

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

PRINTED: 06/22/2010
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 C 06/10/2010
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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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(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
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<p>F 000</p> <p>F 226 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A Recertification/Abbreviated Survey was conducted 06/08-10/10, and a Life Safety Code Survey was conducted 06/08/10. Deficiencies were cited, with the highest scope and severity of a "F". ARO KY00014824 was unsubstantiated with no deficiencies cited. AROs KY00014826, KY00014853, and KY00014854 were substantiated with deficiencies cited. AROs KY00014823, KY00014827, and KY00014828 were substantiated with no deficiencies cited.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to implement policies and procedures related to abuse of residents for two (2) of six (6) abuse investigations reviewed. The facility failed to ensure state agencies were provided the findings of abuse investigations within five days, per facility policy.</p> <p>The findings include: Review of the facility's "Reporting Abuse to State Agencies and Other Entities/Individuals revealed the facility would provide the appropriate stated agencies with a report of the findings of abuse investigations within five (5) days of the occurrence of the event".</p>	<p>F 000</p> <p>F 226</p>	<p>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.</p> <p>F 226 It is the policy of Homestead Nursing Center to complete an investigation and to send a copy of the investigation to the Office of Inspector General within five (5) days of the allegation.</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A. No residents were identified as being affected by this alleged deficiency practice.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice? A. All residents had the potential to be affected by this same deficient practice. B. Reports of allegations of abuse for the past 90 days were reviewed by the Social Services Department and Administration. No other issues were found.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A. A summary log has been initiated by Social Services. The summary log will track all steps of the abuse policy, including but not limited to, sending the final investigations to the OIG Office. B. The summary log will be reviewed daily for the next 90 days by the Administrator.</p>	<p>07/15/10</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vicki Trump</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/2/2010</i>
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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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F 226	Continued From page 1 On 04/09/10 the facility made an initial report of an investigation into employee to resident abuse and on 04/22/10 the facility reported the initiation of an investigation into a second employee to resident abuse allegation. Review of the facility's investigative findings revealed the facility completed the abuse investigations within five (5) days and took appropriate actions. However, there was no documented evidence the facility notified the state licensure agency, as required. Interview, on 06/10/10 at 2:03 PM, with the Medical Social Worker revealed he faxed completed abuse investigations to the state licensure agency. After review of his files the social worker stated he could find no evidence the facility faxed the completed reports, related to the two allegations noted above, to the state survey agency.	F 226	C. Any issues found will be handled immediately. 4. Indicated how the facility plans to monitor its performance to ensure that solutions are sustained. A. All allegations of abuse will be reviewed weekly in the Standard of Care Committee. The SOC consists, but is not limited to, the Administrator, DON, ADON, Charge Nurses, Social Services, Activities, Therapy, Dietary and Quality Assurance Nurse. B. The summary log will be submitted to the monthly Quality Assurance Committee. The QA Committee consists, but is not limited to, the Administrator, DON, ADON, Pharmacy, Social Services, Activities, Therapy, Dietary and Quality Assurance Nurse. C. Any issues will be handled by the QA committee. 5. July 15, 2010.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was	F 315	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 315 D It is the policy of Homestead Nursing Center to adhere to all regulations as it relates to catheter care. It is also the policy of Homestead Nursing Center to ensure that all needed outside appointments are made/kept for our residents. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	07/15/10	

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F 315	<p>Continued From page 2</p> <p>determined the facility failed to ensure one (1) of twenty four (24) sampled residents, Resident # 11, received appropriate treatment and services. Resident #11's indwelling urinary catheter was not changed, as ordered.</p> <p>The findings include:</p> <p>Review of Resident #11's clinical record revealed the resident was admitted on 11/10/03, with diagnoses which included Benign Prostatic Hypertrophy With Obstruction, which required an indwelling urinary catheter. Review of the Resident Assessment Narrative Report dated 1/13/10 revealed Resident # 11 had the urinary catheter changed monthly, by an outside Urology Department.</p> <p>Review of the Physician Orders for this resident revealed his/her indwelling urinary catheter was to be changed on a monthly basis by (an outside) Urology Department.</p> <p>Review of the Comprehensive Care Plan dated 1/13/10 revealed Resident #11 was to have a monthly appointment made and was to be transported to the Urology Department for the catheter change, with arrangements were to be made by nursing.</p> <p>Interview with the Urology Technician, on 06/09/10 at 2:45 PM revealed Resident #11 was not brought to the Urology Department for the catheter change during the months of January and February of 2010.</p> <p>Review of the nurses notes for Resident #11 for the months of January and February revealed no documented evidence the resident was transport</p>	F 315	<p>A. The catheter for Resident #11 was changed March 05, April 09, may 14, June 18, and is scheduled to be changed July 16. Transportation has been arranged for July 16.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>A. All residents with catheters had the potential to be affected by this same deficient practice.</p> <p>B. Residents with catheters were checked by Nursing Administration (i.e. DON, ADON, Nurse Supervisors, and QA Nurse) to ensure that catheters were changed per physician orders.</p> <p>C. Transportation calendars were checked for any missed appointments.</p> <p>D. No other issues were found.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>A. QA audit will be completed weekly by the QA nurse on all residents with catheters. The audit will include, but not limited to, change of catheter. Any issues will be handled immediately.</p> <p>B. The audit will be completed for the next 90 days. If facility is found to be in compliance, monitoring of catheter care will be the responsible of the QA Committee.</p> <p>C. Any nurse receiving an order for an outside appointment will write the new order, date and time of the appointment on the desk calendar, notify the resident/responsible party and Medical Records. Medical Records is responsible for scheduling transportation for outside appointments.</p>	

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F 315	<p>Continued From page 3 to or returning from the outside Urology Department for a catheter change.</p> <p>Review of the Treatment Administration Record (TAR) regarding catheter changes for this resident revealed the date of 01/12/10 was marked with an "x" and a notation next to this which said "changed at urology". There were no initials accompanying this notation. Review of the TAR for for this resident dated 02/01/10 revealed the same notation with an illegible initial under the "x". There was no initial or signature on the TAR legend corresponding to this entry.</p> <p>On 06/09/10 at 3:00 PM, interviews with Licensed Practical Nurses (LPN)'s #8, #6 and #10, who work on this resident's wing, revealed they did not recognize the initial or the handwriting on the January and February TAR.</p> <p>Interview with LPN #8 on 06/09/10 at 3:30 PM revealed it was the responsibility of the charge nurses of the wings to track resident appointments. Further interview with LPN #8 revealed she was the charge nurse on Resident #11's wing, but she was not employed in this position during the months of January and February 2010. Further interview with LPN #8 revealed the facility procedure to track resident appointments was to mark the date, time, and destination on the daily calendar at the nurses station.</p> <p>Review of this calendar revealed no notation of any appointments for the months of January and February 2010 for Resident #11.</p> <p>Interview with the Medical Support Assistant at the Urology Department on 06/09/10 at 3:00 PM</p>	F 315	<p>D. All resident's appointment will be placed on the 24-hour log. The 24- hour log will be reviewed each morning in the Clinical Stand-up. The Clinical Stand-up consists of, but is not limited to, the Administrator, ADON, Unit Managers, QA Nurse, Dietary, Social Service, and Medical Records.</p> <p>E. All admission/s or readmission/s charts will be reviewed daily (M-F) in the Clinical Stand-up meeting. Charts will be reviewed to ensure physician orders are being followed, including but not limited to, catheter care.</p> <p>F. Any issues will be handled immediately.</p> <p>G. Minutes from the Clinical Stand-up will be reported to the weekly SOC Committee.</p> <p>4. Indicated how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>A. Results of the QA audit will be submitted weekly in the Standard of Care Committee. The SOC consists, but is not limited to, the Administrator, DON, Nurse Supervisors, Charge Nurses, Social Services, and Dietary Manager.</p> <p>B. Minutes of the SOC Committee will be submitted to the monthly Quality Assurance Committee. The QA Committee consists, but is not limited to, the Administrator, Medical Director, DON, ADON, QA Nurse, Social Services, Activities, Dietary Manager and SDC and Maintenance Director.</p> <p>C. Corrective action (if applicable) will be the responsibility of the QA committee.</p> <p>5. July 15, 2010.</p>	
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F 315	<p>Continued From page 4</p> <p>revealed no record of a January or February appointment for Resident #11 at that office.</p> <p>On 6/10/10 at 10:20 AM, interview with LPN #9, the Nurse Supervisor on Resident # 11's wing, revealed the procedure for resident appointments involves the following: the 11:00 PM to 7:00 AM nurses check the calendar and compile a packet which contains a copy of the necessary contents of the residents' charts (i.e. Face Sheet, Medication Record, Consultation Sheet). The charge nurse on the wing is also responsible for getting this done if night shift is unable. The charge nurse signs the resident out to and back from the appointment in the nurses notes. The consultation sheet should be returned with a pertinent note, and the date and time of of any follow up appointment. Further interview with LPN #9 revealed if a consultation sheet is not returned with the resident, the charge nurse is responsible for calling that office and obtaining the next appointment, and documenting it on the nurses notes and the nurses station calendar.</p> <p>Interview with the Medical Records Coordinator on 6/9/10 at 3:50 PM revealed she was responsible for scheduling transport to appointments for the facility residents. Further interview with the coordinator revealed the charge nurse and Medical Records Coordinator complete designated sections of the Appointment Communication Form; when this form is received from nursing, the Medical Records Coordinator calls and documents the date, time, and transport agency. The Medical Records Coordinator notifies the residents' charge nurse, who notes this information on the nurses station calendar. Further interview with the Medical Records Coordinator revealed these Appointment</p>	F 315		

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F 315	<p>Continued From page 5</p> <p>Communication Forms are shredded when they are two (2) months old.</p> <p>On 6/10/10 at 10:50 AM interview with an employee at Resident #11's transport agency revealed the agency did not transport this resident to or from outside Urology Department on any date in January or February of 2010.</p>	F 315		

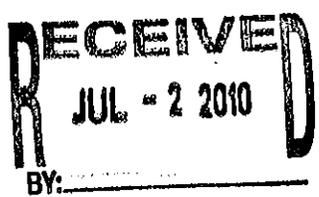
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 06/08/10 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an " F " NFPA 101 LIFE SAFETY CODE STANDARD	K 000		
K 046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure outside exits were illuminated with emergency lighting. The findings include: Observation on 06/08/10 at 12:20 PM, with the Maintenance Director, revealed all outside lighting (9 total) for the emergency exits were not on emergency power. Interview on 06/08/10 at 12:20 PM, with the Maintenance Director, revealed he was unaware if the outside lighting for the emergency exits were hooked to an emergency source of power. There was a total of nine emergency exits. Reference: NFPA 101 (2000 edition) 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.	K 046	 <p>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.</p> <p>K 046 It is the policy of Homestead Nursing Center to comply with all Life Safety Code Standards.</p> <ol style="list-style-type: none"> 1. All egress lighting will be loaded to our existing generator. 2. The generator is tested each week. The Maintenance Director will document the weekly test. 3. The egress lighting will be loaded no later that July 15, 2010. 	07/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vicki Trump</i>	TITLE Administrator	(X6) DATE 7/2/2010
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K 046	Continued From page 1 7.9 EMERGENCY LIGHTING 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way. 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. 7.9.2 Performance of System. 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1	K 046		

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K 046	<p>Continued From page 2</p> <p>lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.2.2*</p> <p>The emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following:</p> <p>(1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply</p> <p>(2) Opening of a circuit breaker or fuse</p> <p>(3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities</p> <p>7.9.2.3</p> <p>Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems.</p> <p>7.9.2.4*</p> <p>Battery-operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electrical Code®.</p> <p>7.9.2.5</p> <p>The emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual</p>	K 046		
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K 046	Continued From page 3 intervention. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure decorations used in the facility was noncombustible. The findings include: Observations on 06/08/10 at 11:55 AM revealed rooms number 209, #212, and #401, had several stuffed animals which did not contain	K 073	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. K 073 It is the policy of Homestead Nursing Center to comply with all Life Safety Code Standards.	07/15/10

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

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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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/08/2010
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	
K 073	<p>Continued From page 4 labels that stated the animals were flame retardant. The Maintenance Director confirmed the observation.</p> <p>Interview on 06/08/10 at 11:55 AM, with The Maintenance Director, revealed the facility did not treat stuffed animals to ensure they were flame retardant.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.</p>	K 073	<ol style="list-style-type: none"> 1. Stuffed animals will be fire retardant. 2. The facility has requested that any decorations such as "stuffed animals" be fire retardant. If not, the facility will spray such items with a fire retardant substance. 3. This will be accomplish no later that July 15, 2010. 		