

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555871	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2020
NAME OF PROVIDER OF SUPPLIER SOMERSET SUBACUTE AND CARE		STREET ADDRESS, CITY, STATE, ZIP 151 CLAYDELLE AVE EL CAJON, CA 92020	
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 0551 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the responsible party prior to medication administration for one of three sampled residents (1). This failure had the potential for the resident's representative to not be informed of the resident's care. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An observation was conducted on 3/14/18 at 2:10 P.M. of Resident 1. Resident 1 was sleeping, the TV was on, and a private caregiver was present. A review of Resident 1's medical record was conducted on 3/14/17 at 12:10 P.M. A review of the physician's orders [REDACTED].[MEDICATION NAME](MS) (concentrate) Solution 20 mg (milligrams)/ml (milliliter). Give 0.25 ml sublingually every 1 hrs (hours) as needed for pain, must call (name of the resident's) (sister: the durable power of attorney- DPOA) first before giving the medication, do not give unless (name of the resident's sister) is called . A review of Resident 1's Medication Administration Record [REDACTED].M., and on March 13, at 12:15 A.M. A concurrent interview and record review was conducted on 3/14/18 at 12:13 P.M. with licensed nurse (LN) 1. LN 1 stated, The MS was given on the night shift. They didn't call the sister. A concurrent interview and record review was conducted on 3/14/18 at 1:42 P.M. with licensed nurse (LN) 2. LN 2 stated, There is no documentation that the sister was called . An interview was conducted with the Director of Nursing (DON) on 3/14/18 at 1:30 P.M. The DON stated, They should have called the sister first. No facility policy was available.</p>		

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

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.