- 8 2021

(X2) MULTIPLE CONSTRUCTION

PRINTED: 12/22/2020 FORM APPROVED

OMB NO. 0938-0391 (X3) DATE SURVEY

COMPLETED

12/09/2020

A. BUILDING B. WING 185218

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NAME OF PROVIDER OR SUPPLIER

BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE **106 GOVER STREET**

Division of Health Care Southern Enforcement Branch

SOMERSE	ET NURSING AND REHABILITATION FACILITY		6 GOVER STREET DMERSET, 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)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	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. Infection Prevention & Control	F 880		0.110/2001
SS=E	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		Somerset Nursing and rehabilitation Facility does not bolleve 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.	01/10/2021
	NOTATION OF PROJECTION OF PROPERTY OF STATE OF			

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

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Any deficiency statement enting with an asteriak (*) 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 deliciencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Provious Versiona Obsolate

Event ID: MTH111

Facility ID: 100524

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
186218 B. WING			12/09/2020				
NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 108 GOVER STREET SOMERSET, KY 42501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
F 880	infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trart to be followed to previous followed the involved, and (B) A requirement the least restrictive possic circumstances. (v) The circumstance must prohibit employ disease or infected a contact with resident contact will transmit to (vi) The hand hygiene by staff involved in disease followed in disease or infected actions taken for followed in the f	can spread to other m possible incidents of se or infections should be namission-based precautions vent spread of infections; colation should be used for a at not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the as under which the facility ees with a communicable kin lesions from direct s or their food, if direct the disease; and a procedures to be followed frect resident contact. em for recording incidents acility's IPCP and the ten by the facility. die, store, process, and s to prevent the spread of	F 86	F880 It is and was on the date of the surpolicy of Somerset Nursing Facility to Man infection prevention and control prog designed to provide a safe, sanitary and comfortable environment and to help pre development and transmission of commu diseases and infections. 1. On 12/9/20 resident #2 and Reside assessed by the RN unit manager to be a and without signs and symptoms of acut and with stable vital signs. 2. Resident number #2 and #7 were not room- mates. Additionally, Employee # employee #2 were assessed on 12/9/20 b nurse to be afebrile, no cough, without M diarrhea, headaches, loss of taste or smel shortness of air, body or muscle aches. C fatigue, sore throat, runny nose or conge 3. On 12/9/20 Employee #1 and Employer given immediate education by Lice Nurse/infection preventionist on transmi based precautions, including as it relates with COVID -19 positive resident, appromask (N-95 usage) including hand hygic Competency exam was given by licenser employee #1 and employee #2 on 12/23/100% score obtained. Education was init 12/9/20 to all staff on care of COVID poresident, transmission based precautions donning of appropriate N-95 mask by licensed nurse prionext work shift with 100% accuracy exp December 28, 2020 127/155 (87%) of st been educated with the remaining to be obefore next scheduled shift.	daintain ram event the enicable at #7 were febrile, e distress eted to be l and ey licensed law y, ethills or estion. eyee #2 ensed ssion e to care opriate ene. d nurse to 20 with liated on estive including ensed ey exam er to the ected. On aff had		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185219			12/01	/09 <u>/2020</u>	
	ROVIDER OR SUPPLIER ET NURSING AND RE	ABILITATION FACILITY		10	REET ADDRESS, CITY, STATE, ZIP CODE 6 GOVER STREET DMERSET, KY 42501	2.	
(X4) IO PREFIX TAG	(FACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 0€	(X5) COMPLETION DATE
F 880	Based on observe and review of facili- facility failed to pre COVID-19. On 12 staff (State Register) were observed #2) were observed #2 and #7 who we without donning the	age 2 ation, interview, record review, ity policy, it was determined the event the possible spread of i/09/2020, two (2) direct care ared Nurse Aide [SRNA] #1 and if entering the room of Resident are both positive for COVID-19 are appropriate Personal ment (a N-95 or higher face	F 880		4.The red cross on the outside of a re will be a visual identification symbol with COVID-19. Education and a porprovided by a licensed nurse/administaff members who are currently wor I/8/21. Employee #1 and #2 were als immediately educated and post given by licensed nurse/administrator with accuracy. Additionally, education and will be provided by a licensed nurse/to all staff members prior to their nex shift and a post test given with 100% expected.	ation symbol of a resident ion and a post test was urse/administrator for all urrently working on d #2 were also ad post given on 1/8/2021 istrator with 100% education and post test ensed nurse/administrator or to their next worked	
	Covid-19 Positive Covid-19 Investig resident should be precautions. All se room shall don (p following Persons Respirator (N95), Review of Reside the facility admitte with diagnoses of and Hypertension	Ilty policy titled, "Managing Residents or Residents Under ation", undated revealed "The a placed in airborne isolation aff who enter the resident's ut on), and doff (take off) the Il Protective Equipment: Gown, Gloves, Eye Protection". Int #2's medical record revealed at the resident on 09/04/2015, "Hypothyroidism, Dysphagia, a. Further record review at #2 tested positive for	(t)		5. On 12/28/20 COVID -19 N95 N compliance Audit was conducted wh observing 3 random staff members of COVID-19 positive resident for wear mask. Audit was conducted by licens 100% compliance was noted with no being identified. Additionally, while -19 unit remains open the N-95 comp for employees while caring for COV positive residents will be conducted in nurse daily starting 12.28/20 and run 1/7/20 (scheduled end date of COVII members will be observed for compliances daily. With no further there are any additional COVID-19 or compliance for care for COVID-19 presidents/PPE usage will be monitore our QAPI process.	ich included aring for ring N-95 led nurse and concerns the COVID pliance audit ID-19 by a licensed ning through D unit) 3 staff iance by the Concerns, If outbreaks, loositive	
	the facility admitt with diagnoses o Cellulitis, and Atr revealed Resider COVID-19 on 12 Observation on 1 signage for drop	ant #7's medical record revealed ed the resident on 07/10/2020 f Diabetes Mellitus Type II, lai Fibrillation. Further review at #7 also tested positive for /08/2020. 2/09/2020 at 10:34 AM, revealed et precautions posted on #7's doors. The signage stated			6.On 1/9/2021 3 staff members of rai departments were selected and asked cross on a resident's door signifies. To completed on 1/9/2021 by a licensed administrator with 100% accuracy, n identified. Additionally, 3 staff mem random departments will be selected nurse 3x's a week for 8 weeks and as red cross on a resident's door signific accuracy is expected and with no corfacility will continue to manitor than	what a red the audit was nurse or o concerns bers from by a licensed ked what a s. 100% accerns the	

CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON	BTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		JUMP DE LES
		185218	B. WNG		12/09/2020
	ROVIDER OR SUPPLIER ET NURSING AND REHA		105 G	T ADDRESS, CITY, STATE, ZIP CODE OVER STREET ERBET, KY 42501	
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	DID BE COWNER
F 880	prior to entry to the remask, gloves, and farmask, gloves, and farmask, gloves, and farmask, face shield ar Resident #2 and Repositive for COVID-Interview with SRN/AM, revealed staff von transmission baseignage posted outselve the stated he was at Resident #7 had test but was unsure who positive COVID-19 or higher level responder interview with SRN/AM, revealed she vand Resident #2 wetherefore, did not deshe was unaware reducation regarding stated they had "test were supposed to a it was read. Further was also providing unit (yellow zone unonlitored for COVINTERVIEW with Lice on 12/09/2020 at 1 and Resident #7 werefore, prior to mask. She further	com, staff must don a gown, ace shield. 19/2020 at 10:37 AM, revealed a #2 donned a gown, surgical and gloves prior to entering sident #7's room (both 19). 14*1, on 12/09/2020 at 10:42 were alerted if a resident was sed precautions by the side the resident's room door, ware that Resident #2 and sted positive for COVID-19, an entering a room of a resident, whether a N95 mask irator was required. 14*2, on 12/09/2020 at 11:31 was unaware that Resident #7 are positive for COVID-19; on a N95. She further revealed now often staff received g isolation precautions, but sechable moments" when they read information and sign that ear, according to SRNA#2, she care for residents were being the staff received of the staff resident on another ontity where residents were being	F 880	7.On 12/30/20 20staff training the Infection Preventionist and Use PPE Correctly for COVID (length 12:01) for all staff with completion of 01/06/21. Attestation statement of completion	DON using the -19 video on you tube a timeline for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLI	
		185218	B. WING		12/0	9/2020
SOMERSE		HABILITATION FACILITY STATEMENT OF DEFICIENCIES	11	REET ADDRESS, CITY, STATE, ZIP CODE 05 GOVER STREET OMERSET, KY 42501 PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
F 880	Interview on 12/09 Infection Control Nate of the wear a N9 a resident who was further revealed it must be worn when COVID-19. Contin Control Nurse revexposure and spread the proper interview with Director of the farmasks; however, currently have a resident tested the nurses were interview with Ad 11:25 AM, reveal personal protection included a gown, respirator and farspread of COVID and the proper of the protection of the protection of the personal protection of the protection of the personal personal protection of the personal personal protection of the personal	M/2020 at 11:42 AM, with the Murse, revealed she expected 5 mask when providing care for as COVID-19 positive. She are facility policy stated a N95 an a resident was positive for bued interview with the Infection called there was a potential for ead of COVID-19 if staff did not	F 880	Somerset Nursing and rehabilitat does not believe nor does the fac any deficiencies exists. Somerset Facility reserves all rights to confindings through the informal dis legal appeal proceedings or any tiegal proceedings. This plan of conticonstitute an admission regal or circumstances surrounding any deficiencies to which it responds to establish any standard of care, obligation or position. Somerset Rehabilitation reserves all rights contentions and defenses in nay criminal claim, action, or proceed contained in this plan of correctic considered as a waiver of any posphicable peer review Quality a critical examination privileges we Nursing and Rehabilitation does reserves the right to asset in any civil or criminal claim, action or Somerset Nursing Facility offers credible allegations of compliant correction as part of its on-going provide the highest quality of carensuring the rights and safety of the content of the process of the RN unit manafebrile, and without signs and sacute distress and with stable vit to be room—mates. A Employee #1 and employee assessed on 12/9/20 by licer be afebrile, no cough, without diarrhea, headaches, loss of shortness of air, body or muchills or fatigue, sore throat or congestion.	ility admit that Nursing test the survey spute resolution, administrative or orrection does ding any facts y alleged ; nor is it meant contract Nursing and to raise possible type of civil or ding. Nothing on should be tentially ssurance or self- hich Somerset not waive and administrative proceeding. its response, se and plan of effort to re while all residents. I Resident #7 anager to be ymptoms of al signs. ad #7 were dditionally, #2 were seed nurse to out N&V, taste or smell, scle aches.	1/10/2021

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPU A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		100524	B. WING		12/09/2020	
	ROVIDER OR SUPPLIER ET NURSING AND REHA	RH ITATION FACILIT	DORESS, CITY, ST ER STREET ET, KY 42501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
N 000	A COVID-19 focused	infection control survey was 2020. Deficient practice was 42 CFR 483.80.	N 000	3. On 12/9/20 Employee #1 and Emp were given immediate education by Lic Nurse/infection preventions on transmis precautions, including as it relates to co COVID -19 positive resident, appropria 95 usage) including hand hygiene. Come xam was given by licensed nurse to en and employee #2 on 12/23/20 with 100 obtained. Education was initiated on 12 staff on care of COVID positive resident transmission based precautions including appropriate N-95 mask by licensed Nurse. Additionally, all staff competent given to staff by licensed nurse prior to work shift with 100% accuracy expected December 28, 2020 127/155 (87%) of seducated with the remaining to be educated with COVID-19. Education and a post in provided by a licensed nurse/administrated staff members who are currently working Employee #1 and #2 were also immediated educated and post given on 1/8/2021 by nurse/administrator with 100% accuracy Additionally, cducation and post test with provided by a licensed nurse/administrated staff members prior to their next worked post test given with 100% accuracy exposites and a staff members cariacovided by licensed nurse compliance was noted with no concerns identified.	ensed sion based are with te Mask (N-petency aployee #1 % score /9/20 to all tt, and donning sey exam was the next d. On taff had been ated before set was tor for all ag on 1/8/21. Itely slicensed //. Il be tor to all d shift and a ected. ek included ag for g N-95 mask, and 100%	

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

TITLE

(XB) DATE

PRINTED: 12/22/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		186218	B. WING	B. WING		09/2020
NAME OF PROVIDER OR SUPPLIER SOMERSET NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 108 GOVER STREET SOMERSET, KY 42501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
€ 000	survey was conducte facility was found to CFR 483.73 Emerge	d Emergency Preparedness ed on 12/09/2020. The be in compliance with 42 ncy Preparedness related to practice was identified.	EO	Additionally, while the COVID open the N-95 compliance and while caring for COVID-19 po be conducted by a licensed nur 12.28/20 and running through end date of COVID unit) 3 stat observed for compliance by the daily. With no further Concern additional COVID-19 outbreak care for COVID-19 positive re will be monitored through our 6.On 1/9/2021 3 staff ment departments were selected a red cross on a resident's. The audit was completed a licensed nurse or administ accuracy, no concerns ider Additionally, 3 staff member random departments will be licensed nurse 3x's a week asked what a red cross on signifies. 100% accuracy with no concerns the facility to monitor through the QA 7.On 12/30/20 20staff training the Infection Preventionist and Use PPE Correctly for COVID you tube (length 12:01) for all for completion of 01/06/21. Attestation statement of completion statement of completion statement of completion of completion statement of completion of 01/06/21.	it for employees sitive residents will se daily starting 1/7/20 (scheduled if members will be elicensed nurse is, If there are any is, compliance for sidents/PPE usage QAPI process. There of random and asked what door signifies. In 1/9/2021 by a rator with 100% attified. It is seen that is the seen is from the selected by a for 8 weeks and a resident's door is expected and it will continue if process. Was started by if DON using the person is the staff with a timeline staff with a timeline in the safe with a timeline in the safe will a timeline in the safe will a timeline in the safe with a timeline in the safe will a timeline in the safe will a timeline in the safe will a timeline in the safe with a timeline in the safe will be safe with a timeline in the safe will be safe will	
				Date of compliance 1/10/2	2021	
LABORATORY	DIRECTOR'S OR PROVIDER	USUPPLIER REPRESENTANYES BIGNATU	JRE	√ nyte		(Xa) 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.

(X8) DATE, 1/8/21