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

PRINTED: 12/04/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING AND REHABILITATION CENTER SIMMANY STATEMENT OF DEPLOEMENES TAGO SOMERSET, KY 42501 PROVIDER OR JUNE OF DEPLOEMENES TAGO REACH CORRECTIVE ALTURE PROVIDER OR JUNE OF DEPLOEMENES TAGO PROVIDER OR JUNE OR JUNE OF DEPLOEMENES TAGO PROVIDER OR	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING AND REHABILITATION CENTER SOMERSET, KY 42501 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 focused infection control survey was initiated on 11/30/2020 and concluded on 12/01/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.			185152	B. WING	B. WING		12/01/2020	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 focused infection control survey was initiated on 11/30/2020 and concluded on 12/01/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.				,	555 BOURNE AVENUE	IP CODE		
A COVID-19 focused infection control survey was initiated on 11/30/2020 and concluded on 12/01/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. No deficient practice was identified.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	X (EACH CORRECTIVE A CROSS-REFERENCED	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 focused initiated on 11/30/202 12/01/2020. The faci compliance with 42 C and has implemented Medicaid Services (C Disease Control and recommended practic COVID-19. No defici The total census was	Infection control survey was 20 and concluded on lity was found to be in CFR 483.80 Infection Control of the Centers for Medicare & CMS) and Centers for Prevention (CDC) coes to prepare for ent practice was identified.					

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.

Facility ID: 100499

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

PRINTED: 12/08/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
185152		185152	B. WING			12/01/2020	
NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 555 BOURNE AVENUE SOMERSET, KY 42501	ODE		
(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 TAG CROSS-REFERENCED TO THE APPROPROFILE DEFICIENCY)			(X5) COMPLETION DATE
E 000	A COVID-19 focused survey was initiated to on 12/01/2020. The compliance with 42 C Preparedness related practice was identifie	I Emergency Preparedness on 11/30/2020 and concluded facility was found to be in SFR 483.73 Emergency It to E0024. No deficient d.		DOOD 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.

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Office of Inspector General

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
100499			B. WING	B. WING			
	NAME OF PROVIDER OR SUPPLIER SOMERWOODS NURSING AND REHABILITATION CEI SOMERSET, KY 42501 SUMPLIES SUMPLIES STREET ADDRESS, CITY, STATE, ZIP CODE SOMERSET, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
N 000	A COVID-19 focused initiated on 11/30/202 12/01/2020. The faci	lity was found to be in to 42 CFR 483.80. No	N 000	DEFICIENCY			

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

TITLE (X6) DATE