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

PRINTED: 06/01/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185152	B. WING_	B, WING			C 05/27/2020	
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING AND REHABILITATION CENTER				555 BOUR	DDRESS, CITY, STATE, ZIP (INE AVENUE BET, KY 42501	CODE	-1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				(X5) COMPLETION DATE
F 000	a COVID-19 focused initiated on 05/26/2020 05/27/2020. The cor and no deficient practices are contacted to the contact of the	dard survey (KY31752) and infection control survey was 20 and concluded on applaint was unsubstantiated tice was identified. The pe in compliance with 42 a Control and has aters for Medicare & EMS) and Centers for Prevention (CDC) ces to prepare for	F	000				
		7/			i Ese			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	iRE	<u> </u>	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 A. BUILDING		COMP	(X3) DATE SURVEY COMPLETED	
185152			B. WING			05/27/2020	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	58	TREET ADDRESS, CITY, STATE, ZIP CODE 55 BOURNE AVENUE OMERSET, KY 42501		::	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000	C			
	survey was initiated of concluded on 05/27/2 to be in compliance v	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No	392	*	25		
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1.40004700	/ DIOPECTORIS OR REQUIRES	VSI IPPLIER REPRESENTATIVE'S SIGNATUI]	TITLE		(X6) DATE	

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FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C 100499 B. WNG 05/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **555 BOURNE AVENUE** SOMERWOODS NURSING AND REHABILITATION CEI SOMERSET, KY 42501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 **Initial Comments** A complaint investigation (KY31752) and a COVID-19 focused infection control survey was initiated on 05/26/2020 and concluded on 05/27/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE