsure when entering a room of a positive COVID-19 resident, whether a N95 mask or higher level respirator was required. Interview with SRNA #2, on 12/09/2020 at 11:31 AM, revealed she was unaware that Resident #7 and Resident #2 were positive for COVID-19; therefore, did not don a N95. She further revealed she was unaware how often staff received education regarding isolation precautions, but stated they had "teachable moments" when they were supposed to read information and sign that it was read. Further, according to SRNA #2, she was also providing care for resident on another unit (yellow zone unit) where residents were being monitored for COVID symptoms. Interview with Licensed Practical Nurse (LPN) #1, on 12/09/2020 at 10:48 AM, revealed Resident #2 and Resident #7 were positive for COVID-19; therefore, prior to entry staff must don a N95 mask. She further revealed she notified staff of the positive test results for Resident #2 and #7 immediately after receiving the test results.	F 880	7.On 12/30/20 20staff training was started by the Infection Preventionist and DON using the Use PPE Correctly for COVID-19 video on you tube (length 12:01) for all staff with a timeline for completion of 01/06/21. Attestation statement of completion attached. Date of compliance 1/10/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185218	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET NURSING AND REHABILITATION FACILITY	105 GOVER STREET SOMERSET, KY 42501

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F 880	Continued From page 4 Interview on 12/09/2020 at 11:42 AM, with the Infection Control Nurse, revealed she expected staff to wear a N95 mask when providing care for a resident who was COVID-19 positive. She further revealed the facility policy stated a N95 must be worn when a resident was positive for COVID-19. Continued interview with the Infection Control Nurse revealed there was a potential for exposure and spread of COVID-19 if staff did not wear the proper mask. Interview with Director of Nursing (DON), on 12/09/2020 at 11:11 AM, revealed staff were expected to wear a N95 or higher level respirator when entering resident rooms who were positive for COVID-19. She stated that the only exception would be if the facility had a shortage of N95 masks; however, she stated the facility did not currently have a mask shortage. Per the DON, if a resident tested positive for the COVID-19 virus, the nurses were responsible to communicate residents' COVID-19 status and the precautions to take when providing care to other staff. The DON stated staff not wearing a N-95 facemask created the potential for spread of COVID-19. Interview with Administrator, on 12/09/2020 at 11:25 AM, revealed he expected staff to wear full personal protective equipment (PPE) which included a gown, gloves, N95 or higher level respirator and face shield to help prevent the spread of COVID-19. He further revealed staff should not enter a resident room with suspected or confirmed COVID-19 without a N95 mask.	F 880	Somerset Nursing and rehabilitation Facility does not believe nor does the facility admit that any deficiencies exists. Somerset Nursing Facility 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 nay 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 Facility offers its response, credible allegations of compliance and plan of correction as part of its on-going effort to provide the highest quality of care while ensuring the rights and safety of all residents. 1. On 12/9/20 resident #2 and Resident #7 were assessed by the RN unit manager to be afebrile, and without signs and symptoms of acute distress and with stable vital signs. 2. Resident number #2 and #7 were noted to be room- mates. Additionally, Employee #1 and employee #2 were assessed on 12/9/20 by licensed nurse to be afebrile, no cough, without N&V , diarrhea, headaches, loss of taste or smell, shortness of air, body or muscle aches. Chills or fatigue, sore throat, runny nose or congestion .	1/10/2021

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100524	A. BUILDING: _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET NURSING AND REHABILITATION FACILIT	108 GOVER STREET SOMERSET, KY 42501

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N 000	Initial Comments A COVID-19 focused infection control survey was conducted on 12/09/2020. Deficient practice was identified pursuant to 42 CFR 483.80.	N 000	3. On 12/9/20 Employee #1 and Employee #2 were given immediate education by Licensed Nurse/infection preventions on transmission based precautions , including as it relates to care with COVID -19 positive resident, appropriate Mask (N-95 usage) including hand hygiene. Competency exam was given by licensed nurse to employee #1 and employee #2 on 12/23/20 with 100% score obtained. Education was initiated on 12/9/20 to all staff on care of COVID positive resident, transmission based precautions including donning of appropriate N-95 mask by licensed Nurse. Additionally, all staff competency exam was given to staff by licensed nurse prior to the next work shift with 100% accuracy expected. On December 28, 2020 127/155 (87%) of staff had been educated with the remaining to be educated before next scheduled shift. 4.The red cross on the outside of a resident's door will be a visual identification symbol of a resident with COVID-19. Education and a post test was provided by a licensed nurse/administrator for all staff members who are currently working on 1/8/21. Employee #1 and #2 were also immediately educated and post given on 1/8/2021 by licensed nurse/administrator with 100% accuracy. Additionally, education and post test will be provided by a licensed nurse/administrator to all staff members prior to their next worked shift and a post test given with 100% accuracy expected. 5. On 12/28/20 COVID -19 N95 Mask compliance Audit was conducted which included observing 3 random staff members caring for COVID-19 positive resident for wearing N-95 mask. Audit was conducted by licensed nurse and 100% compliance was noted with no concerns being identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186218	A. BUILDING _____ B. WING _____	12/09/2020

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SOMERSET NURSING AND REHABILITATION FACILITY	108 GOVER STREET SOMERSET, KY 42501

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 12/09/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000	Additionally, while the COVID -19 unit remains open the N-95 compliance audit for employees while caring for COVID-19 positive residents will be conducted by a licensed nurse daily starting 12.28/20 and running through 1/7/20 (scheduled end date of COVID unit) 3 staff members will be observed for compliance by the licensed nurse daily. With no further Concerns, If there are any additional COVID-19 outbreaks , compliance for care for COVID-19 positive residents/PPE usage will be monitored through our QAPI process. 6.On 1/9/2021 3 staff members of random departments were selected and asked what a red cross on a resident's door signifies. The audit was completed on 1/9/2021 by a licensed nurse or administrator with 100% accuracy, no concerns identified. Additionally, 3 staff members from random departments will be selected by a licensed nurse 3x's a week for 8 weeks and asked what a red cross on a resident's door signifies. 100% accuracy is expected and with no concerns the facility will continue to monitor through the QAPI process. 7.On 12/30/20 20staff training was started by the Infection Preventionist and DON using the Use PPE Correctly for COVID-19 video on you tube(length 12:01) for all staff with a timeline for completion of 01/06/21. Attestation statement of completion attached. Date of compliance 1/10/2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/8/21

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.