

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

PRINTED: 09/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/06/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS On off site revisit was conducted and based on the facility's acceptable POC the facility is deemed to be in compliance as alleged on 09/06/13.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2013
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504	
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F 000	INITIAL COMMENTS A Recertification survey was conducted 08/13/2013 through 08/15/2013. Deficiencies were cited with the highest Scope and Severity of a "D".	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Homestead Nursing Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, review of employee files, and review of facility policy, it was determined the facility failed to implement written policies that prohibit mistreatment, neglect, and abuse of residents as evidenced by one (1) of seven (7) employee files reviewed failed to contain a pre-employment Nurse Aide Abuse Registry Check. The findings include: Review of the facility "Abuse Policy" revealed background checks, to include Nurse Aide Abuse Registry checks, were to be completed prior to employees working at the facility. Review of seven (7) employee files revealed no documented evidence the Nurse Aide Abuse Registry Check was completed on or prior to the date of hire for one (1) employee with a hire date of 04/30/13.	F 226	F226 / N 107 1) No residents were affected. 2) All current employee files were audited to ensure that a Nurse Aide Abuse Registry Check was completed on or prior to the date of hire. 3) The HR Director and Staff Development Coordinator were in-serviced by the Administrator on September 4, 2013 on the importance of reviewing the Nurse Aide Abuse Registry before hiring staff. The HR Director will use a New Hire Employee Checklist that includes all essential reviews, including the Nurse Aide Abuse Registry Checks. This checklist will include the date and initials of the person performing the reviews. The New Hire Employee Checklist will be reviewed for completeness and signed by both the HR Director and Administrator. 4) Quality Assurance will review all new hire folders monthly for six months. If the quality assurance audits are 100%, the HR Director will ask the QA committee to discontinue the audits. 5) The administrator or designee will oversee compliance with this regulation. 6) Completion date: September 6, 2013	

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BY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Gary R Denis
TITLE
ADMINISTRATOR
(X6) DATE
9-6-2013

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

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504
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F 226	Continued From page 1 Interview, with the Staff Development Coordinator on 08/15/13 at 4:05 PM, revealed the background checks were to be completed on all employees prior to hire. She stated any employee, whether a nursing employee or an employee in another department, could have a background as a nurse or nurse aide with a history of being abusive towards residents. Interview with the Administrator on 08/15/13 at 6:31 PM revealed, "We do a sexual predator check, national background check, criminal background check, and drug screen. We look for evidence of felonies and evidence of abuse. We would want to know whether or not there is evidence of abuse or felonies prior to [an employee] going out on the floor."	F 226		
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide care by qualified persons in accordance with each residents written Plan of Care for one (1) of twenty four (24) residents (Resident #9). Resident #9 was required to have the assistance of two (2) persons for transfer with a full body lift per the Comprehensive Plan of Care. Observation on 08/13/2013, revealed Resident #9	F 282	F282 / N194 Preparation and/or execution of this plan of correction does not constitute admission or agreement by Homestead Nursing Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) The charge nurse did intervene as a second assist for Resident #9's transfer that was already in progress on August 14, 2013. The transfer was completed safely without injury to the resident or staff. The SRNA assigned to Resident #9 received prompt in-servicing and written counseling. 2) No other residents were affected. 3) The Staff Development Coordinator ensured the SRNA's received additional in-servicing on September 6, 2013 on the facility policy and the importance of following the resident's plan of care at all times. The QA nurse will have direct observation of at least one transfer in a mechanical lift with two assists per the care plan to be completed daily for seven days for the next four weeks. The QA nurse will audit the care plans weekly for the next four weeks. The QA nurse, D.O.N. and Administrator will review results of audits as they are done and will report to the monthly QA meeting for the next three months. If the audits are 100%, they will be discontinued. 4) The D.O.N. or designee will be responsible for ensuring compliance with this regulation. 5) Completion Date: September 6, 2013	

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F 282	<p>Continued From page 2</p> <p>was being transferred with the assistance of one (1) staff member with a full body lift.</p> <p>The findings include:</p> <p>Review of Resident #9's medical record revealed the resident was admitted to the facility on 10/10/2012, with diagnoses which include Generalized Anxiety Disorder, Dementia with Behavioral Disturbance, and Functional Decline.</p> <p>Observation of Resident #9 on 08/13/13, during the initial tour, revealed one (1) State Registered Nurse Aide (SRNA) was assisting the resident to bed with the use of a full body lift.</p> <p>Review of Resident #9's current Comprehensive Plan of Care, revealed the resident was to be transferred with the use of a full body lift and the assistance of two (2) staff.</p> <p>Interview with SRNA #1, on 08/14/2013, at 2:55 PM revealed this SRNA was assigned to provide care to Resident #9 on 08/13/2013. The SRNA stated the resident was care planned for two (2) assist and a full body lift for transfers. SRNA #1 further stated there was only two (2) SRNA's yesterday and "instead of wasting time to get someone to help me I just did it myself, I know the lifts and have long experience with this kind of work, I'm very comfortable with the lifts". Further interview, revealed SRNA #1 had received training on the lifts and stated "my understanding of the reason for two (2) person assist with the full body lift is safety for the resident and staff".</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 08/14/2013, at 4:05 PM, revealed SRNA #1 should not have transferred Resident #9 without</p>	F 282			

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F 282	Continued From page 3 another staff member. LPN #1 further stated, "I did talk with SRNA #1 yesterday about having two (2) people to assist with full body lifts". Interview with the Director of Nursing (DON) on 08/15/2013, at 5:45 PM, revealed the facility procedure for corrective action would depend on the situation. The DON further stated, this issue had been discussed and SRNA #1 would receive further training on following the care plan when she returned to work.	F 282			

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504
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K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition) Existing</p> <p>Plan approval: 06/21/71</p> <p>Facility type: SNF/NF</p> <p>Type of structure: V (111)</p> <p>Smoke Compartment: Thirteen (13)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors and initiating devices at exits.</p> <p>Sprinkler System: Complete sprinkler system (dry)</p> <p>Generator: Type II (Natural Gas) upgraded in 2012.</p> <p>A standard Life Safety Code survey was conducted on 08/13/13. Homestead Nursing Center was found to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gary R. Deng</i>	TITLE ADMINISTRATOR	(X6) DATE 9-6-2013
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