| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185152 | A. BUILDING _____ B. WING _____ | R 04/10/2025 |

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| SOMERWOODS NURSING AND REHABILITATION CENTER | 555 BOURNE AVENUE SOMERSET, KY 42501 |

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| {F 000} | INITIAL COMMENTS<br><br>Based upon implementation of the acceptable plan of correction, an off-site revisit survey was conducted on 04/10/2025. It was determined the facility was in substantial compliance as of 03/26/2025 as alleged in the acceptable plan of correction. | {F 000} | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 04/23/2025 |

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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| F 000 | INITIAL COMMENTS<br><br>A Recertification Survey was concluded on 02/21/2025, with deficiencies cited at the highest Scope and Severity of "F." The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B.<br><br>Survey Dates: 02/17/2025 - 02/21/2025<br>Total census: 105 | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the | F 609 | | 3/26/25 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/20/2025

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| F 609 | Continued From page 1<br>incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and facility policy review, the facility failed to report a possible incident of resident-to-resident abuse to the state survey agency (SSA) within two hours for two (Resident (R) 78 and R13) of four residents reviewed for abuse.<br><br>The findings included:<br><br>Review of the facility "Abuse, Neglect, or Misappropriation of Resident Property Policy," revised 03/10/2017, revealed "'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm or pain or mental anguish." Further review of the policy revealed that it failed to define/address the meaning of "willful," a term defined in the Code of Federal Regulations at §483.5 in the definition of abuse which "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."<br><br>A facility policy titled, "Abuse, Neglect, or Misappropriation of Resident Property Policy," revised 03/10/2017, revealed the section titled "Reporting/Response" specified, "The Administrator will ensure that the Division of Licensure and Regulation [SSA] and the Department of Social Services, Adult Protective Services will be notified immediately but no later than 2 hours after the allegation is received and determination of alleged abuse is made, of all complaints of abuse, neglect, including injuries of unknown origin, or misappropriation of resident | F 609 | DISCLAIMER:<br>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 the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Somerwoods response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor the accuracy of any deficiency. Further, Somerwoods Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, independent informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.<br><br>CRITERIA 1:<br>On 03/11/2025, The Regional Nurse Consultant provided (re)education to the Administrator related to the regulatory requirement 483.12(c)(1) and 483.12(c)(4) requiring:<br><br>All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are | |

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| F 609 | Continued From page 2<br>property."<br><br>An "Admission Record" revealed the facility admitted R78 on 01/19/2022. According to the Admission Record, the resident had a medical history that included diagnoses of depression, generalized anxiety disorder, and cognitive communication deficit. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/21/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident had intact cognition. R78's "Care Plan Report" included a focus area, initiated 06/03/2024, that indicated the resident exhibited "problematic" behaviors, including manipulative behavior, and seeking things to complain about.<br><br>An "Admission Record" revealed the facility admitted R13 on 03/20/2024. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder, anxiety disorder, and cognitive communication deficit. A quarterly MDS, with an ARD of 11/12/2024, revealed R13 had a BIMS score of 14/15, which indicated the resident had intact cognition. R13's "Care Plan Report" revealed a focus area, initiated 05/29/2024, that indicated the resident had "problematic" behaviors characterized by ineffective coping and anxiety related to loss of control.<br><br>During an interview on 02/19/2025 at 2:37 PM, State Registered Nurse Aide (SRNA) 26 stated she recalled an incident several months prior in which R13 was propelling their wheelchair to the nursing station to get ice, and R78, who was by | F 609 | reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>Report the results of all investigations to the administrator or his /her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>Resident #78 was evaluated on 02/20/2025. Resident was free from injury, at baseline mood and demonstrating no signs/symptoms of distress. On 02/20/2025, the Comprehensive Plan of Care for Resident #78 reviewed and revised to include frequent monitoring, i.e. 15 minute checks. On 02/28/2025, a review of the resident□s record was conducted; and the resident had not demonstrated any further negative interactions with other residents.<br><br>Interdisciplinary Team (IDT): (Members include: Administrator, Director of | |

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| F 609 | Continued From page 3<br>the elevator, mumbled under their breath, "If that [explicit] rolls this way, I'm gonna [going to] kill [them]." SRNA 26 stated she redirected R78, who yelled at R13. SRNA26 stated R13 replied, "You're not going to talk to me that way." SRNA26 stated R78 then pushed R13's wheelchair down the hallway, after R13 had turned their back. SRNA26 stated she was able to intervene before R13 traveled farther than a foot. SRNA26 described R13 as angry but not frightened following the incident. SRNA26 stated she reported the incident to Registered Nurse (RN) 27.<br><br>During an interview on 02/20/2025 at 8:36 AM, the Administrator confirmed the incident in which R78 pushed R13's wheelchair and let go of it, stating R13 rolled a few feet down the hallway. Interview with the Administrator revealed that the facility was aware of the incident but chose to not report it to the state survey agency as a possible allegation of abuse because RN27 stated it was not a reportable incident. Interview with the Administrator revealed they reached the conclusion that the incident was not reportable because there was no harm or intent to harm, and the residents were not angry for more than 30 seconds after the incident. However, review of the federal definitions related to abuse revealed the regulation does not require the individual to intend to inflict injury or harm,<br><br>During an interview on 02/21/2025 at 10:27 AM, the Director of Nursing (DON) stated that it was up to the Administrator to determine what did and did not get reported to the state survey agency.During an interview on 02/19/2025 at 2:37 PM, State Registered Nurse Aide (SRNA) #26 stated she recalled an incident several months | F 609 | Nursing, RN Assistant to Administrator, Business Office Manager, MDS Coordinator, QAPI/Infection Prevention Nurse(s), Maintenance Director, Housekeeping Supervisor, Therapy Department Manager, Staff Development Nurse, Nutritional Services Director (Chef), Social Services Director, RN Unit Manager(s), RN Weekend House Supervisor, Admissions Director, Consultant Pharmacist, Consultant Dietitian, RN Clinical Consultant, Other Administrative Staff as indicated, Other Direct Care Staff as indicated<br><br>Reviews as of 03/07/2025, 03/13/2025 and 03/20/2025, there have not been any further reports of negative interactions between Resident #78 and any other resident. Results of these reviews will be presented to the Quality Assurance/Performance Improvement (QAPI) Team at the Regularly Scheduled Meeting on 03/25/2025. Further monitoring of Resident #78 will continue based upon the recommendation of the QAPI Team at that time.<br><br>On 03/12/2025, the Administrator reviewed all skin checks completed between 01/01/2025 and 03/11/2025 for Resident #13. This review was looking for signs/symptoms of mistreatment. No issues were identified. Results of this review will be presented to the QAPI Team during the regularly scheduled meeting on 03/25/2025. | |

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| F 609 | Continued From page 4<br>prior in which Resident #13 was propelling their wheelchair to the nursing station to get ice, and Resident #78, who was by the elevator, mumbled under their breath, "If that [explicit] rolls this way, I'm gonna [going to] kill [them]." SRNA #26 stated she redirected Resident #78, who yelled at Resident #13. SRNA #26 stated Resident #13 replied, "You're [you are] not going to talk to me that way." SRNA #26 stated Resident #78 then pushed Resident #13's wheelchair down the hallway, after Resident #13 had turned their back. SRNA #26 stated she was able to intervene before Resident #13 traveled farther than a foot. SRNA described Resident #13 as angry but not frightened following the incident. SRNA #26 stated she reported the incident to Registered Nurse (RN) #27.<br><br>During an interview on 02/20/2025 at 8:36 AM, the Administrator confirmed there was an incident in which Resident #78 pushed Resident #13's wheelchair and let go of it. The Administrator stated Resident #13 rolled a few feet down the hallway. The Administrator stated they did not report the incident to the state survey agency because RN #27 stated it was not a reportable incident. The Administrator stated they reached the conclusion that the incident was not reportable, because there was no harm or intent to harm, and the residents were not angry for more than 30 seconds after the incident.<br><br>During an interview on 02/21/2025 at 10:27 AM, the Director of Nursing (DON) stated that it was up to the Administrator to determine what did and did not get reported to the state survey agency. | F 609 | Observation by the Administrator and discussion with Resident number 13 on 02/20/2025, 02/27/2025, 03/12/2025, and 03/18/2025 reveals the resident interacts normally with other residents and staff. He consistently denies having been mistreated; and states he has no unmet needs or concerns.<br><br>CRITERIA 2:<br><br>On 03/11/2025, discussion within the IDT determined all residents have potential to be affected by this practice.<br><br>CRITERIA 3:<br><br>On 03/11/2025, the QAPI Team met and reviewed the information contained in the 2567. The committee developed a plan of correction as required for this practice, including, correction(s) for the individuals, staff and residents involved in the deficient practice as cited, identification of individuals and/or areas which have potential to be affected by the process; (re)education required for individuals involved and potentially involved, actions taken during the survey process to correct the issue, as well as between the exit and receipt of the 2567, and the expectations of (re)education and monitoring until the next regularly scheduled QAPI Team Meeting (03/25/2025) and the expected date to return to compliance, including that all staff must be (re)educated related to the identified issues; and that any staff who has not been (re)educated will not be | |

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permitted to work until having completed the required (re)education and post test(s) after 03/25/2025.

On 02/20/2025, (Re)Education for all staff was initiated by the Staff Development Coordinator related to the facility policy Abuse, Neglect, or Misappropriation of Resident Property. Understanding of the material was demonstrated by completion of a post test.

On 02/20/2025, Safe Surveys were conducted for all residents with a BIMS score of 08 and above, by nurses as assigned by the Director of Nursing. These surveys were to identify any resident with a potentially reportable concern or issues which had not been reported. These surveys included both resident #78 and resident #13. No issues were identified. On 02/20/2025, an audit of the skin of all residents with a BIMS score below 08 or default was completed by Nurses as assigned by the Director of Nursing in order to identify any signs of mistreatment. No issues were identified by any resident with a BIMS of 8 and above; and no issues were identified by the skin checks completed by nurses for residents with BIMS below 08 and default.

As of 03/20/2025, all staff have completed (re)education related to Policy: Abuse, Neglect, or Misappropriation of Resident Property with posttest will be completed by 3/20/25. No staff member scored less than 100 percent on the post test.

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Results of the completion status will be reported to the QAPI Team during the regularly scheduled meeting on 03/25/2025.

Education related to Abuse, Neglect, or Misappropriation of Resident Property is conducted during general orientation for new hires; and annually as well as when needed based upon recommendations from the IDT.

Reviews of all Progress Notes and Incident Reports are conducted by the Director of Nursing and Members of the IDT as assigned by the Director of Nursing 5 days per week to include weekends.

The Director of Nursing has reviewed all progress notes and incident reports from 02/21/2025 until 03/19/2025. No incidents which could have been considered reportable were identified as having not been reported to outside agencies as required. Results of these reviews will be submitted to the QAPI Team during the regularly scheduled meeting on 03/25/2025.

On 03/18/2025, the Administrator conducted an audit of all skin checks completed 03/11/2025 through 16:30 on 03/18/2025. This audit was to identify any signs of mistreatment or negative interactions between residents. No issues were identified. Results of this audit will be presented to the QAPI Team on during

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the regularly scheduled meeting on 03/25/2025.

A final follow up conversation will be held by the Administrator with Resident #13 between 03/20/2025 and 03/25/2025. Results of the 02/20/2025, 02/27/2025, 03/12/2025, 03/18/2025 observations and conversations as well as the final follow up observation/conversation will be presented to the QAPI Team on during the regularly scheduled meeting on 03/25/2025.

CRITERIA 4:

Understanding/Retention of the information provided during (re)education is evidenced by.
Interview of the Administrator by the Regional Nurse Consultant on 03/18/2025.

Interview of 15 randomly selected staff from varying departments and shifts (approximately 10 percent of all staff) regarding Abuse, Neglect, or Misappropriation of Resident Property was conducted by members of the IDT between 03/12/2025 and 03/20/2025. No issues were identified. Results of these interviews will be submitted to the QAPI Team during the regularly scheduled meeting on 03/25/2025.

On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues

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had been identified, there were no recommendations for additions or alterations to the plan.

An additional 5 interviews regarding Abuse, Neglect, or Misappropriation of Resident Property will be conducted of randomly selected staff by members of the IDT between 03/20/2025 and 03/25/2025. Any identified issues will be reported to the Administrator for direction.

Results of these interviews will be submitted to the QAPI Team during the regularly scheduled meeting on 03/25/2025. Thereafter:

As part of the Quality Assurance/Performance Improvement (QAPI) process, An additional 5 interviews regarding Abuse, Neglect, or Misappropriation of Resident Property will be conducted of randomly selected staff by members of the IDT weekly for 3 weeks. Any identified issues will be reported to the Administrator for direction. Results of these audits will be presented to the QAPI Team during the next regularly scheduled meeting tentatively scheduled for 04/22/2025. The schedule for further interviews and reporting of results will be determined during that QAPI Meeting.

As part of the Quality Assurance/Performance Improvement (QAPI) process, reviews of all Progress Notes and Incident Reports will be conducted by the Director of Nursing and

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Members of the IDT as assigned by the Director of Nursing at least 5 days per week, including weekends. to include identification of incidents which are potentially reportable. Any issues will be immediately reported to the Administrator. Results of these audits will be presented to the QAPI Team during the next regularly scheduled meeting tentatively scheduled for 04/22/2025. The schedule for further reviews and reporting of results will be determined during that QAPI Meeting.

As part of the Quality Assurance/Performance Improvement (QAPI) process, the Director of Nursing (DON) or an Administrative Nurse assigned by the DON in the event of her absence will review all Progress Notes and Incident Reports at least weekly for 3 weeks to include identification of incidents which are potentially reportable. Any issues will be immediately reported to the Administrator. Results of these audits will be presented to the QAPI Team during the next regularly scheduled meeting tentatively scheduled for 04/22/2025. The schedule for further reviews and reporting of results will be determined during that QAPI Meeting.

As part of the Quality Assurance/Performance Improvement (QAPI) process, the Administrator will review all skin checks completed during the prior week for 3 weeks to identify any signs of mistreatment or negative interactions between residents. Results

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| F 609 | Continued From page 10 | F 609 | of these audits will be presented to the QAPI Team during the next regularly scheduled meeting tentatively scheduled for 04/22/2025. The schedule for further reviews and reporting of results will be determined during that QAPI Meeting. | |
| F 761 SS=D | Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and facility policy review, the facility failed to store | F 761 | CRITERIA 1: | 3/26/25 |

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| F 761 | Continued From page 11<br>medications securely in one of five medication carts. Specifically, nursing staff left a medication cart unlocked in the hallway while administering medications in resident rooms.<br><br>The findings include:<br><br>Review of a facility policy titled, "Medication Storage," dated 09/2020, revealed, "The medication cart shall be locked at all times, when not under the direct physical supervision of a licensed nurse or medication aide."<br><br>Observation on 02/18/2025 at 8:53 AM revealed a medication cart located on the 200 Hall was unlocked. Registered Nurse (RN) 11 was observed in Room 211, administering medications. RN11 was approximately 16 feet from the medication cart and was not within eyesight of the medication cart.<br><br>Observation and interview on 02/18/2025 at 9:03 AM revealed RN11 was in Room 216 administering medications. The medication cart remained unlocked in the hallway, out of R11's line of sight. RN11 exited Room 216 and returned to the medication cart. When interviewed, RN 11 stated it was important to lock the medication cart when she went into resident rooms. RN11 stated she had not paid attention to whether she had locked the medication cart when she went into the resident rooms.<br><br>During an interview on 02/20/2025 at 3:52 PM, RN13, the Unit Manager, stated the medication cart should be locked when the nurse went into resident rooms to administer medications.<br><br>During an interview on 02/21/2025 at 8:45 AM, | F 761 | On 03/17/2025, The Director of Nursing conducted a counselling session with RN #11 and provided (re)education to RN #11 regarding standard protocols and policy including that medication carts should be locked at all times when not under the direct physical supervision of a licensed nurse or medication aide.<br><br>CRITERIA 2:<br><br>On 03/11/2025, discussion within the IDT determined all residents have potential to be affected by this practice.<br><br>On 03/11/2025, discussion within the IDT determined all medication carts have potential to be affected by this practice.<br><br>On 03/11/2025, discussion within the IDT determined Registered/Licensed Nurses and Medication Aides have potential to be affected by this practice.<br><br>CRITERIA 3:<br><br>On 03/11/2025, the QAPI Team met and reviewed the information contained in the 2567. The committee developed a plan of correction as required for this practice, including, correction(s) for the individuals, staff and equipment involved in the deficient practice as cited, identification of individuals Registered Nurses, Licensed Practical Nurses and Kentucky Medication Aides (RN□s, LPN□s, and KMA□s) and equipment [Medication Carts] having potential to be affected by the practice, (re)education required for individuals | |

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| F 761 | Continued From page 12<br>the Director of Nursing (DON) stated the medication cart should be locked when the nurse was administering medications in resident rooms.<br><br>During an interview on 02/21/2025 at 8:56 AM, the Administrator stated the medication cart should be within sight of the nurse or it should be locked. | F 761 | involved and potentially involved, actions taken during the survey process to correct the issue, as well as between the exit and receipt of the 2567, and the expectations of (re)education and monitoring until the next regularly scheduled QAPI Team Meeting (03/25/2025) and the expected date to return to compliance, including that all RN, LPN and KMA staff must be (re)educated related to the identified issues; and that any staff who has not been (re)educated will not be permitted to work until having completed the required (re)education and posttest(s).<br><br>On 03/11/2025, (re)education was initiated by the SDC related to Medication Storage, with a post test. This education included the facility policy regarding Medication Storage and specifically, medication carts should be locked at all times when not under the direct physical supervision of a licensed nurse or medication aide.<br><br>As of 03/19/2025, 100 percent of the RN, LPN, KMA staff have completed the (re)education. (re)education and posttest. Understanding and retention of this (re)education was demonstrated by a posttest. No Nurse, nor KMA scored less than 100 percent on the post test.<br><br>Results of the completion status of this (re)education will be reported to the QAPI Team during the regularly scheduled meeting on 03/25/2025.<br><br>Education related to Medication Storage is conducted during general orientation for | |

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| F 761 | Continued From page 13 | F 761 | | |

RN, LPN and KMA staff, and in on an as needed basis based upon recommendations from the IDT during regularly scheduled meetings. After 03/25/2025 (re)education will return to the established schedule.

CRITERIA 4:
On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues had been identified, there were no recommendations for additions or alterations to the plan.

Between 02/20/2025, and 03/20/2025, more than 25 observations were made by various members of the IDT including varying shifts, units, carts and staff throughout the facility. No additional instances of medication carts being left unlocked and out of the direct supervision of the individual assigned to the cart were identified. Between 03/21/2025 and 03/25/2025, an additional 10 random observations will be conducted by members of the IDT during routine rounds. Results of these 35+ observations will be presented to the QAPI Team during the regularly scheduled meeting on 03/25/2025.

On 03/18/2025 and 03/19/2025, the Consultant Pharmacist conducted rounds within the facility covering both standard rotations of Nurses/KMA□s. At the request of the Administrator the Pharmacist remotely observed (watching

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| F 761 | Continued From page 14 | F 761 | during passing and while performing other duties) to identify any situation where a medication cart was left unlocked while out of direct sight of the Nurse or KMA. The Consultant Pharmacist also specifically observed the cart assigned to RN#11. No issues were identified.<br><br>As part of the QAPI process, a minimum of 5 random observations per week will be conducted to identify instances of carts being left unlocked by RN, LPN or KMA staff. These observations will be conducted by members of the IDT as assigned by the Administrator. In the event a cart is identified as unlocked when not in direct sight of the individual assigned to the cart, s/he will be immediately (re)educated and the finding will be reported to the Director of Nursing. Results of these audits will be presented to the QAPI Team during the next regularly scheduled meeting tentatively scheduled for 04/22/2025. The schedule for further reviews and reporting of results will be determined during that QAPI Meeting. | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State | F 812 | | 3/26/25 |

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| F 812 | Continued From page 15 | F 812 | | |

and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and facility document and policy review, the facility failed to store food in accordance with accepted professional standards for food service safety. Leftover food items were not labeled with a product name and open or use-by date. Raw meat was stored above cooked food items in a reach-in refrigerator. These failures had the potential to affect all residents receiving meals from the dietary department.

Findings included:

1. The facility's "Dietary Policy Manual," revised 01/23/2018, revealed a policy titled, "Food Storage" that specified, "All incoming foods will have a delivery date and an 'open date' or 'use by' date. When the foods are stored in a container other than the original container, the container will be labeled with the name of the product."

A concurrent observation of the reach-in refrigerator and an interview with the Dietary Supervisor on 02/17/2025 at 9:40 AM revealed leftover green beans and leftover green chili were stored without labels that included a product

CRITERIA 1:
On 02/17/2025, the petit fours (bite-sized desserts) stored in the bag labeled as bologna were discarded.

On 02/17/2025, the petit-fours, green chili, and green beans stored within the reach in but not dated, nor labeled were discarded.

On 02/17/2025, the container of white chickenchili stored below uncooked ground beef was discarded.

On 02/17/2025, The shelving and interior of the reach in refrigerator containing the ground beef was cleaned with a sanitizing cleaner by the Nutritional Services Director (Chef).

CRITERIA 2:
On 03/11/2025, discussion within the IDT determined all residents have potential to be affected by this practice.

On 03/11/2025, discussion within the IDT

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| F 812 | Continued From page 16<br>name or dates. In addition, a bag of petit fours (bite-sized desserts) was inside a bag labeled as bologna. The Dietary Supervisor confirmed the items observed were green beans, petit fours, and green chili. The Dietary Supervisor stated the food items should have been labeled, and the petit fours were in a bag incorrectly labeled as bologna.<br><br>During an interview on 02/20/2025 at 10:37 AM, Dietary Aide (DA) 18 stated the process for putting away left over food items included labeling them with the name of the contents, the use-by date, and the date the item was made.<br><br>During an interview on 02/20/2025 at 10:40 AM, Cook 19 stated leftover food items were to be labeled with the name of the food, the date it was made, and the discard date.<br><br>During an interview on 02/21/2025 at 12:17 PM, the Administrator stated he expected food items to be labeled and dated according to facility policy.<br><br>2. An observation on 02/17/2025 at 9:48 AM of the reach-in refrigerator revealed an undated document titled, "Proper Food Storage in Refrigerators and Freezers" was posted on the refrigerator door. The document specified that raw meats should be stored below produce, cooked food items, and ready-to-eat food items. The inside of the refrigerator contained a bag of raw meat, confirmed by the Dietary Supervisor to be ground beef patties. The raw ground beef patties were stored on the top shelf of the refrigerator above a container of prepared white chicken chili. | F 812 | determined all reach in refrigerators have potential to be affected by this practice. On 03/11/2025, discussion within the IDT determined all Dietary Aides and Dietary Cooks have potential to be affected by this practice.<br><br>CRITERIA 3:<br>On 02/17/2025, The Nutritional Services Director, a Certified Chef conducted a (re)education with the Dietary Aide who placed the uncooked ground beef above other items. The employee verbally stated understanding and verbally restated to the supervisor the proper method of storing food items. Visual signage is provided on all reach in refrigerators within the kitchen for reference/guidance on proper food storage.<br><br>On 02/17/2025, The Nutritional Services Director, a Certified Chef initiated (re)education with all staff related to proper labeling and dating of leftover food items. Staff were provided handouts and verbally restated understanding of the training.<br><br>On 03/11/2025, the QAPI Team met and reviewed the information contained in the 2567. The committee developed a plan of correction as required for this practice, including, correction(s) for the individuals, staff and residents involved in the deficient practice as cited, identification of individuals and/or areas which have potential to be affected by the process, | |

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| F 812 | Continued From page 17<br><br>During an interview on 02/20/2025 at 10:37 AM, DA18 stated raw meats were to be stored below cooked foods.<br><br>During an interview on 02/21/2025 at 12:17 PM, the Administrator stated he expected food items to be stored according to facility policy. | F 812 | (re)education required for individuals involved and potentially involved, actions taken during the survey process to correct the issue, as well as between the exit and receipt of the 2567, and the expectations of (re)education and monitoring until the next regularly scheduled QAPI Team Meeting (03/25/2025) and the expected date to return to compliance, including that all Dietary staff must be (re)educated related to the identified issues; and that any staff who has not been (re)educated will not be permitted to work until having completed the required (re)education and post test(s) after 03/25/2025.<br><br>As of 03/20/2025, 100 percent of dietary staff have completed the (re)education.<br><br>Retention and understanding of the (re)education is demonstrated by the audits by the Administrator and discussion with Dietary Staff during rounds by the Administrator and RN Assistant to the Administrator. No further issues have been identified and staff answer questions related to food storage policies correctly.<br><br>Education regarding food labeling and storage is conducted during orientation and on an as needed basis as identified by the Nutritional Services Director, Kitchen Manager and/or the Interdisciplinary Team based upon rounds and audits. Signage is also posted throughout the kitchen demonstrating proper storage of food items. | |

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CRITERIA 4:
On 02/25/2025, Sanitarian #G1841 employed by the Lake Cumberland Area District Health Department conducted a regular Foodborne Illness Risk Factors and Public Health Interventions Inspection, commonly known as a Food Establishment Inspection. The facility was found to be 100 percent compliant. This inspection consisted of 58 components including, Proper Date Marking and Disposition, Food separated and protected Food properly labeled

Results of this audit were reported to the QAPI Team on 02/25/2025.

Audits conducted by the Administrator on 02/28/2025, 03/07/2025 and 03/12/2025 did not identify any unlabeled or undated food, nor any uncooked meats or hazardous foods stored above other items. Discussion with staff on duty during these audits demonstrated a working knowledge of proper food labeling/dating and to not store uncooked meat or hazardous foods above other food items.

On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues had been identified, there were no recommendations for additions or alterations to the plan.

Between 03/20/2025 and 03/25/2025, an

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| F 812 | Continued From page 19 | F 812 | additional audit will be conducted by the Administrator or member of the IDT assigned by the Administrator to identify instances of undated/unlabeled or improperly stored food. Any identified issues will be immediately corrected and staff (re)educated by the Nutritional Services Director, Kitchen Manager, SDC or Administrator. Results of this audit and the three audits conducted by the Administrator will be presented to the QAPI Team during the next regularly scheduled meeting on 03/25/2025.<br><br>As part of the QA Process, an audit will be conducted by the Administrator or by a member of the IDT assigned by the Administrator weekly for 3 weeks to identify instances of undated/unlabeled or improperly stored food. Any identified issues will be immediately corrected and staff (re)educated by the Nutritional Services Director, Kitchen Manager, SDC or Administrator. Results of these audits will be presented to the QAPI Team during the next regularly scheduled QAPI Team Meeting tentatively scheduled for 04/22/2025. The schedule for further reviews and reporting of results will be determined during that QAPI Meeting. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the | F 880 | | 3/26/25 |

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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(v) The circumstances under which 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; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure staff donned personal protective equipment (PPE) when providing care to two (Resident (R) 42 and R29) of two residents reviewed for contact precautions.

The findings include:

A facility policy titled, "Standard and Transmission - Based Precautions," revised 06/13/2024, revealed the section titled "Contact Precautions," indicated, "Necessary when transmission of microorganism is by direct contact [sic] Precautions include gloves, gown, and

CRITERIA 1:
Resident #42 s infection requiring Contact Precautions resolved and Contact Precautions were discontinued from his/her comprehensive plan of care effective 03/03/2025.

SRNA#2 was provided immediate (re)education by the RN Unit Manager (UM) on 02/17/2025. SRNA #2 stated understanding and was observed to properly don/doff appropriate Personal Protective Equipment (PPE) for contact precautions at that time and during the shift on 02/17/2025.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185152 | A. BUILDING _____ B. WING _____ | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOMERWOODS NURSING AND 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 |
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| F 880 | Continued From page 22 | F 880 | | |

containment of microorganism."

Facility signage titled, "Contact Precautions," revised 04/2023, indicated, "All Healthcare Personnel must ...Wear gloves when entering room and remove before leaving room...Wear a gown when entering room and remove before leaving."

1. An "Admission Record" revealed the facility admitted R42 on 10/16/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of recurrent enterocolitis due to clostridium difficile. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/2025, revealed R42 had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact.

R42's physician orders revealed an order dated 02/17/2025 for vancomycin (an antibiotic) 125 milligrams (mg) four times a day for 10 days for clostridium difficile. R42's "Progress Notes," dated 02/18/2025 at 4:18 PM, revealed that on 02/17/2025 the resident met the criteria for contact precautions. The notes revealed that the medical doctor, resident, and resident representative were aware.

During an observation and interview on 02/17/2025 at 8:31 AM, State Registered Nurse Aide (SRNA) 2 was observed in R42's room, providing care without wearing a gown and gloves. SRNA2 stated she missed the signage, but she knew she should be wearing a gown and gloves while inside rooms that had residents on contact precautions. She stated she was unsure if

Resident #29□s infection requiring Contact Precautions resolved and Contact Precautions were discontinued from his/her comprehensive plan of care effective 03/01/2025

SRNA #7 was provided immediate (re)education by the RN Unit Manager on 02/17/2025. SRNA #7 stated understanding and was observed to properly don/doff appropriate PPE for contact precautions at that time and during the shift on 02/17/2025.

SRNA #8 was provided immediate (re)education by RN Unit Manager on 02/17/2025. SRNA #8 stated understanding and was observed to properly don/doff appropriate PPE for contact precautions at that time and during the shift on 02/17/2025.

CRITERIA 2:

On 03/11/2025, discussion within the IDT determined residents requiring contact precautions have potential to be affected by this practice.

On 03/11/2025, discussion within the IDT determined all direct care staff and members of the Interdisciplinary Team have potential to be affected by be affected by this practice. Reception and clerical staff, as well as Dietary Staff do not enter patient rooms.

CRITERIA 3:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185152 | A. BUILDING _____ B. WING _____ | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SOMERWOODS NURSING AND 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 |
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| F 880 | Continued From page 23<br>the resident was on contact precautions because she had not worked with the resident for a while.<br><br>During an interview on 02/17/2025 at 8:51 AM, R42 confirmed their diagnosis of clostridium difficile and that the previous staff had not worn PPE to provide care.<br><br>2. An "Admission Record" revealed the facility admitted R29's medical history included a diagnosis of zoster (shingles) without complications.<br><br>R29's "Progress Notes," dated 02/18/2025 at 9:27 AM, revealed that on 02/14/2025 the resident had a rash on their forehead that was confirmed as shingles per the medical doctor. An additional "Progress Notes," dated 02/18/2025 at 4:19 PM, revealed that on 02/14/2025 the resident met the criteria for contact precautions. The notes revealed that the medical doctor and the resident were aware.<br><br>Review of R29's "Care Plan Report" revealed a focus area initiated 02/17/2025, that indicated the resident had an actual infection/skin integrity impairment related to shingles. An intervention initiated 02/18/2025, directed staff to use "Contact Precautions."<br><br>During an observation on 02/18/2025 at 12:02 PM, SRNA7 and SRNA8 went into R29's room to | F 880 | On 03/11/2025, (re)Education was initiated by the SDC related to identification of residents in Contact Precautions by the signage placed outside the resident's room. As well as proper donning and doffing of PPE. Understanding and retention of this policy and process was validated by either return demonstration of donning/doffing PPE and verbal discussion related to the signage or by posttest.<br><br>Education related to Contact Precautions, signage and donning/doffing PPE is included in general orientation. (Re)education is conducted annually and as needed as identified by the IDT based upon observations during audits and rounds.<br><br>CRITERIA 4:<br>On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues had been identified, there were no recommendations for additions or alterations to the plan<br><br>Between 03/04/2025 and 03/10/2025, no resident was in Contact Precautions. On 03/10/2025, a resident who was not included in the survey was placed in Contact Precautions.<br><br>Between 03/11/2025 and 03/19/2025, members of the Interdisciplinary Team | |

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| | 185152 | A. BUILDING _____ B. WING _____ | 02/21/2025 |

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| F 880 | Continued From page 24<br>serve the resident a meal tray. Although R29 was on contact precautions for shingles, neither SRNA gowned or gloved before entering the room.<br><br>SRNA7 and SRNA8 were interviewed on 02/18/2025 at 12:03 PM. SRNA7 stated their understanding that contact precautions only applied if staff were providing care, not offering meal trays. SRNA8 added that contact precautions were only necessary if you touched the resident or provided personal care.<br><br>During an interview on 02/19/2025 at 3:32 PM, Administrative Licensed Practical Nurse (LPN) 30, who was also the Infection Preventionist, stated that for rooms where residents were on contact precautions, staff were required to wash their hands before entering and wear a gown and gloves.<br><br>During an interview on 02/21/2025 at 10:27 AM, the Director of Nursing (DON) stated she expected staff to wear a gown and gloves and fully wear PPE before entering a room where contact precautions were in place. The DON stated if the resident had been on enhanced-barrier precautions, staff would not need to wear a gown and gloves if they were not touching the resident, but this did not apply to contact precautions.<br><br>During an interview on 02/21/2025 at 10:42 AM, the Administrator stated if a resident was on contact precautions and not enhanced-barrier precautions, staff should don and doff PPE as directed by the signage. | F 880 | have made 10 observations of staff entering/exiting the resident room with contact precautions. No further issues have been identified.<br><br>Results of these observations will be submitted to the QAPI Team during the next regularly scheduled meeting on 03/25/2025.<br><br>A minimum of 3 observations will be made per week by members of the IDT as assigned by the Administrator to ensure proper use of PPE related to contact precautions. These audits will be conducted for up to three weeks, dependent upon the facility having a resident requiring contact precautions.<br><br>Any identified issues will result in immediate correction and (re)education of the individual. The QAPI Team during the next regularly scheduled QAPI Team Meeting tentatively scheduled for 04/22/2025, or a subsequent routinely schedule meeting in the event the next opportunity for completion of monitoring is beyond 04/22/2025. The schedule for further reviews and reporting of results will be determined during that QAPI Meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185152 | A. BUILDING 01 - **MAIN BUILDING 01**<br>B. WING _____ | R<br>**04/10/2025** |

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| (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<br><br>Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 04/10/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 03/26/2025. | {K 000} | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 04/23/2025 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185152 | A. BUILDING _____ B. WING _____ | 02/18/2025 |

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

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>42 CFR 483.73<br><br>Type of Structure: Three (3) story, (1940, 1975, 2008), Type I (332), protected fire-resistant construction with 12 smoke compartments and a complete automatic wet and dry sprinkler system.<br><br>An Emergency Preparedness Recertification Survey was conducted on 02/18/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. Somerwoods Nursing and Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid. | E 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/20/2025 |

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|---|---|---|---|
| | 185152 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/18/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.90(a)<br>K3 BUILDING: 0101<br>K6 PLAN APPROVAL: 1940, 1975, 2008<br>K7 SURVEY UNDER: 2012 Existing<br>K8 SNF/NF<br><br>Type of Structure: Three (3) story, (1940, 1975, 2008), Type I (332), protected fire-resistant construction with 12 smoke compartments and a complete automatic wet and dry sprinkler system.<br><br>A Life Safety Recertification Survey was initiated and concluded on 02/18/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Somerwoods Nursing and Rehabilitation Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.<br><br>The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by: | K 000 | | |
| K 225 SS=D | Stairways and Smokeproof Enclosures<br>CFR(s): NFPA 101<br><br>Stairways and Smokeproof Enclosures<br>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.<br>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was | K 225 | Somerwoods Nursing and Rehabilitation | 3/26/25 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/20/2025

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|---|---|---|---|
| | 185152 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/18/2025** |

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| **SOMERWOODS NURSING AND REHABILITATION CENTER** | **555 BOURNE AVENUE**<br>**SOMERSET, KY 42501** |

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| K 225 | Continued From page 1<br>determined the facility failed to continuously maintain stairwells free of obstructions in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) stairwell, staff, and 29 residents. The facility had the capacity for 166 beds with a census of 104 on the day of the survey.<br><br>The findings include:<br><br>Observation, during the building inspection tour on 02/18/2025 at 2:11 PM, revealed the storage of a floor dryer, mop bucket, floor buffer, and a five (5) gallon bucket of floor wax stored on the upper level of the North Stairwell by resident room 313.<br><br>Interview, on 02/18/2025 at 2:12 PM, with the Maintenance Director, revealed the facility was not aware someone had stored the items in the stairwell.<br><br>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 02/18/2025.<br><br>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)<br>19.2.2.3 Stairs.<br>Stairs complying with 7.2.2 shall be permitted.<br>7.2.2.1.1 Stairs used as a component in the means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.2, unless otherwise specified in 7.2.2.1.2.<br>7.1.3.2.3* An exit enclosure shall not be used for any purpose that has the potential to interfere | K 225 | 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 the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Somerwoods' response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor the accuracy of any deficiency. Further, Somerwoods Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, independent informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.<br><br>CRITERIA 1:<br>The floor dryer, mop bucket, floor buffer and bucket of wax were immediately removed from the North Stairwell on 02/18/2025 by the Floor Tech whom had temporarily stored the items there.<br><br>The employee who placed floor dryer, mop bucket, floor buffer and bucket of wax on the landing of the stairwell was immediately (re)educated by the Housekeeping Supervisor (his/her direct supervisor) items cannot be placed in the stairwell even for momentary storage.<br><br>CRITERIA 2:<br>Discussion with the employee responsible | |

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| | 185152 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/18/2025 |

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| K 225 | Continued From page 2<br>with its use as an exit and, if so designated, as an area of refuge.<br>7.1.10.1 * General.<br>Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. | K 225 | for the practice on 02/18/2025 revealed this was a one time occurrence related to having been pulled for a priority task. The employee had placed these items behind a locked door momentarily at approximately 14:00 on that date and was returning to retrieve them momentarily.<br><br>On 03/11/2025, discussion within the QAPI Team determined there have been numerous (estimated to be greater than 100 observations) during this employee□s time of employment (greater than 1 year) and no similar instances of floor care, nursing or maintenance equipment having been stored in a stairwell had been identified. These observations have been made by various individuals based upon other audit schedules and have been conducted at various intervals, by various members of the IDT, including but not limited to, the Administrator at least monthly during the audit to determine stairwell lighting is functional, Maintenance Audits of exit signs, fire extinguishers and door locking systems, etc.. at intervals scheduled for those audits. This issue has not been noted prior to 02/18/2025 nor between 02/18/2025 and 03/11/2025.<br><br>However, similar instances could occur by the floor techs at any of the stairwell exits within the facility.<br><br>CRITERIA 3:<br>Verbal (Re)Education was provided on 02/18/2025 to both floor techs on 02/18/2025 by the Housekeeping | |

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| | 185152 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/18/2025** |

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| K 225 | Continued From page 3 | K 225 | Supervisor. Both stated understanding.<br><br>On 03/11/2025, the QAPI Team met and reviewed the information contained in the 2567. The committee developed a plan of correction as required for this identified area including, correction(s) for the individual staff, involved in the deficient practice as cited, identification of individuals and/or areas which have potential to be affected by the process, (re)education required for individuals involved and potentially involved, actions taken during the survey process to correct the issue, as well as between the exit and receipt of the 2567, and the expectations of (re)education and monitoring until the next regularly scheduled QAPI Team Meeting (03/25/2025) and the expected date to return to compliance.<br><br>Retention of the (re)education that nothing can be stored in the stairwell was verbally confirmed the week ending 03/14/2025 by discussion with both floor techs (separately) and the Administrator during routine rounds. Both were asked what can be stored in a stairwell permanently or temporarily. Both responded that nothing can be stored in the stairwell.<br><br>CRITERIA 4:<br>The Director of Maintenance conducted an audit of all stairwells on 02/18/2025. No other stairwell was identified to have any items stored in those stairwells.<br><br>On 02/25/2025, the Administrator conducted an audit of stairwells to include | |

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|---|---|---|---|
| | 185152 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/18/2025 |

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| K 225 | Continued From page 4 | K 225 | that nothing was stored in the stairwell. No issues were identified. Results of this audit were presented to the QAPI Team during the regularly scheduled meeting on 02/25/2025.<br><br>Beginning 02/26/2025 weekly audits of all exit stairwells were initiated by the Administrator to be conducted by the Administrator, Director of Maintenance and/or Maintenance Assistant to identify any items stored within stairwells. Any issues identified are to be immediately corrected and the individual responsible will be (re)educated by the Director of Maintenance or Administrator. As of 3/20/2025 no issues have been identified.<br><br>Results of these audits as well as the audit conducted on 03/24 or 25/2025 will be presented to the QAPI Team during the next regularly scheduled meeting on 03/25/2025. Determination of the need and/or frequency of additional audits will be determined during this meeting.<br><br>On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues had been identified, there were no recommendations for additions or alterations to the plan | |
| K 363 SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than | K 363 | | 3/26/25 |

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|---|---|---|---|
| | 185152 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/18/2025** |

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| **SOMERWOODS NURSING AND REHABILITATION CENTER** | **555 BOURNE AVENUE**<br>**SOMERSET, KY 42501** |

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| K 363 | Continued From page 5<br>required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to maintain doors | K 363 | CRITERIA 1:<br>On 02/18/2025, the furnishings were | |

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| | 185152 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/18/2025** |

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| **SOMERWOODS NURSING AND REHABILITATION CENTER** | **555 BOURNE AVENUE**<br>**SOMERSET, KY 42501** |

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| K 363 | Continued From page 6<br>protecting corridors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect two (2) corridor doors, staff, and four (4) residents. The facility had the capacity for 166 beds with a census of 104 on the day of survey.<br><br>The findings include:<br><br>1. Observation, during the building inspection tour on 02/18/2025 at 2:22 PM, revealed the corridor door to resident room 307 was obstructed from closing due to the placement of a fall mat on the floor. Interview, on 02/18/2025 at 2:23 PM with the Maintenance Director, revealed the facility was not aware the door was obstructed from closing due to the floor mat.<br>2. Observation, during the building inspection tour on 02/18/2025 at 3:33 PM, revealed the corridor door to resident room 142 in the West Wing would was not provided with a means to keep the door closed. Interview, on 02/18/2025 at 3:34 PM with the Maintenance Director, revealed the facility was not aware the door latch would not keep the door closed.<br><br>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 02/18/2025.<br><br>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)<br>19.3.6.3* Corridor Doors.<br>19.3.6.3.1 * Doors, including doors or panels to nurse servers and pass-through openings, protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to | K 363 | repositioned in room 307 by the Therapy Manager in order to accommodate use the fall mat without impeding the swing of the door to the corridor.<br><br>On 02/18/2025, the Director of Maintenance adjusted the strike plate to the corridor door of room 142 in order for the door latch to properly secure the door in the closed position.<br><br>CRITERIA 2:<br>On 02/18/2025, the Administrator and Director of Maintenance discussed that all doors to resident rooms have the potential to be impacted by this identified issue. Only one other room has a resident on the door side using a fall mat. This mat does not impede the swing of the door.<br><br>CRITERIA 3:<br>On 02/18/2025, The Administrator provided (re)education to the Director of Maintenance regarding the fact that all doors must close and latch with one motion, and that items such as door mats must not impede the swing of the door. He stated verbal understanding including that if a similar instance of the mat was identified he would discuss the issue with the QAPI Nurse and/or Therapy Manager to resolve the placement of the mat issue. He also stated he would adjust the monthly audit of resident door rooms latching to be weekly.<br><br>Education related to doors to resident rooms closing and latching is provided to all staff during fire plan training during | |

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| | 185152 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/18/2025** |

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| K 363 | Continued From page 7<br>resist the passage of smoke and shall be constructed of materials such as the following:<br>1. 13/4 in. thick, solid-bonded wood core<br>2. Material that resists fire for a minimum of 20 minutes.<br><br>19.3.6.3.5 * Doors shall be provided with a means for keeping the door closed, and the following requirements also shall apply:<br>1. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.<br>2. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. | K 363 | general orientation, annually and as needed. (Re)education related doors closing and latching in one motion was included in the training initiated on 03/11/2025 by the SDC.<br><br>On 03/11/2025, the QAPI Team met and reviewed the information contained in the 2567. The committee developed a plan of correction as required for this practice, including, correction(s) for the individuals, staff and residents involved in the deficient practice as cited, identification of individuals and/or areas which have potential to be affected by the process, (re)education required for individuals involved and potentially involved, actions taken during the survey process to correct the issue, as well as between the exit and receipt of the 2567, and the expectations of (re)education and monitoring until the next regularly scheduled QAPI Team Meeting (03/25/2025) and the expected date to return to compliance, including that all staff must be (re)educated related to the identified issue; and that any staff who has not been (re)educated will not be permitted to work until having completed the required (re)education beginning 03/26/2026.<br><br>CRITERIA 4:<br>An audit conducted by the Director of Maintenance on 02/18/2025 revealed no other identified issues related to doors not closing and latching in a single motion.<br><br>An audit conducted by the Administrator on 02/25/2025 revealed 100 percent of | |

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| K 363 | Continued From page 8 | K 363 | resident room doors closed and latched with a single motion. No new issues were identified. These audits included room 307 as well as the other room with a fall mat on the door side.<br><br>The findings of these audits were presented to the QAPI Committee during the regularly scheduled meeting on 02/25/2025.<br><br>Discussion during the IDT meeting on 03/03/2025 revealed a fall mat had been placed in room 207. An audit on 03/03/2025 by the Administrator revealed this fall mat does not impede the swing of the door to room 207.<br><br>As of 03/20/25, there are no fall mats within the swing of a door to the corridor within the facility. The IDT will continue to review this as interventions are implemented and adjustments to plans of care are made.<br><br>Between 02/26/2025, and 03/20/2025, weekly audits have been conducted by the Director of Maintenance to ensure all doors to resident rooms close and latch with a single motion. No issues have been identified.<br><br>Results of these audits as well as the audit conducted on 03/24 or 25/2025 will be presented to the QAPI Team during the next regularly scheduled meeting on 03/25/2025. Determination of the need and/or frequency of additional audits will be determined during this meeting but will | |

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| K 363 | Continued From page 9 | K 363 | continue to be conducted at least monthly by individuals assigned by the Director of Maintenance.<br><br>On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues had been identified, there were no recommendations for additions or alterations to the plan | |
| K 372 SS=D | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure smoke barriers could restrict the transfer of smoke in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) smoke | K 372 | CRITERIA 1:<br>On 03/3/2025, the Facility Maintenance Staff sealed the penetration around the metal stud wall top plate and the top of the wall to the roof decking (both) above the west wing shower room. On 03/03/2025, | 3/26/25 |

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| K 372 | Continued From page 10<br>barrier, staff, and 30 residents. The facility had the capacity for 166 beds with a census of 104 on the day of survey.<br><br>The findings include:<br><br>Observation, during the building inspection tour on 02/18/2025 at 12:05 PM, revealed the smoke barrier wall located in the West Wing Shower Room had an unsealed penetration around the metal stud wall top plate that would not resist the passage of smoke and above the West Wing Tub Room was not sealed at the top of the wall to the roof decking.<br><br>Interview, on 02/18/2025 at 12:06 PM with the Maintenance Director, revealed the facility was not aware of the unsealed penetrations in the smoke barrier.<br><br>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 02/18/2025.<br><br>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)<br>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating, unless otherwise permitted by one of the following:<br>(1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply:<br>(a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c).<br>(b) Not less than two separate smoke | K 372 | This was verified as having been done correctly by the Regional Maintenance Director.<br><br>CRITERIA 2:<br>On 02/18/2025, the Administrator and Maintenance Director discussed that all smoke barriers have the potential to be impacted by this identified issue.<br><br>CRITERIA 3:<br>On 02/18/2025, the Administrator reviewed with the Director of Maintenance the criteria that all smoke barriers be constructed to restrict the transfer of smoke in accordance with the NFPA Standards.<br><br>On 02/18/2025, and 02/19/2025, the Director of Maintenance conducted an audit of all smoke walls within the facility. No issues other than those identified in the 2567 were identified. The Director of Maintenace stated understanding and described appropriate actions to be taken to seal the identified area.<br><br>On 03/03/2025, the Facility Maintenance Staff sealed the penetration around the metal stud wall top plate and the top of the wall to the roof decking (both) above the west wing shower room. On 03/03/2025, This was verified as having been done correctly by the Regional Maintenance Director.<br><br>On 03/11/2025, the QAPI Team met and reviewed the information contained in the 2567. The committee developed a plan of | |

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| K 372 | Continued From page 11<br>compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating,<br>and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier.<br><br>8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. | K 372 | correction as required for this identified area including, correction(s) for the individual staff, involved in the deficient practice as cited, identification of individuals and/or areas which have potential to be affected by the process, (re)education required for individuals involved and potentially involved, actions taken during the survey process to correct the issue, as well as between the exit and receipt of the 2567, and the expectations of (re)education and monitoring until the next regularly scheduled QAPI Team Meeting (03/25/2025) and the expected date to return to compliance.<br><br>Beginning 03/03/2025, the Director of Maintenance initiated Monthly audits of smoke walls. As of 03/20/2025, no issues have been identified.<br><br>Results of these audits as well as the audit conducted on 03/24 or 25/2025 will be presented to the QAPI Team during the next regularly scheduled meeting on 03/25/2025. Determination of the need and/or frequency of additional audits will be determined during this meeting but will continue to be conducted at least monthly by individuals assigned by the Director of Maintenance.<br><br>CRITERIA 4:<br>Beginning 02/25/2025, the Director of Maintenance initiated Monthly audits of smoke walls. As of 03/20/2025, no issues have been identified.<br><br>Between 02/18/2025 and 03/19/2025, no | |

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| K 372 | Continued From page 12 | K 372 | contractors have been on-site to perform work above the ceilings or which required penetration of a smoke wall. The Maintenance Department has not completed any work requiring penetration of a smoke wall. The March Audit of smoke walls bill be conducted 03/24 or 03/25/2025.<br><br>Results of these audits as well as the audit conducted on 03/24 or 25/2025 will be presented to the QAPI Team during the next regularly scheduled meeting on 03/25/2025. Determination of the need and/or frequency of additional audits will be determined during this meeting but will continue to be conducted at least monthly by individuals assigned by the Director of Maintenance.<br><br>On 03/19/2025, the QAPI Team met and reviewed the action plan as outlined from the 03/11/2025 meeting. The plan was determined to be on track, no new issues had been identified, there were no recommendations for additions or alterations to the plan | |
| K 916 SS=D | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Alarm Annunciator<br>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer | K 916 | | 3/26/25 |

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| K 916 | Continued From page 13<br>system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to locate the generator annunciator panel in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of one (1) annunciator panel, staff, and all residents. The facility had the capacity for 166 beds with a census of 104 on the day of survey.<br><br>Findings include:<br><br>Observation, during the building inspection tour on 02/18/2025 at 12:00 PM, revealed the annunciator panel for the 250 KW generator was not readily observable during the third shift. The annunciator panel was located on the first (1st) floor which was not regularly staffed between the hours of 9:00 PM and 4:00 AM due to consolidating residents and staff to the second (2nd) and third (3rd) floor.<br><br>Interview, on 02/18/2025 at 12:01 PM with the Maintenance Director, revealed the facility was not using the first floor for residents at this time and didn't realize the annunciator was to be observable by staff at a regular work station.<br><br>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 02/18/2025. | K 916 | CRITERIA 1:<br>The area where the main generator annunciator panel is located is staffed between 04:00 and 21:00 seven days per week. Staff routinely pass through this area between 21:00 and 04:00 located in a main walkway near the employee break area, the elevator and access to the West Unit from the rest of the building.<br><br>On 03/20/2025, the Director of Maintenance installed a video camera and monitor with audio. The camera is directed at the Generator Trouble Annunciator Panel Located on the 1st Floor. The Monitor is located at the 2nd Floor Nurses Station. The camera and monitor were connected to generator powered outlets and both have battery backup.<br>Labeling reading Generator Annunciator Panel Monitor Do Not Touch Notify Maintenance Immediately if Alarm Sounds are affixed to the monitor.<br><br>CRITERIA 2:<br><br>CRITERIA 3:<br>On 02/18/2025, the landlord was notified of the anticipated citation of deficient practice requiring the generator trouble annunciator be (re)located or electronically monitored in an area that is | |

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| K 916 | Continued From page 14<br>Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012)<br>6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows:<br>(1) Individual visual signals shall indicate the following:<br>(a) When the emergency or auxiliary power source is operating to supply power to load<br>(b) When the battery charger is malfunctioning<br>(2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following:<br>(a) Low lubricating oil pressure<br>(b) Low water temperature (below that required in 6.4.1.1.11)<br>(c) Excessive water temperature<br>(d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply<br>(e) Overcrank (failed to start)<br>(f) Overspeed | K 916 | consistently staffed 24 hours per day. The landlord contacted a vendor to have a repeater or duplicate annunciator installed at the 2nd floor nurses station.<br><br>The generator service vendor initially advised the facility and landlord they would be on-site 03/19/2025 to install a duplicate generator trouble annunciator at the 2nd Floor Nurses Station.<br>On 03/19/2025, the vendor advised the Director of Maintenance work would not be completed on that date due to an undisclosed priority situation at another client.<br><br>On 03/20/2025, the Administrator purchased a camera and monitor with audio. Both have battery backup. The Administrator placed labels on the monitor reading Generator Annunciator Monitor; - Do not Touch; If Alarm Sounds Notify Maintenance Immediately On 03/20/2025, the Director of Maintenance installed the camera and monitor connected to the generator powered emergency outlet.<br><br>The RN Unit Manager was advised of this new piece of equipment. The information was placed on the 24 hour report for Nursing staff to pass on from shift to shift.<br><br>Evidence of understanding/retention of the process was evidence by: On 03/20/2025, during a routine process involving the generator, the annunciator panel sounded. The Nurse called the Maintenance Director immediately. The | |

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Maintenance Director said it was less than 60 seconds between him triggering the annunciator alarm and his phone ringing.

CRITERIA 4:
On 03/20/2025, the Director of Maintenance and Maintenance Assistant tested the audio and visual components of the monitoring system. The audio can be clearly heard and the visual can identify that indicator lamps were illuminated on the main panel.

The Director of Maintenance will audit the monitoring device on 03/21/2025. The RN Weekend House Supervisor will audit the device on 03/22/2025, and 03/23/2025. The Director of Maintenance or a member of the IDT assigned by the Director of Maintenance (including Maintenance Assistant(s)) will audit the device daily until the duplicate panel is installed and tested by the vendor.

The results of these audits will be reported to the QAPI Committee during the regularly scheduled meeting on 02/25/2025.

Upon installation of the duplicate panel, it will be tested by the Director of Maintenance Weekly or a member of the IDT as assigned by the Director of Maintenance (including Maintenance Assistants) for four weeks. Any identified issues will be immediately reported to the Administrator and Regional Maintenance Director for direction. The results of subsequent audits between 02/26/25 and