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Division of Health Care
Southern Enforcement Branch

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

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185152		01/12/2012

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 A standard survey was conducted on 01/10-12/12. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	DISCLAIMER: Somerwoods Nursing and Rehabilitation Center (Somerwoods) acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction 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 Plan of Correction is submitted as a written allegation of compliance. Somerwoods' response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Somerwoods reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure or any other administrative or legal proceeding.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure services were provided to one of twenty-five sampled residents (Resident #8) in accordance with the resident's plan of care. Documentation revealed the facility had developed a plan of care for Resident #8 that included a bed alarm on the resident's bed to alert staff when the resident attempted to get out of bed unassisted. However, observations conducted on 01/10/12, 01/11/12, and 01/12/12, revealed the facility failed to ensure the plan of care had been implemented for Resident #8. The findings include: A review of the facility's policy entitled "Resident Care Plan" (dated 09/19/11) revealed the interdisciplinary written care plan would be based on the physician's orders and the assessment of the resident's needs. The policy also revealed a Registered Nurse (RN) would initiate the care plan to the facility upon a resident's admission to	F 282	The Comprehensive Plan of Care and Resident Care Guide for Resident #8 was reviewed on 01/12/12 by the Unit Manager and the Bed Alarm was replaced on the bed as indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian K Jeggers
TITLE: Administrator
(X6) DATE: 02/05/12

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.

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NAME OF PROVIDER OR SUPPLIER: SOMERWOODS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 555 BOURNE AVENUE, SOMERSET, KY 42501

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F 282	Continued From page 1 the facility, that the care plan process would be ongoing, and that the care plan would include current problems and/or identified needs. A review of the medical record for Resident #8 revealed the facility admitted the resident on 04/28/10, with diagnoses that included Dementia, Anxiety, Depression, Diabetes Mellitus, and Osteoarthritis. A review of a Quarterly Minimum Data Set (MDS) assessment dated 12/01/11, revealed the facility had assessed Resident #8's cognition to be severely impaired. The MDS also revealed, based on the assessment, that the resident required extensive assistance of two persons for transfers. In addition, documentation on the MDS revealed the resident had not experienced falls prior to the assessment. A review of the comprehensive care plan for Resident #8 revealed facility staff had assessed the resident to be at risk for falls. Based on the care plan, a bed alarm was to be utilized on Resident #8's bed to alert staff if the resident attempted to get out of bed without assistance. Continued review of documentation revealed facility staff had also developed a Resident Care Guide that identified the resident's care needs and was to be utilized by staff, e.g. Certified Nurse Aides, as a reference of the resident's care needs. Documentation on the Resident Care Guide also revealed facility staff was to ensure the resident had a bed alarm on his/her bed. An interview conducted on 01/12/12, at 2:10 PM, with the MDS nurse revealed the resident liked to	F 282	An Audit of all Care Guides for residents in the unit where resident #8 resides was conducted on 01/12/12 by the Unit Manger and no other issues were identified. Members of the Management Team conducted a facility wide audit and reported to the Quality Improvement Nurse on 01/13/12. All interventions were in place as indicated per Resident Care Guides. To ensure all residents continue to have interventions in place as identified on the care guide: Audits of interventions in place compared to Resident Care Guides will be conducted twice monthly by members of the facility management team, as assigned by the Quality Improvement Nurse or designee. Any identified issues will be immediately corrected and then reported to the Quality Improvement Nurse or designee. Staff Re-education related to reviewing the resident care guide and ensuring interventions are in place, every shift, as indicated on the Resident Care Guide was initiated for all SRNA's, KMA's and Licensed Nurses by the Staff Development Coordinator on	

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NAME OF PROVIDER OR SUPPLIER: SOMERWOODS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 558 BOURNE AVENUE, SOMERSET, KY 42501	

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F 282	Continued From page 2 sit up on the side of the bed, would try to stand up unassisted, and as a result would often "roll" onto the floor. According to the MDS nurse, Resident #8 had been assessed to require a bed alarm since 03/10/11. Observations conducted on 01/10/12, at 3:05 PM, 4:00 PM, and 5:00 PM; on 01/11/12, at 9:25 AM, 10:15 AM, 11:10 AM, 1:45 PM, 2:45 PM, 3:45 PM, and 5:00 PM; and on 01/12/12, at 9:50 AM and 10:00 AM, revealed Resident #8 lying in bed. The observations further revealed a bed alarm had not been placed on Resident #8's bed as planned in the comprehensive plan of care or on the Resident Care Guide. An interview conducted with CNA #1 on 01/12/12, at 10:00 AM, revealed Resident #8 was supposed to have a bed alarm on. The CNA stated he did not know why there was not an alarm on the resident's bed. The CNA confirmed information related to the resident's care was documented on the Resident Care Guide which was kept in the resident's closet. The CNA stated he should have checked the Resident Care Guide at the beginning of the shift but failed to do so. An interview conducted with CNA #2 on 01/12/12, at 10:05 AM, revealed she provided care to Resident #8 on 01/12/12. The CNA stated she was not aware Resident #8 required a bed alarm. The CNA stated the information regarding the care required by the resident could be found hanging in the resident's closet on the Resident Care Guide. The CNA stated she was expected to check the Resident Care Guide every day but failed to review the guide on 01/12/12.	F 282	01/31/11. Education related to reviewing the Resident Care Guide and ensuring interventions are in place will be included during General Orientation for newly hired NA's, SRNA's, KMA's and Licensed Nurses. The Quality Improvement Nurse will report to the Quality Improvement Committee on a monthly basis for three months and per the established schedule thereafter. Date of Completion This Section Intentionally Blank	2/15/12

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F 282	Continued From page 3 An interview conducted on 01/12/12, at 10:15 AM, with the Unit Manager (UM) of the Third Floor of the facility revealed she was required to conduct daily rounds on the unit to monitor resident care, however, according to the UM, she might not always observe every resident room during her rounds. In addition, the UM stated CNAs were expected to check the Resident Care Guide at the beginning of their shift to determine the needs of each resident. An interview conducted on 01/12/12, at 10:30 AM, with the Licensed Practical Nurse (LPN) revealed the LPN provided nursing care to Resident #8 on 01/12/12. The LPN stated Resident #8 had been observed to "scoot" off the bed at times and was also identified as being at risk for falls. According to the LPN, as a result of the resident's identified needs, the resident was to have a bed alarm on the bed. However, at the time of the interview, the LPN stated she had not completed her daily rounds and was unaware of the status of the resident's bed alarm. An interview conducted on 01/12/12, at 1:45 PM, with the Director of Nursing (DON) revealed CNAs were expected to review the Resident Care Guide at the beginning of every shift to familiarize themselves with the resident's needs, including safety devices the resident required. The DON stated information on the Resident Care Guide was taken from the interdisciplinary care plan. In addition, according to the DON, nurses were expected to conduct rounds every shift and, as part of the rounds, were to ensure alarms were in place for those residents determined to require them.	F 282	This Section Intentionally Blank	
F 366	483.35(d)(4) SUBSTITUTES OF SIMILAR	F 366	This Section Intentionally Blank	

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

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F 366 SS=D	Continued From page 4 NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to ensure residents were provided with appropriate substitutes for documented dislikes for one of twenty-five residents. Resident #25 was served polish sausage when sausage and hot dogs were listed as dislikes on the resident's meal tray card. The findings include: A review of the facility policy Preparation of Food (dated September 2008) revealed "individual's likes and dislikes will be met whenever possible to encourage residents to enjoy their meals. Substitutes or an alternate menu will be prepared at each meal and offered by the nursing staff to residents refusing to eat." Observation of Resident #25 on 01/10/12, at 12:25 PM, revealed the resident was being assisted by his/her family to eat. The resident had not eaten the polish sausage and the family said he/she would not eat sausages. Resident #25's meal tray card had sausage and hot dogs listed as a dislike. No substitute was offered to Resident #25 for the sausage during the 01/10/12 noon meal.	F 366	Interview with the Food Service Manager on 01/12/12 revealed that the line staff in the kitchen had interpreted the dislike to mean breakfast sausage. The kitchen staff was instructed that word sausage would indicate any type of sausage and not be limited to breakfast sausage. Resident #25's family member was informed by the facility Administrator that s/he may ask for a substitute for any food item at any meal and that s/he may contact the Administrator or Director of Nursing at any time related to any concerns which are not resolved. The Resident Council has meetings twice monthly and will be presented a question specifically related to the facility honoring food preferences and offering substitutes during each of their meetings for the next 3 months. This question will be presented by the staff member taking minutes the council meeting. The Quality Improvement Nurse or designee will randomly, but at least weekly, audit meal services to ensure residents who do not attend council meetings , including resident #25, are eating appropriately and are	

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

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F 366	Continued From page 5 Interview with Resident #25's family members on 01/10/12, at 12:25 PM, revealed the family members came to the facility "most days" and assisted the resident with eating. Resident #25's family members further stated the resident often received food items that were listed on the meal card as foods he/she disliked. Resident #25's family member also stated they had attended the resident's care plan meetings and had discussed the resident's food preferences with facility staff, but the resident continued to receive food items he/she did not like and would not eat. Resident #25's family stated no food substitution was offered for the polish sausage on 01/10/12. Interview with CNAs #1, #2, and #3 on 01/10/12, at 12:30 PM, 12:35 PM, and 12:40 PM, revealed the CNAs were to look at meal tray cards when the meal trays were delivered to determine if resident food preferences were honored. The CNAs acknowledged Resident #25 should not have received the polish sausage on his/her meal tray due to documentation on the meal card that the resident did not like sausage. In addition, the CNAs stated the resident should have been offered a substitute for the sausage when the resident did not eat the sausage. Interview with the Kitchen Supervisor on 01/12/12, at 2:30 PM, revealed she did not work on 01/10/12, when Resident #25 received sausage on the meal tray. The Kitchen Supervisor stated the employees serving food on the tray line should have identified the mistake and that a substitute should have been offered to the resident. Interview with the Director of Nursing (DON) on	F 366	being offered substitutes of equal nutritive value and that likes and dislikes are being honored. Any identified concerns related to residents receiving foods noted to be disliked will be addressed as indicated. Staff Re-education was initiated by the Staff Development Nurse on 01/31/12 for All Dietary Staff Members regarding review of the resident tray card for likes and dislikes when preparing meal trays for delivery and for all SRNA's, KMA's and Licensed Nurses regarding monitoring resident tray cards for food preferences and offering of substitutes of equal nutritive value for foods not being consumed. The minutes of the Resident Council Meetings and random QI audits will be presented to the Quality Improvement Committee monthly for further follow up as indicated. Date of Completion This Section Intentionally Blank	02/15/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERWOODS NURSING & REHABILITATION CENTER	565 BOURNE AVENUE SOMERSET, KY 42501

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F 366	Continued From page 6 01/12/12, at 3:00 PM, revealed CNAs should look at meal tray cards when trays were delivered to a resident and should offer replacements or substitutes if a resident did not like a food item or was not eating well.	F 366		
F 371 SS=D	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain the kitchen under sanitary conditions. The facility failed to ensure the confectioner's oven, steam table for hot foods, and the commercial toaster were cleaned on a routine schedule and as a result, a buildup of a black substance was observed on the interior of the confectioner's oven, the steam table (for hot food storage) had a buildup of a dark substance in the steam table wells, and the commercial toaster contained a buildup of a dark substance in the interior portion of the toaster. The findings include: A review of the facility's dietary cleaning policy	F 371	The confectioner's oven, steam-table and commercial toaster were thoroughly cleaned by Dietary staff on 01/10/12. The Cleaning Schedule for Food Service Equipment was amended beginning 02/01/12 to include the commercial toaster to be cleaned on a weekly basis. All other food preparation and storage equipment was reviewed by the Food Service Manager and Kitchen Manager 01/11/12 no build up was identified on any additional equipment. Staff re-education related to the equipment cleaning schedule was initiated for the Dietary Department Staff by the Food Service Manager on 01/16/12. The Food Service Manager or designee will review the cleaning schedule on a weekly basis and report to the Quality Improvement Committee monthly for three months and then per the established schedule. The Registered Dietitian	

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F 371	Continued From page 7 and procedures revealed the confectioner's oven and steam table were to be thoroughly cleaned on a weekly basis. However, the facility did not have a policy for cleaning the commercial toaster. Observation during the initial tour of the kitchen at 9:45 AM on 01/10/12, revealed a buildup of a black substance that covered the entire interior of the confectioner's oven, including the glass doors of the confectioner's oven. The steam table (for hot food storage) was observed to have a buildup of a dark substance in the steam table wells. Further observation revealed the commercial toaster contained a buildup of a dark substance in the interior portion of the toaster. Interview with the Dietary Manager (DM) at 9:50 AM on 01/10/12, revealed the equipment should be wiped off daily and an overall thorough cleaning should be completed weekly for the confectioner's oven and the steam table. In addition, according to the DM, staff was to thoroughly clean the toaster on a monthly basis. However, the DM stated staff did not always take the time to clean the equipment. A review of the December 2011 and the January 2012 cleaning schedule revealed staff documented the steam table and the commercial toaster had been cleaned daily. However, there was no documented evidence the steam table and commercial toaster had received a thorough cleaning on a monthly basis for December 2011 as required. Based on documentation, staff had failed to clean the confectioner's oven on a weekly basis as required by facility policy. Documentation revealed the confectioner's oven was cleaned on 12/07/11, approximately five	F 371	will conduct an audit for food safety and sanitation monthly and prepare a copy of his/her findings for the Director of Nursing and Administrator monthly for three months and per the established schedule thereafter. Date of Completion This Section Intentionally Blank	2/15/12

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F 371	Continued From page 8 weeks prior to the day of observation on 01/10/12.	F 371	This Section Intentionally Blank	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure clinical information on clinical records/documents was accurate for two of twenty-five residents (Residents #16 and #17). A review of physician's orders for Residents #16 and #17 revealed the resident's physicians had requested a "Do Not Resuscitate" (withhold life-saving care) status for the residents. However, a review of the Care Guides utilized by Certified Nurse Aides (CNAs) to identify care needs/status and to direct the care of residents revealed documentation that identified Residents #16 and #17's resuscitative status as "full code" (in the event of cardiac/respiratory failure a person wishes that every possible measure available would be used	F 514	An audit was conducted by the DON, Unit Coordinator, MDS Nurses, QI Nurse, & Social Services on 1/12/12 to ensure the accurate code status was identified on the medical record for all residents including resident #16 and resident #17. Any areas of concern were immediately corrected as indicated including the Resident Care Guides for resident #16 and resident #17. Review of the facility protocol for initiating CPR was completed by The Administrator, Director of Nursing, Unit Coordinators, MDS Nurses and Social Services on 01/27/2012. The review determined non-licensed staff, including Certified Nursing Assistants, are to immediately alert a Licensed Nurse in the event that a resident is unresponsive. The Licensed Nurse would immediately look at the signed Advance Directive in the resident's hard chart to determine code status and then act in accordance with those directives. The decision was made to discontinue use of the "code status	

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

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F 514	Continued From page 9 to resuscitate them). The findings include: There was no policy available for code status stickers for the Resident Care Guides according to the Social Worker, It was an understanding at the facility that the code stickers were to be placed on the Resident Care Guides by the Social Workers. 1. Review of Resident #16's medical record revealed the facility admitted Resident #16 on 10/03/11, with a signed consent from the guardian and physician's orders for Do Not Resuscitate (DNR) status. The facility had placed a "DNR" label on the resident's medical record to indicate the resident's/family's wishes related to the resuscitative status of the resident. However, documentation on the Resident Care Guide utilized by CNAs and posted on the inside of the resident's closets listed Resident #16 as a full code. Interview with the Director of Nursing (DON) on 01/12/12, at 2:10 PM, revealed the facility Social Workers were responsible to identify the code status of the residents on the Resident Care Guide and place the guides on the inside of the resident's closet door. According to the DON, in the event a CNA finds a resident unresponsive, the CNA would check the Resident Care Guide on the inside of the closet door and then get a nurse immediately. The DON stated if the resident's code status changed the information on the Resident Care Guide should be changed as soon as possible.	F 514	stickers" on the care guide. The signed Advance Directive information was relocated into an easy to grab "sleeve" and placed in the front of the Advance Directive section of the chart for each resident and the "code status" sticker was covered or removed from each Resident Care Guide on 01/27/12. Staff Re-education was initiated on 01/12/12 by the Staff Development Nurse on the facility protocol that non-licensed staff, including Certified Nursing Assistants, are to immediately alert a Licensed Nurse in the event that a resident is unresponsive. The Licensed Nurse will immediately look at the signed Advance Directive in the resident's hard chart under the Advance Directive Tab to determine code status and then act in accordance with those directives. New hires will receive this information during the orientation process. A random audit will be conducted monthly by the Quality Improvement Nurse or designee to ensure the Advance Directive information included in the medical record is in accordance with the documented wishes of the resident	

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

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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 01/12/2012
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 10 Interview with the Social Worker and Assistant on 01/12/12, at 2:15 PM, revealed it was the Social Worker's responsibility to make sure the family's/resident's wishes for DNR status was accurate on the Resident Care Guides. The Social Worker stated the DNR status for Resident #16 must have been missed and a review of all the Resident Care Guides would be made for accuracy regarding code status. 2. A review of the medical record for Resident #17 revealed the facility admitted the resident on 09/14/11, with physician's orders and a signed consent form which read "Do Not Resuscitate" (DNR). However, the facility had placed a "Full Code" label on the Resident Care Guide located inside Resident #17's closet door in order for staff to know Resident #17's code status in the event of an emergency. Interviews with Licensed Practical Nurse (LPN) #1 and Certified Nurse Aides (CNAs) #4 and #5 at 1:45 PM on 01/12/12, revealed the Resident Care Guide was located on the inside of each resident's closet door and in the event staff needed to determine a resident's "code" status they could find the information on the Resident Care Guide. CNAs #4 and #5 stated that according to Resident #17's Resident Care Guide if the resident exhibited distress they would call for a nurse and obtain equipment needed to "code" the resident. LPN #1 also acknowledged she would have also looked at the Resident Care Guide to determine Resident #17's code status and, based on the information documented on Resident #17's Resident Care Guide, would have initiated CPR if the resident had stopped breathing.	F 514	or person authorized to make advance directive on behalf of the resident. The results of the audit will be reported to the Quality Improvement Committee monthly for three months and then per the established schedule thereafter. Date of Completion This Section Intentionally Blank	2/15/12

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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 01/12/2012
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
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Amended 50D

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

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RECEIVED FEB 06 2012 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185152		01/10/2012
NAME OF PROVIDER OR SUPPLIER: SOMERSWOODS 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 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1975 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Three story, Type 1 (332) SMOKE COMPARTMENTS: Twelve COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 01/10/12. 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. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	DISCLAIMER: Somerwoods Nursing and Rehabilitation Center (Somerwoods) acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction 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 Plan of Correction is submitted as a written allegation of compliance. Somerwoods' response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Somerwoods reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure or any other administrative or legal proceeding. This Section Intentionally Blank	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Boggs — TITLE: Administrator — (X6) DATE: 02/05/12

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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X6) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185152		01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERWOODS NURSING & REHABILITATION CENTER	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 025	Continued From page 1 least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke barrier walls to ensure a half-hour fire resistance rating as required. This deficient practice affected 9 of 12 smoke compartments, staff, and approximately 140 residents. The facility has the capacity for 166 beds with a census of 160 on the day of the survey. The findings include: During the Life Safety Code survey on 01/10/12, at 10:55 AM, with the Director of Maintenance (DOM), unsealed penetrations of electrical wiring and conduit were observed through the fire/smoke barrier walls above the fire doors next to the first floor lobby. In a fire situation, unsealed penetrations of fire/smoke barrier walls aid in the spread of fire and smoke to other parts of the building. The second and third floor fire/smoke barriers had these same types of unsealed penetrations as well. An interview with the DOM on 01/10/12, at 10:55 AM, revealed the facility	K 025	The identified penetrations in the smoke/fire walls above the fire doors were sealed with fire-rated material by the Maintenance Assistant on 01/10/12. On 01/10/12, the Maintenance Assistant audited the fire/smoke barrier walls above each set of corridor fire doors for unsealed penetrations and installed fire rated material to any identified area of penetration The facility Administrator met with the Director of Maintenance on 02/01/12 and provided the Director of Maintenance materials demonstrating that the fire/smoke barrier wall above each set of fire doors must be maintained to prevent the passage of smoke/fire from one corridor compartment to the next. The facility Director of Maintenance will oversee any additional renovations and ensure any fire/smoke barrier wall penetration is sealed with fire-rated material. The facility Director of Maintenance or designee will audit the smoke/fire	

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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 01/10/2012
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501	

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K 025	Continued From page 2 had been undergoing some renovations in the past year. The DOM stated he was aware that these types of penetrations in the fire/smoke barrier walls needed to be properly sealed.	K 025	barrier walls above the fire corridor fire doors semi-annually to ensure there are no unsealed penetrations. These audits will be presented to the Quality Improvement Committee every six months for one year and then based on the established schedule.	
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 maintain corridor walls above the drop ceiling to ensure a half-hour fire resistance rating as required. This deficient practice affected 3 of 12 smoke compartments, staff, and approximately 40 residents. The facility has the capacity for 108 beds with a census of 100 on the day of the survey. The findings include: During the Life Safety Code survey on 01/10/12, at 12:10 PM, with the Director of Maintenance (DOM), a third floor corridor wall above the drop ceiling near the nurses' station was observed to	K 029	Date of Completion The Director of Maintenance and Maintenance Assistants will install fire-rated material to seal penetrations identified by during the life safety inspection on 01/10/2012. The facility Administrator and Director of Maintenance audited the areas above the drop ceiling in the corridors throughout the facility on 02/01/12. The Director of Maintenance and Maintenance Assistants will install fire-rated material during the week ending 02/12/12 to ensure all corridor walls are sealed to the floor or roof above. The facility Administrator met with the Director of Maintenance on 02/01/12 and provided the Director of Maintenance materials	2/15/12

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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 01/10/2012
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 955 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 3 have unsealed penetrations of wiring and conduit. This wall had some holes in it as well. Unsprinkled facilities' corridor walls must be maintained to the floor or roof above the drop ceiling to help prevent the passage of fire or smoke. The second floor had these same types of deficiencies as well. An interview with the DOM on 01/10/12, at 12:10 PM, revealed the facility had been undergoing renovations in the past year. The DOM stated he was unaware corridor walls had to be maintained above the drop ceiling. Reference: NFPA 101 (2000 Edition). 19.3.6.2 Construction of Corridor Walls. 19.3.6.2.1* Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1*: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke.	K 029	demonstrating that the corridor wall must be maintained to the floor or roof above in order to prevent the passage of smoke/fire from one compartment to the next. The facility Director of Maintenance will oversee any additional renovations and ensure any fire/smoke barrier wall penetration is sealed with fire-rated material. The facility Director of Maintenance or designee will audit the smoke/fire barrier walls above the drop ceiling semi-annually to ensure there are no unsealed penetrations. These audits will be presented to the Quality Improvement Committee every six months for one year, and then based on the established schedule. Date of Completion This Section Intentionally Blank	2/15/12

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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 01/10/2012
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 551 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	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 02 PLAN APPROVAL: 2007 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 11 (111) SMOKE COMPARTMENTS: Two COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 01/10/12. 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. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	DISCLAIMER: Somerwoods Nursing and Rehabilitation Center (Somerwoods) acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction 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 Plan of Correction is submitted as a written allegation of compliance. Somerwoods' response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Somerwoods reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure or any other administrative or legal proceeding.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those	K 054	On 01/31/12, the Director of Maintenance relocated the two ceiling fans identified as being too	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 02/03/12

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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185152	A. BUILDING 02 - MAIN BUILDING 02 B. WING	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERWOODS NURSING & REHABILITATION CENTER	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 054	Continued From page 1 activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detector placement met NFPA standards. This deficient practice affected 2 of 12 smoke compartments, staff, and 26 residents. The facility has the capacity for 166 beds with a census of 160 on the day of the survey. The findings include: During the Life Safety Code survey on 01/10/12, at 11:30 AM, with the Director of Maintenance (DOM), two corridor smoke detectors located in the West Wing were observed to be in close proximity of ceiling fans. This could prevent the smoke detectors from detecting smoke and from operating as intended. An interview with the DOM on 01/10/12, at 11:30 AM, revealed that he had not noticed nor was aware of the smoke detectors being in close proximity to the ceiling fans. Reference: NFPA 72 (2002 Edition). 5.7.1.7 The selection and placement of smoke detectors shall take into account both the performance characteristics of the detector and the areas into which the detectors are to be installed to prevent nuisance alarms or improper operation after installation.	K 054	close to smoke detectors on 01/31/11 identified during the Life Safety Inspection. The Director of Maintenance audited the remainder of the ceiling fans to ensure the fans were not in close proximity to smoke detectors. The facility Administrator provided the Director of Maintenance information on 01/31/2012 related to installation of smoke alarms to ensure proper functioning. The facility Director of Maintenance will oversee any additional renovations and ensure ceiling fans are not installed in close proximity to smoke detectors. The Director of Maintenance or designee will conduct an audit of the smoke detectors every six months to ensure that there have not been any detectors or fans relocated resulting in close proximity of each other. Results of these audits will be presented to the Quality Improvemen Committee every six months for one year, and then per the established schedule. Date of Completion	02/15/12

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