DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/13/2020 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING _ COMPLETED C 185144 B. WING 04/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD **HOMESTEAD POST ACUTE** LEXINGTON, KY 40504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 An Abbreviated Survey investigating Complaint KY#00031575 and a COVID-19 Focused Infection Control Survey was initiated on 04/27/2020 and concluded on 04/28/2020. Complaint KY#00031575 was unsubstantiated with no deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 121.

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.

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

TITLE

(X6) DATE

TATEMEN1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII 3	TIPLE CON	NSTRUCTION		O. 0938-0	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185144	B. WING				C 4/28/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		DE I		
HOMEST	EAD POST ACUTE				ERSAILLES ROAD IGTON, KY 40504			
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-	Survey was initiate concluded on 04/2	used Emergency Preparedness ed on 04/27/2020 and 28/2020. The facility was found se with 42 CFR 483.73 related						
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(X6) DATE

Office c	of Inspector General				FORM	D: 05/13/20 APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		100108	B. WING		04/28/2020	
NAME OF	PROVIDER OR SUPPLIER	₹ STREET #	ADDRESS, CITY, S	STATE 710 CODE	1 07/	2012020
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N 000	Initial Comments		N 000			
	KY#31575 and a Co Control Survey was concluded on 04/28 KY#00031575 was was found to be in C CFR 483.80 infection	ey investigating Complaint COVID 19 Focused Infection in itiated on 04/27/2020 and 8/2020. Complaint is unsubstantiated. The facility compliance pursuant to 42 ion control regulations and has benters for Medicare and				
	Medicaid Services ((CMS) and Centers for				dice-e
	Disease Control and	nd Prevention (CDC)				
	recommended practico COVID-19. Total ce	stices to prepare for				
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE