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	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Nursing and Rehabilitation Facility	106 Gover Street Somerset, KY 42501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to implement the comprehensive person-centered care plan for 1 of 6 sampled residents (Resident (R)1). The findings include: Review of the facility's policy titled, Care Plan Policy, reviewed on [DATE], revealed the facility would develop and implement a person-centered care plan for each resident to include measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment. Continued review of the facility's policy revealed each resident's Comprehensive Care Plan was designed to incorporate identified problem areas and risk factors associated with the identified problems. Review of R1's admission Record revealed the facility admitted the resident on [DATE], with diagnoses of osteoporosis, presence of right artificial hip joint, and dementia. Review of R1's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed R1 as rarely/never understood. In addition, the facility assessed the resident as severely cognitively cognition. Review further revealed the facility assessed R1's functional status as dependent for bed mobility, toileting, and transfers. Review of R1's Care Plan/Kardex, revised on [DATE], revealed the facility identified a problem for Activities of Daily Living (ADLs) and developed a care plan with a goal to achieve/maintain maximum functional mobility through the next review period. Further review of the Care Plan/Kardex revealed the facility developed an intervention for R1 to use two staff assistance for bed mobility, toileting, and transfers as of [DATE]. Review of the facility's Incident Report dated [DATE], for an incident that occurred at 1:50 PM, involving R1 revealed it was noted by Licensed Practical Nurse (LPN) 1. Continued review revealed State Registered Nurse Aide (SRNA)1 had been providing perineal care for R1 and rolled the resident on to her left side. Per review, when SRNA1 rolled R1 to her left side it caused the resident to roll out of bed and fall to the floor on her right side. Further review revealed LPN 1 noted the root cause (of R1 rolling out of bed) as the resident was rolled too far over causing her to roll out of bed. Review of the Progress Note, dated [DATE] at 2:35 PM, noted by LPN 1, revealed the Nurse Practitioner (NP) had been notified of R1 rolling out of the bed on [DATE]. Review further revealed new orders were received to obtain x-rays of R1's right shoulder, right hip, and right knee. Review of the facility's mobile x-ray report, dated [DATE] at 4:49 PM, revealed the resident had sustained a right femoral diaphyseal fracture (femur shaft fracture) with complete displacement and foreshortening (of the limb). Review of the x-ray report revealed an orthopedics consult was recommended as soon as possible. Review of the Progress Note dated [DATE] at 5:10 PM, documented by LPN 1, revealed the NP had been notified of R1's stat x-ray results and orders were received to send the resident to the hospital for evaluation and treatment. Review of the hospital's x-ray report, dated [DATE] at 6:34 PM, revealed R1 had a comminuted (three or more resulting bone pieces) and moderately displaced mid to distal right femoral shaft fracture. Review of the hospital's surgical progress note dated [DATE], revealed the surgical team repaired R1's hip. Per review, of hospital documentation revealed the resident was deceased on [DATE], while a patient on the hospital's hospice unit. In interview on [DATE] at 1:36 PM, SRNA 1 stated she knew R1 was a two (continued on next page)

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.

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	person staff assist, but her partner had been in another room. She stated she thought she would just get R1's care started. However, when she turned the resident, she (R1) rolled out of the bed onto the floor. SRNA 1 stated she had been trained, during her orientation in [DATE] on following resident's Care Plan/Kardex. However, she stated, in the incident involving R1, she had not followed the resident's Care Plan/Kardex. SRNA 1 further stated she found out later R1 sustained a fracture from the fall and she was completely devastated that she had caused an injury to the resident. In interview on [DATE] at 2:14 PM, LPN 1 stated staff were trained on the Care Plan/Kardex during their orientation and updated when there was a change in a resident's condition. She stated R1's Care Plan/Kardex showed the resident was a two person staff assist and had been for quite some time. LPN 1 stated that to her knowledge, there had been no Care Plan changes for R1 on the day of the incident. She explained she had been called into R1's room on the day of the incident by SRNA 1, and upon her arrival to the room the resident was lying on the floor on her right side. LPN 1 stated Unit Manager (UM) 1, who had also been in the room, helped to assess the resident. She stated the Nurse Practitioner (NP) was notified and ordered stat x-rays. She stated the results showed a right femoral head fracture. R1 was sent to the hospital for further evaluation. In interview on [DATE] at 2:49 PM, SRNA 2 stated all staff got orientation to the Kardex information during orientation in both the classroom and on the floor training. She stated any changes to the Kardex were communicated verbally by either the Charge Nurses or Unit Managers. The SRNA stated she was not aware of any changes to R1's Kardex prior to the incident. She stated she was aware R1 was a two person staff assist (on the Kardex). However, SRNA2 stated SRNA 1 started providing care for R1 before she (SRNA 2) got to the room. SRNA 2 stated when she got to R1's room to assist SRNA1, the resident was already lying on the floor and was being assessed by LPN 1 and UM 1. She further stated R1 had been a two person assist for years. In interview on [DATE] at 2:48 PM, UM 1 stated she heard SRNA1 yelling for help (on the day of the incident) and when she got to R1's room, the resident had been lying on the floor. She stated R1 did not appear to be in distress and when LPN 1 arrived in the room, she left to go call the NP and the resident's family. UM 1 explained the NP ordered stat x-rays for R1. She stated as R1 was not in distress, and there had been no obvious injuries assessed, the resident was assisted back to bed with no further issues noted. UM 1 further stated she later saw the x-ray results, which showed R1 had a fracture to the right femoral area. In interview on [DATE] at 3:59 PM, the Infection Preventionist (IP) Nurse, who was also the facility's acting Director of Nursing (DON), stated it was her expectation that Care Plans/Kardex for all staff to follow residents' Care Plan/Kardex when providing care for the residents. She stated she found out about R1's fall during the facility's stand down meeting on [DATE]; however, she was not aware of the resident's fracture until the following morning meeting (on [DATE]). The IP Nurse/acting DON further stated SRNA 1 had not followed R1's Care Plan as the resident was a two person assist with most of her Activities of Daily Living (ADLs). In interview on [DATE] at 4:00 PM, the Administrator stated it was her expectation that staff follow the residents' Care Plans when providing care so accidents/incidents did not occur. She stated she was made aware of R1's fall on [DATE] by UM 1. The Administrator stated she was notified of the x-ray results on [DATE] at 5:12 PM, by the NP, who gave the order to send R1 to the hospital for further evaluation. She stated the Interdisciplinary Team (IDT) met on [DATE] to develop and implement an action plan to prevent another such incident from occurring. The Administrator further stated she was involved in providing a written warning to SRNA 1 for not following R1's Care Plan (as required).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide each resident with adequate supervision to prevent accidents for 1 of 6 sampled residents (Resident (R)1). R1 sustained a fall with a fracture. The findings include: Review of the facility's policy titled, Falls Policy, reviewed [DATE], revealed the policy was to ensure the facility provided an environment as free from accident hazards as possible, over which the facility had control to prevent avoidable falls/accidents. Review of R1's admission Record revealed the facility admitted the resident on [DATE], with diagnoses of osteoporosis, presence of right artificial hip joint, and dementia. Review of R1's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident as rarely/never understood. The facility assessed R1 as severely cognitively impaired. Continued review of R1's MDS Assessment revealed the facility additionally assessed the resident's functional status for bed mobility, toileting, and transfers as dependent. Review of R1's Care Plan revised on [DATE], revealed the facility identified a risk problem for Activities of Daily Living (ADLs). The goals included to achieve/maintain maximum functional mobility through the next review period. Continue review of the ADL care plan revealed the facility developed an intervention on [DATE], to use two staff assist for the resident's bed mobility, toileting, and transfers. Review of the facility's Incident Report, dated [DATE], noted by Licensed Practical Nurse (LPN) 1, revealed an incident occurred on that date at 1:50 PM involving R1. Per review, LPN 1 documented State Registered Nurse Aide (SRNA) 1 had been providing perineal care for R1 and rolled the resident to her left side. According to the Report, LPN 1 noted when SRNA 1 rolled R1 to her side it caused the resident to roll out of bed on her right side onto the floor next to the other bed in the room. Continued review of the Report revealed LPN 1 noted the root cause (of R1 rolling out of bed) as the resident was rolled too far over causing her to roll out of bed when staff was providing care. Further review of the Incident Report revealed the predisposing physiological factors noted were weakness and the predisposing situational factors documented as history of falls, and the INTERDISCIPLINARY TEAM (IDT) determined the root cause as the SRNA failed to follow R1's Kardex (The Kardex is the care plan the RNA's use to let them know the resident's care needs). Review of SRNA 1's employee file revealed a written warning, dated [DATE], signed by SRNA 1 and Unit Manager (UM) 1, related to the SRNA failing to follow (R1's) Kardex for specific resident needs. Continued review of the document revealed it had also been signed by the Administrator. Review of R1's Progress Note, dated [DATE] at 2:35 PM, documented by LPN 1, revealed the Nurse Practitioner (NP) and family had been notified of R1 rolling out of the bed on [DATE]. Continued review revealed new orders had been received to obtain x-rays of R1's right shoulder, right hip, and right knee. Review of the facility's mobile x-ray report, dated [DATE] at 4:49 PM, revealed R1 had sustained a right femoral diaphyseal fracture (femur shaft fracture) with complete displacement and foreshortening (of the limb). Further review of the x-ray report revealed an orthopedics consult was recommended as soon as possible. Review of R1's Progress Note, dated [DATE] at 5:10 PM, documented by LPN 1, revealed the NP had been notified of R1's stat x-ray results and orders received to send the resident to the hospital for evaluation and treatment. Continued review of the Progress Note revealed R1's power of attorney (POA) was also notified.Review of the hospital's x-ray report, dated [DATE] at 6:34 PM, revealed R1 had a comminuted (three or more resulting bone pieces) and moderately displaced mid to distal right femoral shaft fracture. Review of the hospital's surgical open reduction and internal fixation (ORIF) progress note, dated [DATE], revealed the surgical team performed an interval realignment of the complete oblique mid to distal femoral shaft fracture components with placement of a long stem plate and screw fixation device. Further review of hospital documentation revealed R1 expired [DATE] (15 days after the incident), while on the hospital's hospice unit. During (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interview with SRNA 1 on [DATE] at 1:36 PM, she stated she had known R1 was a two person staff assist; however, her partner had been in another resident's room and her partner would join her to finish the resident's care. SRNA 1 stated she was just focused on getting the care started for R1 and never dreamed the resident would roll off the bed. She stated she thought she would just get the care started for R1, but when she turned the resident in the bed, she (R1) rolled out of the bed onto the floor. SRNA 1 explained she had been trained on following a resident's care plan/Kardex during her orientation in [DATE]. She stated in R1's case she had not followed the resident's care plan/Kardex. SRNA 1 further stated she found out later R1 had sustained a fracture from the fall and she was completely devastated that she had caused such an injury to the resident. During interview with Licensed Practical Nurse (LPN) 1 on [DATE] at 2:14 PM, she stated R1's Care Plan/Kardex showed the resident was to be a two person staff assist and had been that way for quite some time. LPN 1 stated prior to the incident involving R1, the nurses never really spot checked the SRNA's to ensure they were following the Care Plan/Kardex. However, she had assisted the SRNA's whenever they asked for assistance. She stated on the day of the incident, she had been called into R1's room by SRNA 1. LPN 1 stated when she got to R1's room, the resident was lying on the floor on her right side and had not appeared to be in distress. She explained that UM 1 had also been in the room and helped assess the resident. LPN 1 stated stat x-rays were ordered by the NP and the results noted a right femoral head fracture. The LPN stated R1 was sent to the hospital for further evaluation by the NP. She further stated staff were trained on following residents' Care Plans/Kardex during orientation and were updated whenever there was a change in a resident's condition. LPN 1 stated that to her knowledge, there had been no Care Plan changes for R1 on the day of the incident. During interview with SRNA 2 on [DATE] at 2:49 PM, she stated she had been aware R1 was a two person staff assist, but on the day of the incident SRNA 1 had started providing care for the resident before she (SRNA 2) had gotten to the resident's room. She stated when she arrived at R1's room to assist SRNA 1, R1 had already been lying on the floor and LPN 1 and UM 1 were already assessing the resident for injuries. SRNA 2 stated R1 had been a two person assist for years. She stated all staff received introduction to the (facility's) Kardex information during their orientation in both the classroom and on the floor training. During interview with UM 1 on [DATE] at 2:48 PM, she stated (on the day of the incident involving R1) she heard SRNA 1 yelling for help and when she got to R1's room the resident was lying on the floor. She stated R1 did not appeared to be in distress. When LPN 1 came to R1's room, she left to go call the NP and the resident's family. UM 1 stated the NP ordered stat x-rays for R1. She stated as R1 had not been in distress, and there had been no obvious injuries observed, the resident was assisted back to bed with no issues noted. UM 1 stated she later saw the x-ray results, which showed a fracture to the right femoral area. She stated prior to the incident involving R1, she had not routinely spot checked the SRNAs to ensure they were providing residents' care as per the Kardex. During interview with Infection Preventionist (IP) Nurse, who was also the facility's acting Director of Nursing (DON), on [DATE] at 3:59 PM, she stated it was her expectation that residents' Care Plans/Kardex were updated for any changes and for all staff to follow the Care Plans/Kardex when providing care for the residents. The IP Nurse/acting DON stated prior to the incident involving R1 she had monitored 10 SRNAs a month regarding perineal care and that the appropriate number of staff were providing that care; however, now the facility was doing audits specifically geared towards staff following the Kardex. She stated she found out about R1's fall during the facility's stand down meeting on [DATE]; however, she was not aware of the resident's fracture until the following morning meeting. The IP Nurse/acting DON said all the information necessary for the SRNAs to provide care for every resident was on the resident's Kardex. She stated any changes made during the shift were communicated by the Unit Managers and/or Charge Nurses to the SRNAs. The IP Nurse/acting DON stated SRNA 1 had not followed the Care Plan for R1 as the resident had been a two person assist with most of her ADLs. During interview with the Administrator on [DATE] at 4:00 PM, she stated it was her expectation for staff to follow the Care Plans when providing care for the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	residents, so accidents/incidents did not occur in the facility. The Administrator stated staff should always follow the residents' Care Plan and Kardex. She stated if they said assist of two staff; she expected two staff to perform the care. She stated she was made aware of R1's fall on [DATE] by UM 1. She was notified of the x-ray results on that day at 5:12 PM, by the NP, who gave the order to send the resident to the hospital for further evaluation. The Administrator stated the Interdisciplinary Team (IDT) met on [DATE], to develop and implement an action plan to prevent another such incident from occurring. She stated R1 required two staff members to provide her care for toileting, transfers, and bed mobility. The Administrator further stated however, there had only been one staff member present providing care to R1 when the incident occurred. She stated the incident involving R1 would not have occurred if SRNA 1 had followed R1's Care Plan. She additionally explained she had been involved in providing the written warning to SRNA 1 for not following R1's Care Plan, and the SRNA had received re-education on following the care plan.