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

PRINTED: 11/10/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			11/10/2020		
NAME OF PROVIDER OR SUPPLIER HOMESTEAD POST ACUTE				STREET ADDRESS, CITY, STATE, ZI 1608 VERSAILLES ROAD LEXINGTON, KY 40504	PCODE	11110/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	SHOULD BE COMPLETION	
F 000	was initiated on 11/ 11/10/2020. The fa compliance with 42 regulations and has Medicare & Medica Centers for Disease	sed Infection Control Survey 09/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and control and Prevention ed practices to prepare for	FO	000	· · · · · · · · · · · · · · · · · · ·		
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	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.

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

PRINTED: 11/10/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER HOMESTEAD POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504			11/10/2020	
(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	
E 000	Survey was initiate concluded on 11/1	used Emergency Preparedness ed on 11/09/2020 and 0/2020. The facility was found e with 42 CFR 483.73 related	E 000				
			25				
BORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	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.

PRINTED: 11/10/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 100108 11/10/2020 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 PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 11/09/2020 and concluded on 11/10/2020. 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 111.

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

TITLE

(X6) DATE