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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerwoods Rehabilitation and Healthcare Center	555 Bourne Avenue Somerset, KY 42501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and review of facility documentation, the facility failed to immediately report all allegations and incidents of potential abuse, to the appropriate external authorities, including law enforcement and/or the State Survey Agency (SSA), in accordance with facility policy and federal regulations for 1 of 38 sampled residents, (Resident (R)95). The findings include: Review of the facility's policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, undated, revealed the facility's policy prohibited abuse of residents by any other person, including any member of the facility's staff. Continued review of the policy revealed the facility was to educate all staff so that every employee understood the policy. Additionally, review of the facility's policy was to report all instances of alleged or suspected abuse. Review of the facility's policy titled, Resident Rights in Kentucky Nursing Homes, undated, revealed residents had the right to be free of abuse. Review of R95's electronic Health Record (EHR) Face Sheet revealed the facility admitted the resident on 06/22/2018. Continued review of R95's EHR revealed the resident was noted to have a diagnosis of Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance since 10/02/2022. Review of R95's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/23/2023, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R95's most recent Comprehensive MDS Assessment, with an ARD of 03/15/2026, revealed the facility assessed the resident as having a BIMS score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Review of the facility documentation titled, Administrator Review, Family Concern, dated 09/12/2024, revealed the facility had prior knowledge of allegations involving an inappropriate relationship between Registered Nurse (RN) 1 and R95, including exchanged messages, kissing, and discussions regarding life insurance policies. Continued review of the documentation revealed the facility implemented interventions which included instructing RN 1 not to provide care for R95. Further review of the documentation revealed however, there was no documented evidence the allegation had been reported to the State Survey Agency (SSA) upon discovery of the incident. Review of a facility memorandum dated 04/30/2026, revealed the memorandum noted the facility had prior knowledge, dating back to approximately 02/2024, related to inappropriate interactions between RN 1 and R95, which include social media communication, and conversations regarding R95's life insurance policy. Per continued review of the memorandum, the facility instructed RN 1 to cease social media contact with R95. Further review revealed no evidence the allegation had been reported to the SSA or local law enforcement upon discovery of the inappropriate interactions between RN 1 and R95. Record review of a Staff Questionnaire on Abuse Reporting and Awareness, dated 02/03/2026, completed by RN 1 revealed the RN acknowledged having received training related to identifying and reporting abuse, neglect, and exploitation. Per continued review, RN 1 identified herself as a mandated reporter, and indicated suspected abuse was to be reported immediately to the Director of Nursing (DON) as an individual to whom suspected abuse should be reported. Further review revealed RN 1 also noted the facility's responsiveness to abuse concerns was fair. Review of R95's social media messages, (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided by Family Member (FM) 1 (the resident's wife) on 04/29/2026 at 9:23 PM, revealed the FM thought were inappropriate communication between Registered Nurse (RN) 1 and R95. Per review of the social media messages, they included inappropriate language directed toward R95 from RN 1; discussion of R95's life insurance policy by RN 1; and communication that indicated a personal relationship between RN1 and R95. During interview with (R95's) FM 1 on 04/29/2026 at 6:21 PM, the FM stated she became aware of an inappropriate relationship between R95 and RN 1 that began approximately two years ago. FM1 reported she believed the relationship was sexual in nature and stated R95 had told her (FM 1) they had kissed. She said RN 1 attempted to have R95 remove her (FM 1) as his Power of Attorney (POA), and the RN had asked questions about the resident's life insurance policies. FM 1 explained RN 1 had inappropriate conversations with R95, and she reported her concerns about that to the facility's Administrator. She stated the Administrator told her he would attempt to no longer assign RN 1 to R95's floor; however, due to staffing needs, the RN might still have to work on the resident's floor. FM 1 further stated she observed RN 1 on the unit after her concerns were reported to the Administrator. She reported she also had shown the social media messages, containing inappropriate messages between RN 1 and R95, to the Administrator and DON from her phone. During interview with R95 on 04/30/2026 at 2:15 PM, he stated he had exchanged social media messages with RN 1 and verbally confirmed the messages were inappropriate and not something I would do with other staff. R95 reported he previously had kissed RN 1 on the lips and said he had communicated with the RN as recently as six months prior to the current interview. R95 further stated RN 1 had never been removed from his floor; however, he had been told the RN was not supposed to enter his room. He additionally stated however, RN 1 had been in his room. During interview on 04/30/2026 at 2:21 PM, RN 1 denied having a personal relationship with any resident and stated, No, I would never do that. During the interview, the SSA Surveyor informed RN 1 the State Survey Agency (SSA) had reviewed messages between herself and R 95, and the RN requested to continue the interview in the medication room for privacy. In the medication room, RN 1 stated she and R95 had a few conversations. RN 1 said, I know how it looks. RN 1 reported R95's wife (FM 1) had contacted the Administrator alleging inappropriate conduct between her and R95. RN 1 said she denied the allegations when the Administrator asked; however, the Administrator instructed her she was no longer to work on R95's floor or enter his room. She further stated although staff had been notified she was not permitted to work on that (R95's) floor, she had continued to be floated there at times. During interview with the Administrator on 04/30/2026 at 3:19 PM, he stated FM 1 met with him approximately two years prior to the current date. He said the FM alleged RN 1 and R95 had kissed. The Administrator explained he informed FM 1 that RN 1 would not be assigned to work on R95's floor, unless there was an emergency staffing situation requiring her presence. He said the facility had not performed a sexual consent assessment on R95 because the resident had never expressed a desire to have a sexual relationship. The Administrator reported the facility's leadership, including administrative and legal staff, discussed FM 1's allegations and collectively determined the allegations did not rise to the level of reporting to State Agencies or local law enforcement. The Administrator further stated he had not believed a kiss on the cheek constituted a reportable offense.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to prepare, store, and serve food in a sanitary manner to help prevent potential contamination and foodborne illness, which had the potential to affect all residents consuming food from the dietary department. The findings include: Review of the facility's policy titled, Dietary Employee Personal Hygiene, date reviewed/revised 09/01/2024, revealed the facility was to utilize guidelines for employee personal hygiene to prevent contamination of food by foodservice employees. Continued review revealed hands were to be washed after engaging in activities that contaminated the hands, and employees were not to use their bare hands to contact with ready-to-eat foods. The policy additionally stated gloves were to be worn and changed appropriately to reduce the spread of infection. Review further revealed all dietary staff were required to wear hair restraints, including hairnets, hats, and/or beard restraints, to prevent hair from contacting food. 1). Review of the 2013 U.S. Public Health Service Food Code, revealed food employees should wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covered body hair. Continued review of the Code revealed the hair restraints were to be designed and worn to effectively keep food employees' hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Observation during the initial kitchen tour on 04/27/2026 at 1:10 PM, revealed three male dietary aides (DA's) working in the kitchen area without beard guards in place. Per observation, a cook was actively preparing food without a beard guard and the Dietary Manager (DM) was present in the kitchen area without wearing a beard guard. Further observation of the kitchen area at 1:33 PM, on that same date, revealed a fifth male dietary employee working in the kitchen area without a beard guard in place, and the DM, who had been present for the entire tour of the kitchen, was not wearing a beard guard for any of the tour. Observation, conducted from the kitchen entrance, on 04/27/2026 at 2:55 PM, revealed [NAME] 7 working on the tray line with a beard guard pulled down beneath his chin, leaving his facial hair exposed. Observation further revealed DA 5 wearing a beard guard with his facial hair not fully covered while working in the kitchen area. Observation, conducted during supper tray line service, on 04/27/2026 beginning at 4:30 PM, revealed [NAME] 4 working on the tray line without a beard guard in place. Observation revealed the DM present in the tray line area without a hairnet or beard guard in place. DA 5 was observed wearing a beard guard; however, it did not fully cover his mustache, while he working on the tray line. Observation at 4:45 PM, revealed DA 5 was rolling silverware while his facial hair remained exposed outside of his beard guard. Observation on 04/27/2026 at 5:00 PM, revealed the DM was again observed in the kitchen area without wearing a beard guard and then exited the kitchen area. The DM was observed to reenter the kitchen area at 5:07 PM, and remained in the kitchen without wearing a beard guard while tray line service continued. Observation, conducted during lunch tray line service, on 04/28/2026 beginning at 11:35 AM, revealed DA 9 entered the kitchen area wearing a hairnet without a beard guard leaving his facial hair exposed. Per observation, DA 9 was also wearing a scrub top without an undershirt, which left his chest hair exposed. Observation on 04/28/2026 at 3:48 PM, revealed [NAME] 7 working on the tray line with his mustache not fully covered by his beard guard. Observation further revealed DA 21 working in the kitchen area without a hairnet in place. Observation on 04/29/2026 at 3:28 PM, revealed DA 5 working in the kitchen area with a beard guard worn improperly, leaving his facial hair exposed. Continued observation revealed [NAME] 7 working on the tray line with the beard guard pulled beneath his chin, leaving his mustache exposed. Observation on 04/29/2026 at 7:53 PM, revealed the DM working in the kitchen area without a beard guard in place. Per observation, [NAME] 7 was wearing a beard guard pulled beneath his chin, leaving his mustache exposed; DA 5 was working without a beard guard; and DA 22 was working without a hairnet or beard guard in place. Continued observation revealed when staff became aware the State Survey Agency (SSA) Surveyor had entered the kitchen area, they (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dispersed throughout the kitchen and began adjusting and applying hair and beard coverings. During interview on 04/27/2026 at 1:34 PM, [NAME] 7 stated he knew he was supposed to wear a beard guard but did not realize that staff with only a mustache were required to wear facial hair protection over their mustache. [NAME] 7 additionally stated facility management had never corrected the manner in which he wore the beard guard or instructed him to wear it differently. During interview on 04/27/2026 at 1:38 PM, Dietary Aide 5 stated he had never been trained on the importance of wearing a hairnet and reported that he just does it. Dietary Aide 5 further stated he forgot to put on a beard guard and no staff member or manager had previously instructed him to wear one. During interview on 04/29/2026 at 8:01 PM, the Dietary Manager (DM) stated he had, at times, forgotten to wear his beard guard throughout the SSA Survey dates. 2). Observation during the initial kitchen tour on 04/27/2026 at 1:10 PM, revealed clean cups and bowls loosely piled and improperly stored in milk crates on metal shelving in the dry storage area and additional clean cups and bowls loosely stacked in milk crates on the floor of the dish room, and serving bowls stacked face-up along the tray line. Observation on 04/27/2026 at 4:49 PM, revealed bowls were stacked face-up on the tray line with the food contact surfaces exposed. Observation on 04/30/2026 at 2:28 PM, revealed clean cups loosely stored in milk crates placed directly on the floor of the wash room. During interview on 04/29/2026 at 8:01 PM, the Dietary Manager stated the cups and bowls stored in milk crates should have been covered to prevent contaminates from falling on them. During interview on 04/30/2026 at 2:28 PM, DA 23 stated clean dishes should not have been stacked in milk crates placed on the floor. The DA further stated clean dishes should not be stored that way because the floor was dirty and could contaminate the dishes with germs, potentially causing illness to residents. 3). Review of the Smucker's (name brand) website's (https://www.smuckers.com/frequently-asked-questions) frequently asked questions (FAQs) section revealed, We recommend refrigerating our fruit spreads, jams, jellies and preserves after opening, per the instructions on the back label of our products. For maximum freshness and flavor, we do not recommend using opened products if they have been without refrigeration for more than 48 hours. Observation during the initial kitchen tour on 04/27/2026 at 1:10 PM, of the refrigerator, revealed pimento cheese stored without a date label; pre-cracked eggs stored in a bucket without an open date; 10 Jello containers labeled Dinner 04/20; and seven vanilla pudding bowls labeled 04/24. Observation of the freezer revealed undated, opened garlic bread; premade pot pies dated 03/18/2026; and fish stored in the freezer without date labeling. Observation, conducted during supper tray line service, on 04/27/2026 beginning at 4:30 PM, revealed a container of Smucker's grape jelly labeled 04/16 stored on a shelf in the food preparation area, and not refrigerated as according to the manufacturer's instructions on the container. Observation of the bread room revealed a red plastic cup lying on the floor in the corner of the room. Observation on 04/28/2026 at 11:47 AM, revealed the previously observed opened container of grape jelly remained unrefrigerated on a shelf in the food preparation area. Observation at 11:48 AM, revealed the red plastic cup remained lying in the same corner of the bread storage room. Observation of the second-floor nourishment refrigerator, on 04/28/2026 at 12:09 PM, revealed a quarter-full pitcher of tea that was undated and lacked a lid. Observation on 04/29/2026 at 3:28 PM, revealed the previously observed opened grape jelly container remained unrefrigerated stored on a shelf in the food preparation area. Observation of the first-floor nourishment refrigerator, on 04/29/2026 at 7:57 PM, revealed one undated fruit salad; one undated pudding; and six pre-made sandwiches dated 04/28/2026. Observation of the sandwiches revealed the bread on the sandwiches was hard to the touch. Observation of the third-floor nourishment refrigerator, on 04/29/2026 at 8:25 PM, revealed six pre-made sandwiches dated 04/28/2026, and the bread on the sandwiches was hard to the touch. Observation of the [NAME] unit nourishment refrigerator, on 04/29/2026 at 8:40 PM, revealed five pre-made sandwiches dated 04/28/2026, with bread that was hard to the touch. Additionally, observation revealed two pitchers containing a flavored beverage observed to be undated and uncovered. During interview on 04/29/2026 at 8:01 PM, the DM stated staff were expected to follow refrigeration instructions for food items, but reported (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food might have been left unrefrigerated for the convenience of staff. He explained the kitchen area was to be swept thoroughly on a daily basis and said he did not have an explanation for why a red plastic cup had remained on the floor for multiple days in the bread room. 4). Observation on 04/27/2026 beginning at 4:30 PM, revealed a red plastic cup lying on the floor in the corner of the bread storage room. Observation on 04/27/2026 at 4:49 PM, during dinner meal service, revealed [NAME] 6 was observed rolling silverware, then walking to the tray line and food preparation area without removing gloves or performing hand hygiene. Observation revealed [NAME] 6 opened a drawer, retrieved a ladle, placed the ladle on the tray line, exited the tray line area, and returned to rolling silverware, all while continuing to wear the same gloves. Continued observation, during tray line service, revealed [NAME] 7 removed multiple plates from the plate warmer and stacked the plates face-up on the tray line while repeatedly touching the inside food-contact surface of the plates where resident food was to be placed. Observation further revealed [NAME] 6 touched the inside food-contact surfaces of the salad bowls during tray line preparation. In addition, [NAME] 7 was also observed touching his face while working on the tray line and not removing gloves or performing hand hygiene prior to resuming food service activities. Observation, conducted during lunch tray line service, on 04/28/2026 beginning at 11:35 AM, revealed [NAME] 10 touched rolls with gloved hands after touching serving utensils, and was also observed touching the inside food-contact surfaces of bowls where resident food would be placed. Continued observation revealed [NAME] 10 left the tray line, walked to the oven area, retrieved a tray of rolls, and touching the bottom surface of the baking tray while moving it from the top of the oven to a table located behind the tray line. Further observation revealed [NAME] 10 then returned to the tray line and resume preparing resident meal trays without changing gloves or performing hand hygiene. Observation on 04/28/2026 at 11:47 AM, revealed revealed the red plastic cup remained lying in the same corner of the bread storage room. During interview on 04/27/2026 at 4:53 PM, [NAME] 6 stated she should have changed her gloves and washed her hands between tasks to prevent cross contamination and reduce the spread of germs that could cause residents to become ill. During interview on 04/27/2026 at 5:26 PM, [NAME] 7 stated he should have removed his gloves and washed his hands after touching his face with gloved hands while working on the tray line. [NAME] 7 reported he should not touch the food contact surface of plates where resident food was to be placed. [NAME] 7 further stated proper hand hygiene was important to reduce the spread of germs to residents. During interview on 04/28/2026 at 11:41 AM, [NAME] 10 stated she should not have touched the rolls with gloved hands after touching serving utensils and leaving the tray line to retrieve additional rolls. [NAME] 10 reported she was unsure whether tongs should have been used to serve the rolls and said she would need to ask the Dietary Manager (DM). However, observation revealed [NAME] 10 did not consult the DM and continued serving residents without using tongs or changing gloves. During interview on 04/29/2026 at 11:42 AM, with the Director of Nursing (DON), she stated she expected all nurses and staff to follow the facility policies and procedures. During interview on 04/29/2026 at 8:01 PM, the DM stated he expected dietary staff to follow all facility policies and procedures to ensure resident safety. He further stated he was responsible for supervising the dietary staff and ensuring dietary staff followed the facility policies and procedures. During interview on 04/30/2026 at 3:19 PM, the Administrator stated the DM had oversight of the kitchen. The Administrator said the expectation was for all policies and procedures to be followed for the safety of residents and staff. Additionally, the Administrator stated dietary staff should have been following all manufacturer guidelines for storing food items. During interview on 04/30/2026 at 3:35 PM, the Infection Preventionist (IP) stated all new dietary staff received infection control training, as well as the facility's annual infection control training. During a follow-up interview on 05/01/2026 at 11:38 AM, the Administrator stated cups and bowls should have been covered if stored in milk crates to prevent contaminants from falling into them. The Administrator reported clean dishes should never have been stacked directly on the floor due to infection control concerns. The Administrator further stated cups and bowls were to be dried face down to prevent contaminants from falling into them.