

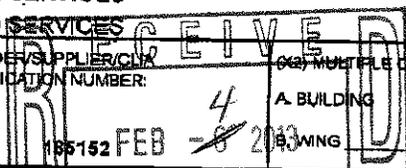
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/25/2013

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152 FEB -8 2013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/10/2013
--------------------------------------------------	------------------------------------------------------------------------------	------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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	F 000	<b>DISCLAIMER:</b> Somerswoods Nursing and Rehabilitation Center (Somerswoods) acknowledges receipt of the Statement of Deficiencies (SOD) and proposes this Plan of Correction (POC) to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The POC is submitted as a written allegation of compliance. Somerswoods' response to this SOD does not denote agreement with the SOD nor does it constitute an admission that any deficiency is accurate. Further, Somerswoods reserves the right to refute any of the deficiencies on this SOD through Informal Dispute Resolution, formal appeal procedure or any other administrative or legal proceeding.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens	F 441	LPN #5 was provided re-education on 01/08/2013 related to the cleaning of the glucometer before starting her blood glucose checks and following each individual patient according to the facility policy. This re-education was conducted by the Director of Nursing. The Director of Nursing reviewed the Inspector's observation and determined that other residents who receive blood glucose checks had the potential for a similar situation to occur.  Staff reeducation was initiated for all licensed nurses on 01/10/2013 related to the cleaning of the glucometer before starting blood glucose checks and following each individual resident according to the facility	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian K. Jagers</i>	TITLE <i>Administrator</i>	(X6) DATE <i>02/07/2013</i>
-------------------------------------------------------------------------------------------------	-------------------------------	--------------------------------

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.

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/10/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 556 BOURNE AVENUE 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 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to maintain an Infection Control program to help prevent the development and transmission of disease and infection. Observations conducted during medication administration revealed facility staff failed to appropriately clean/sanitize the glucometer when conducting accuchecks for one of twenty-four sampled residents (Resident #17). In addition, the facility failed to ensure personnel processed lines so as to prevent the spread of infection.</p> <p>The findings include:</p> <p>1. A review of the Cleaning and Disinfection of Glucometers policy (dated August 2005) revealed the glucometer should be wiped with a cloth dampened with soap and water to remove any visible organic material if visible blood or a bloody fluid is noted on the glucometer. The policy further revealed the glucometer was to be disinfected after each use following the manufacturer's directions using a cloth/wipe with either a detergent/germicide or a dilute bleach solution of 1:10 to 1:100 concentration.</p> <p>Observations conducted on 01/08/13, at 11:05 AM, revealed Licensed Practical Nurse (LPN) #5 performed an accucheck for Resident #17. LPN</p>	F 441	<p>policy. This re-education was a written in-service with follow up by the individual Unit Coordinators. The policy regarding the cleaning of glucometer will be reviewed during orientation for newly hired licensed nurses.</p> <p>The facility QI Nurse or designee will conduct random audits weekly of blood glucose checks conducted by direct care staff to ensure the glucometer is cleaned prior to starting the blood glucose checks and following each resident per facility policy. Any identified issues will be corrected with immediate one to one re-education. These audits will be conducted weekly during February 2013 and March 2013 and then per the schedule established by the QI Committee. Results of the weekly audits will be reported to the QI committee on a monthly basis.</p> <p>Laundry Workers #1, #2, and #3 were provided verbal re-education on 01/09/2013 regarding the requirement to wear lab coats or disposable gowns when handling soiled linen. This education was provided by the Director of Environmental Services and the QI Nurse who oversees infection control.</p> <p>The Director of Environmental Services and the QI Nurse reviewed the Inspector's observation and determined potential for a similar situation to occur with all laundry staff. Re-education regarding the requirement to wear a lab coat or disposable gown was initiated for all laundry staff on 1/11/13 with follow up on 1/14/13, 1/16/13</p>		

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/10/2013
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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 441	<p>Continued From page 2</p> <p>#5 was observed to remove the glucometer from the medication cart and obtain the blood specimen using a disposable lancet. The LPN was then observed to clean/sanitize the glucometer with a germicidal wipe. However, the LPN failed to clean/sanitize the glucometer prior to obtaining the blood specimen.</p> <p>Interview with LPN #5 on 01/08/13, at 11:10 AM, revealed the LPN had been trained to clean/sanitize the glucometer before and after each use for two minutes with a germicidal wipe. The LPN stated she had not used the glucometer since reporting to work that morning and assumed the glucometer had been cleaned/sanitized appropriately by the night shift nurse.</p> <p>Interview with the Director of Nurses (DON) on 01/08/13, at 6:10 PM, revealed staff had been trained to clean/sanitize the glucometer with the germicidal wipe before and after each resident use. The DON stated the nurse should have cleaned/sanitized the glucometer prior to obtaining the blood specimen for Resident #17.</p> <p>2. A review of the facility's laundry policy entitled "Sorting and Washing Functions" with a revision date of December 1998, revealed that gowns or aprons should be used by laundry personnel while sorting and processing soiled linen to reduce the risk of contamination of exposed areas of skin and soiling of clothing. Additional review of the facility infection control manual with a revision date of 12/18/12 revealed it was staff responsibility to always wear personal protective equipment (PPE), gown, and gloves when handling soiled linen.</p>	F 441	<p>and 1/23/11 by the Director of Environmental Services</p> <p>Newly hired laundry staff will be educated regarding the requirement to wear a lab coat or disposable gown while handling soiled linen during orientation to the department.</p> <p>The facility QI Nurse (who oversees infection control) or designee will conduct random audits to identify laundry staff are wearing a lab coat or disposable gown during the sorting of soiled linen. Any identified issues will be corrected with immediate one to one re-education. These audits will be conducted weekly during the month of February, 2013 and with a summary report to the QI Committee. Further audits, if necessary, will be conducted on a schedule established by the QI Committee.</p> <p>F 441 Date of Completion</p> <p>This Section Intentionally Blank</p>	2/15/13
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/10/2013</b>
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SOMERWOODS NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>565 BOURNE AVENUE SOMERSET, KY 42501</b>
-------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 441	Continued From page 3  Observation of the facility Laundry conducted on 01/09/13, at 2:50 PM, revealed three laundry staff members sorting soiled linen without the use of the required (PPE) gowns to protect clothing and skin from contamination.  Interviews conducted with Laundry Workers #1, #2, and #3 on 01/09/13, at 2:50 PM, revealed the laundry workers were in a hurry to attend a meeting and did not put on gowns prior to sorting the soiled linen.  An interview conducted with the facility Environmental Services Supervisor on 01/09/13, at 2:50 PM, revealed the staff should have been wearing lab coats or disposable gowns and the lab coats were required to be removed and washed when the sorting of soiled linen was completed to prevent cross-contamination of the linen.	F 441	This Section Intentionally Blank	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a safe and functional environment for residents, staff, and the public. Hallway doors which divided the long hall and the short hall on the second and third floors were observed	F 465	The wood filler in the 3 <sup>rd</sup> floor doors was sanded smooth on 1/10/13 by the Maintenance Assistant. The Maintenance department placed Kydex vinyl door covering on the 2 <sup>nd</sup> floor doors. The facility Administrator reviewed the Surveyor observation and identified that other sets of fire doors had the potential for similar circumstances to occur. The Administrator audited all fire doors in the facility on January 11, 2013 and did not identify any additional fire doors needing repair.  The monthly Environmental Rounds tool used by the facility Director of Environmental Services or designee has been revised to include reviewing the fire	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/10/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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 465	Continued From page 4 chipped, splintered, and with rough edges from wood filler.  The findings include:  A review of facility policy titled "Preventative Maintenance" with a revision date of December 1998 revealed the facility had a preventive maintenance program to ensure the interior and exterior of the building was clean and orderly. Further review revealed all equipment would be maintained in a safe operating condition and concerns were to be reported on repair requisition forms immediately.  Observations during an environmental tour conducted on 01/10/13 at 2:45 PM, revealed hallway doors on the second and third floors were chipped, splintered, and had rough edges from wood filler that had been placed in the doors.  A review of a facility work order revealed that wood filler had been placed on a third floor door on 01/08/13 due to the door being chipped. There was no evidence of any work orders for the second floor doors.  An interview with the Maintenance Director on 01/10/13 at 2:45 PM, revealed maintenance staff made daily rounds to pick up work orders, and the work orders were then prioritized. According to the Maintenance Director, the wood filler had been placed on the third floor door and had not been sanded. The Maintenance Director had not identified the chipped and splintered doors on the second floor.	F 465	doors for rough edges. A written staff re-education will be issued by the facility administrator, to all current employees with paychecks on 02/07/2013 reminding staff to utilize the work order system for issues including rough edges on doors. All new hires receive training related to the work order system during general orientation. Results of the monthly Environmental Audit regarding the fire doors will be reported to the QI Committee in February and March and then per the schedule established by the QI Committee.	
		F 465	Date of Completion  This Section Intentionally Blank	2/15/13
F 514 SS=D	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514	The Advance Directive quick reference sticker in the front of the medical record for resident #3 was immediately changed to	

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/10/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 665 BOURNE AVENUE 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 514	<p>Continued From page 5 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility in-services, it was determined the facility failed to ensure clinical information on clinical records/documents was accurate for one of twenty-four sampled residents (Resident #3). A review of a physician's order for Resident #3 dated 12/17/12, revealed the resident had a status of "Do Not Resuscitate" (withhold life-saving care). However, a review of Resident #3's medical record revealed the first page of the medical record had been labeled as "full code" (in the event of cardiac/respiratory failure a person wishes that every possible measure available would be used to resuscitate them).</p> <p>The findings include:  An interview conducted with the Director of Nursing (DON) on 01/10/13, at 3:05 PM, revealed</p>	F 514	<p>DNR upon identification of the Surveyor observation.</p> <p>The facility Social Services Director and Social Services Assistant immediately audited all resident charts to ensure each Advance Directive quick reference sticker matched the Advance Directive paperwork in the Advance Directive sleeve of the medical record. No other issues were identified.</p> <p>The facility has a double check system where the pink carbon copy of all telephone orders are reviewed by the Administrative Nurse responsible for the unit, and are passed through the interdisciplinary team, including the Medical Records Coordinator, Social Services and the Director of Nursing. The facility has a double check system where the monthly physicians orders are reviewed by licensed nurses to ensure that the upcoming month matches the current month and any orders received during the current month have been transcribed correctly to the upcoming month. Carbon copies of corrections are returned to the pharmacy for revision before the next printing.</p> <p>The facility's Advance Directive Protocol includes that the physicians do not resuscitate order be inserted into the advance directive sleeve for quick and easy access. This is the only type of order not filed under the physicians order tab.</p> <p>Interdisciplinary Team investigation of the Surveyor's observation determined that the Physician had written the Do Not</p>	

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/10/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 655 BOURNE AVENUE SOMERSET, KY 42601		
(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 514	<p>Continued From page 6</p> <p>the facility had no policy related to labeling the medical record with the resident's code status. The DON stated it was an understanding at the facility that the code labels were to be placed on the resident's charts by the medical records staff.</p> <p>A review of the medical record for Resident #3 revealed the facility admitted the resident on 02/10/12, with diagnoses including Closed Fracture of the Vertebral Column, Cerebral Vascular Disease, Cirrhosis of the Liver, and Depression. On admission to the facility, the resident's "next of kin" had signed consent on 02/10/12, and the resident's physician had written an order dated 02/10/12, for the resident to be a "full code." The facility staff had placed a "full code" status label on the front page of the medical record. Continued review of the medical record revealed on 12/14/12, the resident's "next of kin" had signed consent for the resident's code status to change to a "Do Not Resuscitate" (DNR). However, a review of the medical record revealed the front page of the medical record continued to contain a label indicating Resident #3 was a "full code."</p> <p>An interview with Licensed Practical Nurse (LPN) #4 on 01/10/13, at 10:20 AM, revealed the LPN had received the physician's order for Resident #3 to become a "DNR" status on 12/17/12. The LPN stated she was required to fax a copy of the physician's order to the pharmacy and to notify Social Services of the code status change of any resident. The LPN stated she had failed to fax a copy to the pharmacy, and stated the pharmacy had the responsibility of adding the physician's orders to the monthly order sheet. The LPN stated she had also failed to notify Social</p>	F 514	<p>Resuscitate order on a personal prescription pad instead of a facility physicians telephone order. The prescription pad order was directly placed into the Advance Directive Sleeve. This action circumvented the double check system.</p> <p>The facility QI Nurse conducted re-education with LPN#4 and the facility Social Services Director and Designee on 01/09/13 regarding protocols for DNR orders. A written in-service was issued to all licensed nurses by the Director of Nursing on 1/25/13 advising that all orders, including Do Not Resuscitate orders are to be transcribed to a telephone order and faxed to the pharmacy. This measure ensures that DNR orders are included in the double check system. Follow-up to the written in-service is being conducted by the LPN Staff Facilitator to ensure all Nurses are aware of the protocol.</p> <p>The LPN QI Assistant audited the February 2013 monthly physicians orders to ensure the code status was correct. The LPN QI Assistant or designee will Audit the March 2013 monthly physicians orders and report the findings to the QI Committee. Audits will be continued as per the schedule established by the QI Committee following the March Audit.</p> <p>The QI Nurse or designee will conduct random audits of the quick reference sticker to the Advance Directive documents. Any identified issues will be addressed immediately. Findings of the audits will be reported to the QI Committee quarterly for</p>		

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/10/2013</b>
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>SOMERWOODS NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>556 BOURNE AVENUE SOMERSET, KY 42501</b>
-------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

(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 514	Continued From page 7 Services of the change in the resident's code status. The LPN stated Social Services were responsible for notifying Medical Records to change the code status labels on the medical records. The LPN stated she had failed to make the notifications.  An interview conducted with Social Worker (SW) #1 on 01/10/13, at 1:46 PM, revealed nursing staff was responsible for notifying her of any changes in the code status of the residents. The SW stated she was responsible for notifying Medical Records to change the label on the front page of the resident's medical record when a change was noted. The SW confirmed she had not been made aware on 12/17/12 that nursing staff had received an order to change the code status of Resident #3 to a "DNR" status.  An interview conducted with Medical Records Staff Member #1 on 01/10/13, at 2:50 PM, revealed Social Services was responsible to notify Medical Records staff of a change in a resident's code status. Medical Records Staff Member #1 also stated that after being notified Medical Records staff was required to change the label on the front page of the medical record with the correct code status label. Medical Records Staff Member #1 stated she had not been notified of the change in code status for Resident #3.  An interview conducted with the DON on 01/10/13, at 3:05 PM, revealed nursing staff was required to notify Social Services when a resident had a physician's order and a signed consent for a change in their code status. The DON acknowledged the nurse failed to notify Social Services of the change in the code status for	F 514  F 514	three quarters and then per the established schedule.  Date of Completion  This Section Intentionally Blank	2/15/13
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------	-------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/10/2013
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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 514	Continued From page 8 Resident #3 and stated she should have. The DON stated the nurse was required to fax a copy of the physician's order to the pharmacy so the order could be placed on the monthly physician's orders, and stated the LPN had also failed to fax the order to the pharmacy. The DON revealed the Social Services Department audited the medical records of residents to ensure the correct code status had been placed on the medical records, but Resident #3's record had been overlooked.	F 514	This Section Intentionally Blank	
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------	--

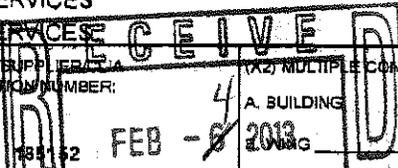
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/25/2013

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 4 01 - MAIN BUILDING #1 FEB - 6 2013 G	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Services 55 BOURNE AVENUE SOMERSET, KY 42501 Southern Enforcement Branch
--------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1975</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three story, Type 1 (332)</p> <p>SMOKE COMPARTMENTS: Twelve</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 01/08/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p><b>DISCLAIMER:</b></p> <p>Somerwoods Nursing and Rehabilitation Center (Somerwoods) acknowledges receipt of the Statement of Deficiencies (SOD) and proposes this Plan of Correction (POC) to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The POC is submitted as a written allegation of compliance. Somerwoods' response to this SOD does not denote agreement with the SOD nor does it constitute an admission that any deficiency is accurate. Further, Somerwoods reserves the right to refute any of the deficiencies on this SOD through Informal Dispute Resolution, formal appeal procedure or any other administrative or legal proceeding.</p>	
K 018 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than</p>	K 018	<p>The hold-open devices were removed from the office doors. The air transfer grill was covered with a metal plate and a strip was</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 02/07/13
---------------------------------------------------------------------------	------------------------	-----------------------

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.

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were held open in an approved manner or were able to resist the passage of smoke. This deficient practice affected one of twelve smoke compartments and staff. The facility has the capacity for 166 beds with a census of 155 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/08/13 at 11:00 AM with the Director of Maintenance (DOM), two office corridor doors located near the</p>	K 018	<p>placed on the community room doors to prevent the passage of smoke by the facility Maintenance Department. All other corridor doors were inspected by the facility Administrator on January 28, 2013 for dropdown devices, transfer grills or gaps which might permit the passage of smoke. The occupants of the offices were instructed by the Director of Maintenance that drop-down hold open devices are not allowed on their doors. The Facility Administrator provided re-education to the facility Maintenance Director on January 28, 2013, regarding NFPA 101 (2000 Edition) 19.3.6.4 regarding air transfer grilles. The facility Director of Maintenance will oversee any additional renovations and ensure corridor doors are in compliance with the Life Safety Code Standards. The facility Director of Maintenance or designee will audit corridor doors monthly for three months and then per the established schedule. These audits will be presented to the QI Committee based on the established schedule.</p> <p>Date of Completion</p> <p>This Section Intentionally Blank</p>	2/15/13
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 655 BOURNE AVENUE SOMERSET, KY 42601	
(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
K 018	<p>Continued From page 2</p> <p>ground floor lobby were observed to have drop-down devices to hold the doors open. Corridor doors cannot be held open in this manner. One office door had an air transfer grill located in the bottom of the door. Transfer grills allow the passage of smoke in a fire situation. An interview on 01/08/13 at 11:00 AM with the DOM revealed he was not aware corridor doors could have drop-down devices or transfer grills.</p> <p>At 11:15 AM on 01/08/13 a set of corridor doors to the community room located on the ground floor level were observed to have an excessive gap between the doors. This gap could allow the passage of smoke in a fire situation. An interview with the DOM on 01/08/13 at 11:15 AM revealed he was not aware the gap between the doors could be a problem.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.4 Transfer Grilles. Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in these walls or doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall be permitted to have ventilating louvers or to be undercut.</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or</p>	K 018	This Section Intentionally Blank	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 018	Continued From page 3 plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	This Section Intentionally Blank	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors to hazardous areas were maintained as required. This deficient practice affected three of twelve smoke compartments, staff, and approximately twenty-six residents. The facility has the capacity for 166 beds with a census of 155 on the day of the survey.  The findings include:  During the Life Safety Code survey on 01/08/13 between 11:05 AM and 3:30 PM, with the Director of Maintenance (DOM), a corridor door to the	K 029	A door closer was installed on the copier room door. The door to the Oxygen Storage Room was replaced with a 1 hour rated door and the dead-bolt lock was replaced with a self latching device.  The dead-bolt latches on the Soiled Utility Rooms were removed and replaced with a key-code latch which does not create a gap between the door and frame during the week ending January 18, 2013.  An audit of the facility was conducted by the facility Administrator on January 28, 2013 and there were no other areas identified to need door closers installed or with door latches creating gaps. The facility only has one oxygen storage room. The facility Administrator reviewed the requirements of NFPA 101 (2000 Edition) 19.3.2.1 with the facility Maintenance Director on January 28, 2013.  The facility Director of Maintenance or designee will oversee any additional renovations and ensure corridor doors are in compliance with the Life Safety Code Standards. Any additional issues will be reported to the QI Nurse for QI Committee review.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 029	<p>Continued From page 4</p> <p>copier/storage room located on the ground floor level was observed not to have a self-closing device as required.</p> <p>An interview with the DOM on 01/08/12 at 11:05 AM revealed he was aware doors to hazardous areas were required to have a door-closing device. The DOM stated this room was turned into a hazardous area during a remodel and was overlooked.</p> <p>On 01/08/13 at 3:00 PM, a corridor door to the oxygen storage room was observed not to latch or have a 45-minute rated door. An interview with the DOM at 3:00 PM revealed he was not aware hazardous area doors were required to latch or have a 45-minute rating.</p> <p>At 3:30 PM on 01/08/13, a corridor door to the soiled linen room was observed to have an excessive gap due to a large latch between the door and doorframe. Corridor doors must be able to resist the passage of smoke in a fire situation.</p> <p>An interview with the DOM on 01/08/13 at 3:30 PM revealed he was aware corridor doors should be smoke tight. The DOM was not aware this door had an excessive gap.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the</p>	K 029	<p>Date of Completion</p> <p>This Section Intentionally Blank</p>	2/15/13
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-------------------------------------------------------------------	---------

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  01/08/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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	
K 029	Continued From page 5 sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	This Section Intentionally Blank		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	Review of the Surveyor's observation by the facility Administrator revealed that although the facility had held unannounced fire drills with different circumstances with at least one per shift per quarter, the time of day was not varied enough to meet the CMS guidance. The Administrator reviewed the guidance with the Director of Maintenance and Maintenance Assistants who oversee the fire drill process on 01/28/13. The Administrator also reviewed the		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 566 BOURNE AVENUE 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
K 050	Continued From page 6  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidences of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 166 beds with a census of 155 on the day of the survey.  The findings include:  During the Life Safety Code survey on 01/08/13 at 6:00 PM, an interview and record review with the Director of Maintenance (DOM) revealed the facility had not been performing fire drills at unexpected times and varying conditions on the first and second shifts as evidenced by the following. CMS requires fire drills to be at least one hour apart per shift.  --Four fire drills on the first shift from 05/18/12 thru 11/30/12 were conducted between 10:43 AM and 11:05 AM. However, the fire drill conducted on 05/18/12 did not have a time recorded.  --Three fire drills on the second shift from 04/30/12 thru 12/28/12 were conducted between 2:30 PM and 3:15 PM. However, the fire drill conducted on 04/30/12 did not have a time recorded.  The DOM stated he was not aware fire drills should be conducted at unexpected times and	K 050	requirement that the date and time be included on all fire drill documents.  The Administrator reviewed the observation and determined that there were no additional areas affected by this CMS guidance.  The Maintenance Department will plan fire drills in accordance with the CMS guidance to include varying circumstances including that the fire drill for the shift varies in time by more than one hour from the prior drill for that shift. The Director of Maintenance will review all fire drill documents following each fire drill to ensure that they have the correct date and time for the drill documented.  The facility Administrator or designee will audit the records for fire drills on a monthly basis for 6 months to ensure that the date and time are recorded on the document and that the time is in accordance with the CMS guidance of being more than one hour different than the prior drill for that shift. The results of these audits will be submitted to the QI Committee. After six months audits will be as per the schedule established by the QI Committee.	2/15/13
		K050	Date of Completion  This Section Intentionally Blank	

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 655 BOURNE AVENUE 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
K 050	Continued From page 7 under varying conditions.	K 050	This Section Intentionally Blank	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher. This deficient practice affected one of twelve smoke compartments, staff, and no residents. The facility has the capacity for 166 beds with a census of 155 on the day of the survey.  The findings include:  During the Life Safety Code tour on 01/08/13 at 4:00 PM with the Director of Maintenance (DOM), a Class-K portable fire extinguisher located in the kitchen area was observed not to have signage near the extinguisher for the proper use of this type of extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.  An interview on 01/08/13 at 4:00 PM with the DOM revealed he was not aware this extinguisher was required to have the proper signage in place.  Reference: NFPA 10 (1998 Edition).	K 064	Signage was placed with the Class K extinguisher in the kitchen identifying it as a secondary measure to the fire protection system. There is only one Class K extinguisher in the facility. The requirement regarding placement of signage required by NFPA 10 (1998) 2-3.2.1 was reviewed with the Maintenance Director by the Administrator on 1/28/13. The Environmental Services Director will note that the signage is present when auditing the fire extinguishers for proper charge on a monthly basis. Any identified missing signage will be replaced and reported to the QI Committee as appropriate.	
		K064	Date of Completion	2/15/13
			This Section Intentionally Blank	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 655 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 064	Continued From page 8 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	This Section Intentionally Blank	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the safety of residents, staff, and other occupants of the building by allowing unapproved portable space heating units in office areas. This deficient practice affected one of twelve smoke compartments, staff, and approximately thirteen residents. The facility has the capacity for 165 beds with a census of 155 on the day of the survey.  The findings include:  During the Life Safety Code tour on 01/08/13 at 3:15 PM with the Director of Maintenance (DOM), unapproved portable space heaters were observed in the treatment nurse and unit coordinator offices. Portable space heating units must be tested and approved for use in these areas. An interview with the DOM on 01/08/13 at 3:15 PM revealed he was aware of the requirements for the proper use of portable space	K 070	Interview with the treatment nurse on 1/9/13 by the facility Administrator identified the space heater in her office was not in use and had not been used during her time as treatment nurse – more than 5 years. She had pulled it out of its stored location to remove it from the office. Interview with the Maintenance Assistant on 1/11/13 revealed that he had inspected the heater in the Unit Coordinator Office and that it worked within the allowable limits. The unused heater in the treatment nurse office was removed and discarded. The heater in the Unit Coordinator Office was labeled to identify that it is in compliance with the regulation with a maximum temperature of 135 degrees per laser thermometer on high heat. All staff members with offices were reminded that all electrical devices including heaters must be approved by maintenance before use. The Maintenance Assistant was reminded that he should have identified the heater as an approved device. Staff members with offices will have any space heaters inspected by Maintenance and Maintenance will label approved heaters as approved. The Director of Environmental Services or designee will audit all offices monthly during February, March, and April 2013 and will report the findings of these audits to the QI Committee.	

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  01/08/2013
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 666 BOURNE AVENUE 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	
K 070	Continued From page 9 heaters. The DOM stated he was not aware these space heaters were in the office areas.  Reference: NFPA 101 (2000 Edition).  19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	Date of Completion	2/15/13	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected twelve of twelve smoke compartments, staff, and all the residents. The facility has the capacity for 166 beds with a census of 155 on the day of the survey.  The findings include:  During the Life Safety Code survey on 01/08/13,	K 144	The Director of Maintenance has contracted an electrician to connect additional areas of the facility and equipment to the backup generator in order to bring the monthly load test above 30 percent of the EPS nameplate rating. The facility does not have any additional generator equipment. On 01/28/13, the facility Administrator reviewed NFPA 110 (1999) 6-1.1 with the director of maintenance regarding the 30 percent of EPS nameplate requirement. The facility electrical needs and backup power needs were reviewed. It was determined there was sufficient generator power available to add additional areas and equipment and maintain sufficient power supply in the event of an actual lengthy power outage. An electrician was contacted to connect additional equipment and areas of the facility to the generator. The electrician will document the estimated percentage rating upon completion of the added load. This will be reported to the QI Committee. The Director of Maintenance will record the monthly load tests and will		

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 565 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 144	<p>Continued From page 10</p> <p>at 5:45 PM, an interview and record review with the Director of Maintenance (DOM) revealed the diesel fueled generator operated at 20 percent of the load capacity rating when tested on a monthly basis. Diesel powered generators are required to run at 30 percent capacity or the generator must be properly loaded on an annual basis. This type of testing helps ensure the generator operates as intended in an emergency situation. The DOM stated a generator contractor used to perform this type of testing. The DOM stated he was not aware of the proper testing requirements for the generator.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.2.2</p>	K 144  K144	<p>report any issues to the facility Administrator.</p> <p>Date of Completion</p> <p>This Section Intentionally Blank</p>	2/24/13
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------	---------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 144	Continued From page 11 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144	This Section Intentionally Blank	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors to hazardous areas were maintained as required. This deficient practice affected two of twelve smoke compartments, staff, and approximately twenty-six residents. The facility has the capacity for 166 beds with a census of 155 on the day of the survey.  The findings include:  During the Life Safety Code survey on 01/08/13 at 12:10 PM, with the Director of Maintenance (DOM), two electrical junction boxes with no covers and wiring protruding were observed above the lay-in ceiling on the first floor corridor.  During the survey an open junction box was observed above the lay-in ceiling on the second	K 147	The Maintenance Assistant placed cover plates on the identified junction boxes at the time they were identified. During the week of 1/14-1/18/13, The Maintenance Assistants audited the area above the drop ceiling throughout the facility and placed cover plates on junction boxes that did not have cover plates. Administrator discussion with the Director of Maintenance and Maintenance Assistants demonstrated their knowledge that junction boxes are required to have cover plates. The facility Director of Maintenance will oversee work completed by electrical contractors and ensure junction box covers are replaced and used per the code. The facility Director of Maintenance or designee will audit the area above the drop ceiling semi-annually to identify any issues with life safety code above the drop ceiling. Identified issues will be immediately corrected. Results of these audits will be reported to the QI Committee for one year and will continue per the established schedule thereafter.	
		K147	Date of Completion	2/15/13

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------	----------------------------------------------

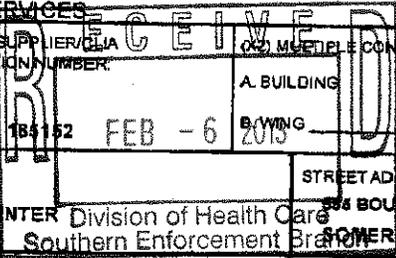
NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501
--------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 147	<p>Continued From page 12 floor corridor and the second floor dining room.</p> <p>An interview with the DOM on 01/08/13 at 12:10 PM revealed he was aware that electrical junction boxes were required to have covers. The DOM stated he was not aware the junction boxes had no covers.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147	This Section Intentionally Blank	
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------	--

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

PRINTED: 01/25/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - MAIN BUILDING 02 B. WING: _____	(X3) DATE SURVEY COMPLETED  01/08/2013
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SOMERWOODS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 705 BOURNE AVENUE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 02</p> <p>PLAN APPROVAL: 2007</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 11 (111)</p> <p>SMOKE COMPARTMENTS: Two</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 01/08/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000	<p>The facility was found to be in substantial compliance. No plan of correction is necessary.</p> <p>Completion Date</p>	02/04/2013
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------------------------------------------------------------------------------------------------------	------------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian K. [Signature]</i>	TITLE Admin	(X6) DATE 02/04/13
------------------------------------------------------------------------------------------------------	----------------	-----------------------

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.