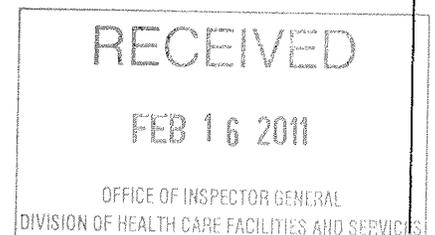


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2011
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40050	
(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 226	<p>Continued From page 1</p> <p>Review of the facility's investigation of the allegation that Employee #1 was verbally abusive to Resident #1 revealed the facility initiated the investigation on 08/10/10 when a former employee Certified Nurse Aide (CNA) #2 called in the complaint involving CNA #1. The investigation was completed on 08/13/10.</p> <p>Review of the facility's staffing schedule revealed CNA #1 worked on three (3) days during the investigation: 08/10/10, 08/11/10 and 08/12/10.</p> <p>Interview with Resident #1 on 02/01/11 at 8:10am revealed the resident was unable to answer any questions regarding the incident.</p> <p>Review of the clinical record for Resident #1 revealed the resident had an annual Minimum Data Set assessment completed by the facility on 11/14/10. The resident had short and long term memory deficits and was nonambulatory and required extensive assistance. The resident was incontinent of bowel and bladder. The resident also refused care.</p> <p>Interview with Social Services on 02/01/10 at 8:40am revealed CNA #1 denied she had been verbally abusive to Resident #1. She stated the facility's policy was to protect residents from abuse during an investigation and normally this meant a suspension from the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/01/11 at 8:50am revealed the administrator made the decision not to suspend CNA #2 during the investigation of the abuse allegation. She stated the facility normally suspended employees alleged with abuse per facility policy during the investigation. The Administrator was not available</p>	F 226	<p>F266 Continued.</p> <p>Assurance committee for three (3) months after which the committee will determine need for continuation.</p> <p>5. The Administrator is responsible for compliance under the guidance of the Director of Operations.</p>	3-15-2011



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

PRINTED: 02/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2011
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050	
(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)	(X6) COMPLETION DATE
F 226	Continued From page 2 for interview. Interview wllh CNA #1 on 02/01/11 at 9:45am revealed she did not verbally abuse Resident #1. She stated she was not suspended during the course of the facillity's investigation for verbal abuse.	F 226		

