STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964604	11/02/2015
NAME OF PROVIDER OR SUPPLIER SOMERSET HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 1540 OAK HARBOR BOULEVARD VERO BEACH, FL 32967	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Limited Nursing Service monitoring survey was conducted at Somerset House on /. Somerset House had a deficiency found at the time of the visit.

0055 Medication - Storage and Disposal

Based on observation, record review and interviews, the facility failed to ensure that discontinued medication and/or medications belonging to expired residents were returned to family member and/or destroyed within 30 days, for 1 of 1 medication cabinets observed.

Findings include:

An observation of medication storage was conducted on / at 9:30 AM, accompanied by Employee A. Employee A stated that current medications were kept in the resident's drawer on the cart and extra supply were kept in the large medication cabinet inside the medication . The surveyor asked the Nurse where expired or discontinued medications were kept. She opened a smaller locked cabinet which contained a large quantity of medications. The surveyor asked the nurse when the medications were discontinued and if any had been returned to family members. The Nurse stated that she was unaware if any medication had been returned and did not know the date the medications were discontinued as nothing was written on the packaging except the letters, "dc". The surveyor with the assistance of the Nurse compared the medications to the physician orders to determine when the medications had been discontinued. The following medications had been discontinued and/or the patient expired in excess of the 30 day requirement:

1) 1 package of tablets
2) 1 bottle of liquid
3) 3 tube of cream
4) ointment
5) 1 card
6) 1 box of patches
7) 1 package of suppositories
8) 1 card of DS
9) 1 box of tablets
10) 1 package of tablets
11) 1 bottle of
12) 1 package of gas X
13) 1 package of Lipogen tablets

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

14) 1 box of tablets
15) 1 bottle of powder
16) 1 package of capsules
17) 1 tablets
18) 1 bottles of Milk of Magnesia
19) 1 bottle of
20) 2 cards of of tablets
21) 1 Ketotenfli opth gtt
22) 1 bottle of powder
23) 1 package of tablets
24) 1 bottle of tablet
25) 1 package of tablets
26) 1 bottle of
27) 1 bottle of
28) 1 package of Vesicare tablets
29) 1 package of Terazyme tablets
30) 1 bottle Triamcolone lotion
31) 1 card
32) 1 bottle Zadita drops
33) 1 package of tablets

The Assistant Administrator was called to observe the medications removed from the cabinet on // at 12:22 PM. She confirmed that the facility should return expired/ discontinued medications to family members and/or destroy them by the 30 day limit as required by the regulation.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Somerset House
1540 Oak Harbor Boulevard
Vero Beach, FL 32967

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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