

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

PRINTED: 05/06/2010
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 04/22/2010
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40060	
(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 A standard health survey was conducted on 04/20/10 through 04/22/10 and a Life Safety Code survey was completed on 04/28/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	Submission of this plan of correction does not constitute admission of agreement with conclusions set forth in the statement of deficiencies. However, in an effort to enhance the care furnished to our residents, we have augmented some of our existing policies and protocols. We acknowledge that federal and state regulations require a plan of correction, and we are therefore submitting this plan.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior on two (2) of three (3) hallways in the facility. Floor tiles located on the halls were worn, torn, and black areas were visible. The findings include: Observation of the East Hall on 04/22/10 at 1:00pm revealed the floor located by the beauty shop showed multiple areas of wear and tear with black showing through. The floor was uneven from these areas. Observation of the North Hall on 04/22/10 at 1:00pm revealed the floor located outside Room 124 was torn and worn away in multiple areas and black areas could be seen.	F 253	1. On 5-12-2010, the black marks were removed from the two (2) identified areas on the East and North halls. Marking tape was applied to the uneven areas on the floor to warn people of the uneven surface until a permanent patch is applied. The residue on the resident room doors will be removed and the doors will be resurfaced with a polyurethane finish to restore the doors. All handrails that were cited were repaired and stained. 2. An inspection of the building by the Maintenance Director revealed no other areas as identified in this deficiency. 3. A policy was written prohibiting the use of tape on the doors that leave residue. All staff was educated regarding this policy. Door, floor and handrail checks was added to the monthly preventive maintenance program to be conducted by the Director of Maintenance or designee. 4. The Director of Maintenance or designee will audit the building floors for uneven surfaces and will check finishes on handrails and doors. These audits will be conducted	

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

[Signature]

TITLE

[Signature] Administrator

(X6) DATE

05/25/10

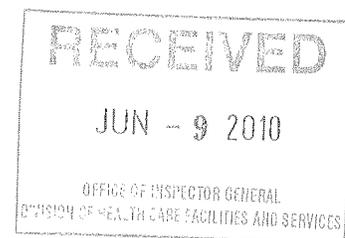
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

MP

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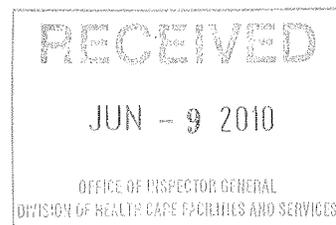
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F 253	Continued From page 1 Interview with the Maintenance Director on 04/22/10 at 1:30pm, revealed the flooring could not be replaced due to asbestos being present. He stated the floor could be patched and had been patched in the past. Observation of the North and South Hallways on 04/22/10 at 2:00pm, revealed the residents' room doors to the hallways and the bathroom doors were covered in tape residue. Some doors had more than fifty (50) visible residue strips, which caused the doors to have dull areas where tape was applied in the past. The rooms included: 101, 103, 104, 106, 106, 107, 108, 109, 110, 112, 113, 115, 116, 119, 120, 122, 123, 124, and 126. The doors also had scuffs and scratches. In addition, the handrails outside rooms 105, 106, 114, 115, and 116 were in disrepair and the finish was worn away. Interview with the Maintenance Director on 04/22/10 at 2:00pm, revealed he was aware the doors and handrails needed repair; however, those repairs had not been planned. He stated he thought the doors would have to be replaced.	F 253 cont.	weekly for one (1) month then biweekly for two (2) months; with monthly reports given to the Quality Assurance Committee. At the conclusion of this twelve (12) week audit, a determination by the QA committee, will be made for continuation. 5. The Maintenance Director is responsible for compliance.	6-6-2010
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	1. Residents #7 and #9 care plans were revised by 5-11-10 to include individualized aspiration precaution care plans. The "Butterfly Program" Policy and Procedure was reviewed and revised 5-10-2010 and Residents #9 and #10 care plans were revised by 5-14-2010 to include interdisciplinary interventions for comfort measures and participation in the "Butterfly Program".	



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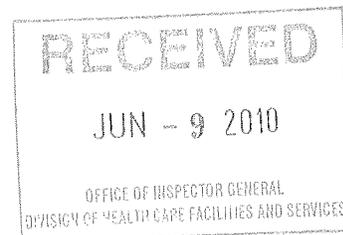
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F 279	<p>Continued From page 2</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to utilize the assessment to develop individualized care plans for five (5) of fourteen (14) sampled residents. Residents #7, #8, #9, and #13 had risks for aspiration and Residents #8, #9, #10 and #13 were placed on comfort measures only program called the "Butterfly Program" without a care plan being developed.</p> <p>The findings include:</p> <p>Review of the facility policy on care planning (the MDS Manual) revealed care plans should address individual needs.</p> <p>1. Review of the clinical record for Resident #7 revealed the resident was admitted with diagnoses of Aphasia, Dysphagia, and Alzheimer's with Behavior Disorder. The facility completed a quarterly Minimum Data Set (MDS) assessment on 02/14/10 which revealed the resident had a severe cognitive impairment in the ability to make daily care decisions and had behaviors which included anger, anxiety, and restlessness. The resident required extensive</p>	F 279 cont.	<p>Residents #8 and #13 are now deceased.</p> <p>2. All resident charts will be audited by 5-14-2010 to identify residents with a risk for aspiration. Identified residents with risk of aspiration will have a Risk of Aspiration care plan that will include aspiration precautions.</p> <p>No other residents except the ones listed in the Statement of Deficiencies have a consent form signed by the family for the "Butterfly Program". Therefore, no other residents, at this time, are affected by the deficient practice.</p> <p>3. Policy and Procedures for identifying and care planning residents with risks for aspiration that require aspiration precautions was developed and implemented. All residents at risk for aspiration as determined on admission by a diagnosis of a swallowing problem, resident on thickened liquids, or determined to be at risk by a Speech Therapist will have a Risk for Aspiration care plan to include aspiration precautions as noted by the admitting nurse on the initial/ immediate needs care plan and certified nursing assistant care plan and followed up on the comprehensive plan of care by the MDS Coordinator by the 14th day after admission. The certified nursing assistant care plan will note "Aspiration Precautions". All nursing staff will be inserviced on the policy and procedural change by 5-14-2010.</p>	



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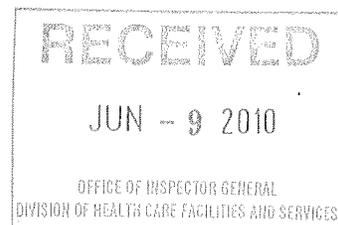
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F 279	<p>Continued From page 3</p> <p>assistance with bed mobility and transfers, and had to be totally fed by staff. The resident's intake of food orally was not sufficient to meet the nutritional requirements and was supplemented with a tube feeding. The resident was assessed by the dietitian to require thickened liquids and a pureed diet to compensate for the resident's difficulty swallowing.</p> <p>Review of Resident #7's care plan revealed no evidence the facility developed a care plan with interventions to prevent aspiration related to dysphagia.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 04/21/10 at 4:30pm, revealed Resident #7's head should be elevated slightly and had no further information on interventions to prevent aspiration of foods. She stated the resident did cough at meal time infrequently.</p> <p>Interview with the MDS Coordinator on 04/22/10 at 9:25am, revealed she did not develop a care plan to address prevention of aspiration of food taken orally or by gastric tube. She stated the care plan should include interventions to prevent aspiration as the resident was at risk.</p> <p>Review of the facility policy entitled "Butterfly", undated, revealed the purpose of the program was to provide comfort through palliative care and individualized attention for those residents who are at or near the end of their life as identified by the facility staff. There are three distinct stages to this program and the progression through the stages is determined by the completion of each stage. Each stage has interventions to be provided to the resident.</p>	F 279 cont.	<p>On 5-10-2010, the "Butterfly Program" policy and procedure was reviewed and revised to include on-going documentation guidelines for spiritual and emotional needs of the family and/or resident to be completed by the Social Services Director. A care plan will be initiated with advancement in stages of the "Butterfly Program". The care plans will address the individualized needs of each resident based on their stage in the program. Inservicing on the policy and procedure revisions for all staff will be completed 5-28-2010.</p> <p>The MDS Coordinator will use copies of all orders to update comprehensive and certified nursing assistant care plans to reflect individualized precautions during the morning nursing meetings.</p> <p>4. The Quality Assurance Coordinator or designee will audit the resident care plans for aspiration precautions and participation in the "Butterfly Program". A 25 % sample of all resident care plans will be audited monthly for four (4) months and these audits will be reported monthly to the Quality Assurance Committee. After four (4) months the committee will determine the need for further action and/or continuation of audit.</p> <p>5. The Director of Nursing is responsible for compliance.</p>	6-6-2010



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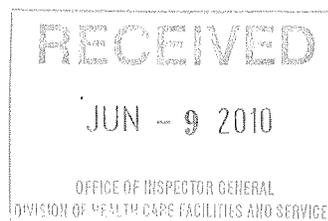
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F 279	<p>Continued From page 4</p> <p>2. Review of the clinical record for Resident #8 revealed the resident was admitted with diagnoses of Cancer of the Bone and Anemia. The facility completed an annual MDS assessment on 02/01/10 which revealed the resident was alert and oriented with a cognitive impairment in daily decision making in new situations only. The resident was able to communicate effectively.</p> <p>Review of the dietary notes from 03/08/10 revealed the resident did have a chewing and swallowing problem and a pureed diet with nectar thick liquids had been recommended by the Dietician and ordered by the physician. Review of the Speech Therapist notes from 02/26/10 revealed the family requested regular food and liquids for the resident and did not wish any further speech therapy. The resident had refused to follow the physician's orders and would only eat regular food and drink thin liquids. On 03/26/10, the resident was determined, by staff, to need a comfort only program provided by the facility entitled "Butterfly". Review of the care plan revealed the facility did not develop interventions to address the resident's end of life medical, social, and emotional needs or prevention of aspiration.</p> <p>3. Review of the clinical record for Resident #13 revealed the resident was admitted with diagnoses of Dysphagia, Adenocarcinoma of the Liver, Malnutrition, and Multiple Decubiti. The facility completed an admission MDS assessment on 01/26/10 which revealed the resident had a moderate cognitive impairment in daily decision making skills and had insomnia. The resident was a total transfer and required extensive assistance from staff to bathe, dress, and turn in</p>	F 279		



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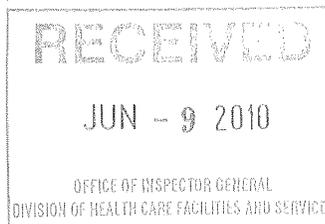
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F 279	<p>Continued From page 5</p> <p>bed. Nursing notes from 01/20/10 revealed the resident was alert and oriented. Speech therapy notes from 01/26/10 revealed the resident completed treatment for moderate oropharyngeal dysphagia and was to be rescreened if problems arose. The resident was to receive thin liquids. There was no evidence to show the facility developed a care plan to monitor the resident for signs and symptoms of aspiration.</p> <p>Review of the nursing notes from 02/11/10 revealed Resident #13 had experienced a decline and the staff made the decision to place the resident in the "Butterfly" program. Review of the care plan revealed the facility did not develop a care plan to address the residents' end of life medical, emotional, or social needs.</p> <p>Interview with the Social Services Director on 04/22/10 at 9:30am, revealed she had received no training on completion of the MDS or developing a care plan for resident specific needs. She stated she was not sure what her job entailed concerning providing end of life care to residents on the Butterfly program.</p> <p>Interview with the MDS Coordinator on 04/22/10 at 9:25am, revealed the interventions for the end of life program were not added to the care plan.</p> <p>Interview with the Director of Nursing on 04/22/10 at 9:00am revealed there were specific stages to the end of life program and a care plan should have been developed to meet each resident's specific needs.</p> <p>4. Review of the clinical record for Resident #9 revealed the resident was admitted with diagnoses of Chronic Obstructive Pulmonary</p>	F 279		



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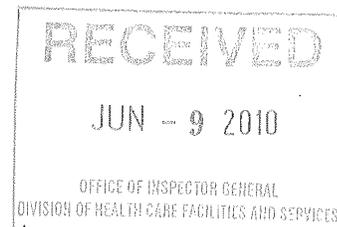
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F 279	<p>Continued From page 6</p> <p>Disease, Lung Cancer and Dysphagia. The Minimum Data Set (MDS) assessment on 02/08/10 revealed the resident had a severe cognitive impairment in the ability to make daily care decisions and record review of Resident #9's diet revealed an order for a mechanical soft diet, with nectar thick liquids. Record Review also revealed that Hospice was discontinued on 02/12/10 and the Butterfly Program was started on the same day.</p> <p>Observation of lunch on 04/21/10 at 12:15pm of Resident #9 revealed another Resident offering Resident #9 thin liquids. Resident #9 took a drink of the thin liquids and started coughing uncontrollably and staff assisted the resident back to their room. Observation on 4/22/10 at 8:27am revealed Resident #9 lying flat in bed, with a pitcher of thin liquids at the bedside. Resident # 9 was observed taking a drink from the pitcher while lying flat in bed and coughing shortly thereafter.</p> <p>Interview on 04/21/10 at 12:00pm with a Licensed Practical Nurse (LPN) revealed Resident #9 refused to drink nectar thick liquids and preferred to drink thin liquids.</p> <p>Review of Resident #9's care plan revealed the facility did not develop a care plan with interventions to prevent aspiration though the resident refused to drink thickened liquids. The care plan only addressed observing the resident for signs and symptoms of aspiration and did not include any interventions to prevent the aspiration.</p> <p>Interview on 04/22/10 at 9:30am with Minimum Data Set (MDS) Coordinator revealed that</p>	F 279		



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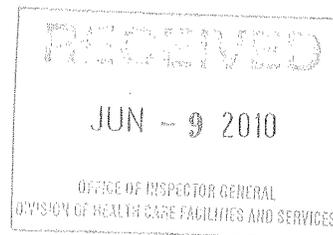
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F 279	<p>Continued From page 7</p> <p>Interventions should be put into place to prevent aspiration.</p> <p>Interview on 04/22/10 at 9:00am with the Director of Nursing (DON) revealed the Butterfly Program is a program to support family and residents through the resident's dying process. She stated there were three stages of the Butterfly Program, the Caterpillar, Cocoon and Butterfly. Each stage represented the transitions of the dying process. The DON stated Social Services staff were responsible for developing specific care plan interventions based on assessment when a resident was placed on the Butterfly Program.</p> <p>Interview on 04/22/10 9:30am with the Social Services staff revealed that her primary job was to assess residents on their feelings and behaviors. She was unable to provide evidence a care plan was developed to address the resident's and family's needs.</p> <p>5. Review of the clinical record for Resident #10 on 04/21/10 revealed the resident was admitted to the facility with diagnoses of Hypothyroidism, Failure to Thrive, Macular Degeneration, Dementia with Psychotic Features, and Edema to the Lower Extremities.</p> <p>Continued review of the resident's clinical record revealed the resident was terminal and was placed on the Butterfly Program on 11/20/09. Review of the MDS assessment dated 02/08/10 revealed the resident was noted to have a severe cognitive deficit, and was experiencing a physical decline.</p> <p>Interview with the MDS Coordinator on 04/22/10 at 9:00am revealed that an individualized care</p>	F 279			



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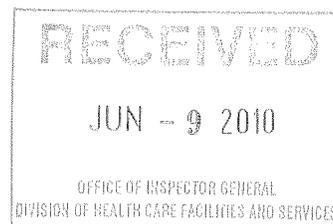
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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to revise one of fourteen (14) sampled residents (Resident #11) care plan for a weight loss	F 280	1. The dietary care plan of resident #11 was reviewed and revised on 4-22-2010, by the MDS Coordinator to reflect interventions aimed at the goal set by the Dietician of 1-2 pound weight loss per month. 2. An audit to ensure goals match the interventions on all dietary care plans was completed by the MDS Coordinator on 4-22-2010. No further residents were affected by the deficient practice. 3. A policy was developed outlining responsibilities for completing the dietary care plan and reviewed with the dietician and MDS Coordinator on 5-12-2010. The Dietician will be responsible for setting the goal for the resident's dietary care plan in accordance with the MDS schedule. The MDS Coordinator will then update and/or develop an individualized care plan for that resident based on the set goal. 4. The Quality Assurance Coordinator or designee will audit dietary care plans for goals and interventions that meet the individual needs of the resident as determined	



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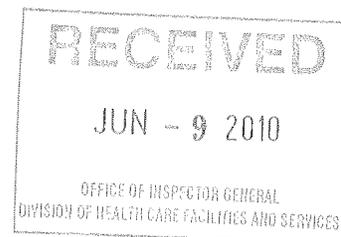
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40050	
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F 280	<p>Continued From page 9 program.</p> <p>The findings include:</p> <p>Record Review of Resident #11's record revealed the resident had diagnoses of Immobility, Dementia, and Obesity. Record review of the resident's weight revealed the resident had a twenty (20) pound weight gain between the months of January and December of 2009. Starting weight as of January 2009 was 199 with a weight of 223 pounds as of March 2010. Care Plan as of 03/18/10 revealed Resident #11 to start a slow slight weight loss of 1-2 pounds a month. The Care Plan approach was offering appealing meals, offer house snacks per menu or per resident request, encourage family to bring snacks from home and provide nutritional supplements as ordered.</p> <p>Interview on 04/22/10 at 9:50am with Minimum Data Set (MDS) Coordinator revealed the Dietician is responsible for doing her own care plans. The Dietician gives the MDS Coordinator the assessments, notes and assessment summaries and the MDS Coordinator puts them into the computer.</p> <p>Interview on 04/22/10 at 2:25pm with Director of Nursing (DON) revealed that Dietician updates and changes goals of the care plan and the MDS Coordinator inputs the information in the computer.</p> <p>Interview on 04/22/10 at 1:55pm with Dietician revealed that she was not capable of putting in the approaches because of a four-hour work schedule per week. Dietary Services was to update Nutritional Care Plans. The Dietician</p>	F 280 cont.	<p>by the dietician. A 25% sample of all resident care plans will be audited monthly for four (4) months and will be reported monthly to the Quality Assurance Committee. After four (4) months the committee will determine the need for further action and/or continuation of audit.</p> <p>5. The Director of Nursing is responsible for compliance.</p>	6-6-2010



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F 280	Continued From page 10	F 280		
F 363 SS=E	<p>stated that she would not introduce extra snacks to Resident #11's nutritional needs.</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet the nutritional needs of Resident #11 in accordance with the recommended dietary allowances as planned by the facility's Registered Dietician for one (1) of fourteen (14) sampled residents. (Resident #11)</p> <p>The findings include:</p> <p>Review of the Portion Control In-service Manual, undated, revealed a correct portion size is served to meet the nutritional needs of the resident, that the Federal and State regulations specify food groups and portion sizes that must be served, and that scales are necessary to weigh portions.</p> <p>Record review of Resident #11 on 04/22/10 at 9:30am revealed an admission date of 03/21/09 with diagnoses of Hypertension, Coronary Artery Disease, a history of Intracranial Hemorrhage, a history of Left Wrist Fracture, Dementia, Left Intertrochanteric Femur Fracture, Immobility Syndrome, Muscle Disorder, Depression and Neuropathy.</p>	F 363	<ol style="list-style-type: none"> 1. Resident #11 nutritional status was assessed by the dietician and there was no adverse affects noted. Subsequently, proper food portions were served in accordance with the recommended dietary allowances as planned by the registered Dietician. 2. A nutritional status review of all residents was conducted and there was no evidence of any adverse affects due to improper serving portions. 3. The facility's policy on food portion control was reviewed and found to be in compliance with the recommended dietary allowances of the Food and Nutrition Board. Cook #1 was disciplined and re-educated on proper portion controls, serving scoops and food scales. The Dietary Manager and Assistant Manager were reeducated as to proper supervision to ensure serving of proper portions. All staff received mandatory reeducation from the Registered Dietician and/or Administrator on proper serving portions, controls, therapeutic menus, food scales, portion control devices, and the importance of maintaining resident nutrition. A temporary dietary manager consultant was hired to assist in educating and training dietary staff and to assess and recommend improvements in 	



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F 363	Continued From page 11 Observation of the noon meal in the dining room on 04/21/10 at 12:15pm revealed portions of corned beef being served to residents appeared small. Resident #11's serving size of corned beef was found to be only 1.5 ounces instead of the 3 ounces prescribed on the regular diet therapeutic menu. The therapeutic menu was noted to be posted over the serving line and legible. Interview with Cook #1 on 04/22/10 at 12:50pm revealed she never weighed or measured any meat portions in the past, nor had she ever been instructed to do so. She stated that protein is very important because it helped the residents stay strong. She stated she guessed at the meat portion sizes. Interview with the Registered Dietician on 04/21/10 at 12:15pm revealed the resident should have been served three (3) ounces of meat. Review of the resident's chart on 04/22/10 at 9:00am revealed the resident had a physician's order for a Regular Diet. Interview with the Dietary Manager on 04/22/10 at 10:36am revealed that the residents needed portioned foods according to their recommended and prescribed diet. She stated that apparently the cook did not utilize the food scales to portion the food out, like she should have done. She continued to state that she had not observed the use of any meat portioning/use of food scales since she had worked at the facility. She stated that it was ultimately her responsibility to see that the cooks weigh out the food portions prior to serving the residents.	F 363	dietary systems. 4. An audit was designed to ensure the dietary staff serves proper food portions. The quality assurance audits will be conducted for each meal daily for four (4) weeks, then five (5) days a week for four (4) weeks and then biweekly for four (4) weeks. These audits will be reported monthly to the Quality Assurance Committee and at the conclusion of the twelve (12) week audit will determine further action and need for continuation. 5. The Dietary Manager is responsible for compliance.	6-6-2010



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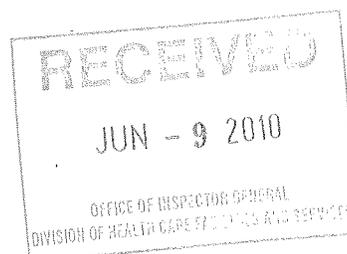
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F 363	Continued From page 12 Interview with the Assistant Dietary Manager on 04/22/10 at 1:15pm revealed that each resident should receive their prescribed diet and portions as ordered. She continued to state that food is measured out or weighed sometimes, but not consistently. This is part of her responsibility as the Assistant Manager.	F 363		
F 368 SS=E	483.36(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide resident meals at regular times for five (5) of fourteen (14) sampled residents (#9, #15, #16, #17, and #18). Residents were observed to spend long periods of time in the dining room waiting for meals. The findings include:	F 368	1. Resident #9 does not usually eat in the dining room as he is receiving end of life care and his deterioration is expected. Resident #15, #16, #17 and #18 are not on the resident roster form provided to us as there were only fourteen (14) names listed on the roster. Immediate action was taken by the dietary department to ensure meals are served timely and at regular times. 2. All residents were reviewed on 4-22-10, by nursing, and none were noted to have any physical deterioration due to sitting in the dining room while waiting for their meal. 3. A review of meal service in the dining room was completed. Policies and procedures were reviewed and revised where necessary by the Dietician and Dietary Manager to ensure residents were served at regular times and without waiting for unreasonable periods of time. The dietary staff received mandatory education on methods to improve speed in preparing and delivering meals and on reducing interruptions in the delivery system. Nursing staff were reeducated on when to bring residents to the dining room so as to minimize resident wait time. A	



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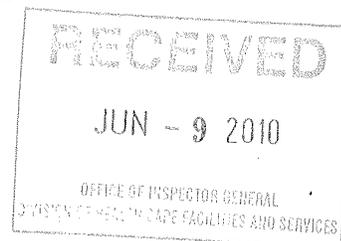
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F 368	<p>Continued From page 13</p> <p>The facility did not have a policy regarding meal services.</p> <p>The Group Interview held on 04/21/10 at 10:00am and attended by the Ombudsman revealed five (5) of six (6) residents, #9, #15, #16, #17, and #18, present felt they had to sit too long in the dining room while waiting for the meals to be served. They stated the Certified Nurse Aides assist them to the dining room and get everyone in their place so that trays can be served. They stated the dietary staff was too slow and then in the middle of serving the dining room, everything stopped while trays were prepared and sent to the unit for residents not eating in the dining room. They stated they waited as long as two (2) hours for the entire dining room to be served.</p> <p>Observation of the lunch meal on 04/21/10 at 11:00am, revealed most of the residents were brought to the dining room by the staff at 11:00am. The trays started coming from dietary at 11:30am and by 12:00pm, only half of the thirty (30) residents had received a tray. The dining room service stopped at 12:00pm and trays were prepared and sent to the unit. At 12:10pm, the dining room tray service was restarted. There were twelve (12) residents sitting with bowed heads and closed eyes awaiting their meal. Tray service was completed at 1:00pm</p> <p>Observation of the lunch meal on 04/22/10 at 11:00am, revealed thirty-two (32) residents in the dining room. The tray pass started at 11:30am and was not completed until 1:00pm. Observation revealed staff in the kitchen left the area to get food items, new utensils, and other items and the tray service was interrupted</p>	F 368 cont.	<p>temporary dietary manager consultant was hired to assist in educating and training dietary staff and to assess and recommend improvements in dietary systems.</p> <p>4. An audit was designed to ensure resident meals are served promptly thereby reducing resident wait time. This audit will be conducted daily for four (4) weeks for each meals, then three (3) times a week for eight (8) weeks. This audit will be reported monthly to the Quality Assurance Committee. At the conclusion of the twelve (12) week audit the committee will determine further action and need for continuation.</p> <p>5. The Dietary Manager is responsible for compliance.</p>	6-6-2010



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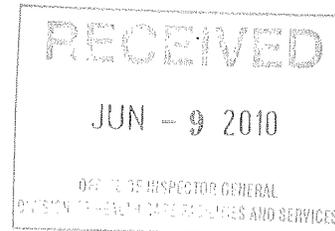
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F 368	Continued From page 14 frequently. Interview with Resident #8 on 04/22/10 at 12:00pm, revealed he/she was among the residents that were served earlier during the meal service. The resident stated he/she would finish the meal and leave the dining room before other residents were served. The resident stated many residents slept during the wait for their meal and the meal service was very slow. Interview with CNA #1 and #2 on 04/21/10 at 1:00pm, revealed meal trays were slow to come from the dietary department for service to residents on a frequent basis. They stated there was adequate staff to pass the trays and staff had to stand and wait for dietary. Interview with the Dietary Manager on 04/21/10 at 1:00pm, revealed she only had her position for two weeks and had not noticed the meal service for the fifty-six (56) residents was slow. Interview with the Director of Nursing on 04/22/10 at 2:00pm revealed she was aware the meal service was slow; however, she had no control over dietary.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. No resident was identified as being affected by the cited deficiency. 2. No other residents were notably affected by the cited deficiency. 3. On the evening of 4-20-10, the facility's Infection Control Nurse/DON met with dietary staff to immediately address and educate staff on proper thawing procedures as outlined in facility policy. On 4-26-10, a review	



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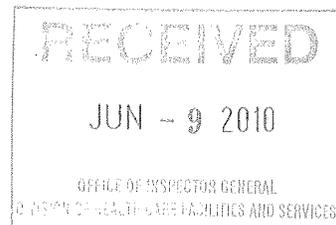
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F 371	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to store, prepare, and distribute food under sanitary conditions. Frozen chicken was observed in a large metal pan soaking in standing water. Milk temperatures were not obtained prior to the milk being served to the residents. Observation of the freezer revealed frozen meat and biscuits that had been opened and the facility failed to date the opened items. The refrigerators contained opened and unlabeled milk, cheese sandwiches, cake, sweet rolls and buns that were not labeled, limed, or dated. The facility failed to ensure sanitary conditions as evidenced by a vendor, with a full beard, being in the kitchen food prep area without a hair restraint and a dietary employee was noted wearing a hair net that did not cover the front of her hair. The facility failed to ensure hand washing was completed by staff correctly. Two (2) dietary employees were observed incorrectly washing their hands. No documentation of freezer/refrigerator temperatures had been completed from April 14th through April 20th, 2010. The facility failed to sanitize a food thermometer between each food item tested. The facility sanitized the thermometers used to test food temperatures with a solution of a chemical which was not tested for potency prior to the thermometer being used in the food. In addition, the facility failed to properly mix and test sanitizing solutions for the proper strength. The findings include:	F 371 cont	and revision of dietary policies and procedures was initiated and completed on 4-28-10 by the dietician and dietary manager to ensure compliance with regulations to store, prepare, distribute and serve food under sanitary conditions. DA #1 was disciplined for failing to follow thawing procedures and was reeducated on these procedures. The dietary manager and assistant manager were reeducated as to their responsibilities to be knowledgeable and to enforce proper sanitation procedures. All dietary staff received mandatory educational programs on policies for Food Preparation Cooking & Holding Delivery, Sanitation and Safety and Purchasing Receiving Storage. These policy review programs commenced on 4-29-10 and are scheduled thru 6-1-10 with post tests given to ensure competencies. Starting on 4-29-10, outside consultant dietary managers are being deployed to work with our dietary managers on a periodic basis. 4. To ensure compliance, the Dietary Manager or designee will conduct audits on proper thawing of foods; food temperature monitoring on the tray line to ensure proper temperatures; Refrigerator/Freezer monitoring for appropriate food covering, labeling, time and dating; proper hair and beard coverings of anyone in the kitchen; proper hand washing; documentation of refrigerator and freezer temperatures; and testing sanitizing solution for proper strength. Each of these audits will be conducted daily for thirty (30)	



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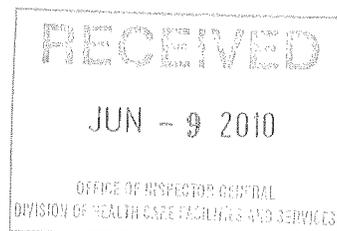
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F 371	<p>Continued From page 16</p> <p>1. Review of the facility's policy titled Thawing Methods dated "04/20/10" revealed foods not completely thawed by production time may be thawed by completely submerging the item under cold running water that is running fast enough to agitate and float off loose ice particles. Food will not be thawed at room temperature, in standing warm water, or in ovens due to increased risk of bacterial contamination.</p> <p>Observation of the kitchen on 04/20/10 at 9:15am revealed a large metal container filled with water and multiple pieces of partially thawed chicken.</p> <p>Interview with Dietary Assistant (DA) #1 on 04/20/10 at 9:30am and 11:00am revealed that she usually sets frozen meats in cold water with a little bit of salt for no more than ninety (90) minutes to thaw. She stated she was told to defrost frozen meats in cold water and to change the water every 30 (minutes). She was unsure about the chicken's temperature or the water temperature the chicken had been submerged. The DA revealed she was instructed by her previous supervisor to defrost meats in water and to change the water every fifteen (15) minutes, making sure the water does not get warm. She stated she had never seen an actual policy on thawing meats and that she went from a job in the activities department straight into a job in the kitchen, whereas she relied on the other kitchen workers to show her what to do. She stated she had never received any training on Infection Control that she could remember. She stated the chicken had been in the cold water for approximately forty-five (45) minutes and she had not checked the temperature of the water. She stated she had changed the water once during that time period. She stated she thought the</p>	F 371	<p>days then twice (2) a week for sixty (60) days. These audits will be reported monthly to the quality assurance committee and at the conclusion of ninety (90) days the committee will determine further action and need for continuation.</p> <p>5. The Dietary Manager is responsible for compliance.</p>	6-6-2010



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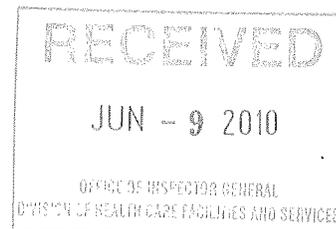
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F 371	<p>Continued From page 17 chicken would be fine thawing in the cold water.</p> <p>Observation of the kitchen on 04/20/10 at 9:45am revealed the chicken had already been placed in the oven in preparation for the lunch meal. The chicken was removed from the oven and discarded by dietary staff.</p> <p>Interview with the Dietary Manager on 04/20/10 at 9:30am revealed she was not sure how to defrost meats other than putting them into the refrigerator overnight. She stated she was unsure what the facility policy on defrosting frozen meat, including chicken was. She stated she did not really know there was anything wrong with how the chicken had been thawed until she was questioned about the chicken. She stated she knew now that the chicken should have been thawed under cold running water to avoid bacteria growth. She stated she had not been trained as a food service manager but had worked at another facility in the kitchen.</p> <p>Interview with the Assltant Dietary Manager on 04/20/10 at 10:15am revealed that frozen foods are usually put into the sink with water dripping on it. She stated when chicken was defrosted; we do not use running water. It all depends on which meat it is on how it is defrosted.</p> <p>Review of the facility training records revealed DA #1 had attended a facility in-service on 01/15/10 at 1:30pm entitled Food Temperature/Safe Food Handling Practices: Food Temperatures. Review of the in-service handout revealed Temperature Control-Thawing was addressed during the training. POTENTIALLY HAZARDOUS FOOD shall be thawed: At a water temperature of 21 (twenty-one) degrees Celsius or below and with</p>	F 371			



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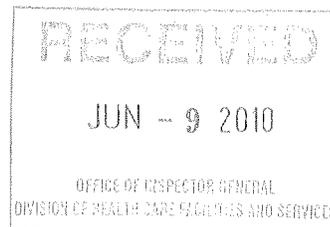
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F 371	<p>Continued From page 18</p> <p>sufficient water velocity to agitate and float off loose particle in overflow.</p> <p>2. Review of the facility's Food Storage Policy, undated, revealed all stock is rotated with each new delivery to insure freshness, and leftover food is stored in covered containers or wrapped carefully and securely, clearly labeled and dated before being refrigerated. Leftover food is used within 48 hours.</p> <p>Observation of the facility's kitchen on 04/20/10 at 9:15am revealed multiple previously opened food items stored in the freezer and refrigerators that were not labeled with a date or time. In the freezer, one (1) bag of frozen Chicken Kiev, and one (1) bag of frozen biscuits were noted. In the refrigerators, one carton of milk, four (4) dishes of cake, and one bag of hamburger buns had all been previously opened and noted not to contain labels, dates and times. On 04/21/10 at 10:00am, one (1) opened bag of sweet rolls was observed in the refrigerator without a cover, label, date or time.</p> <p>Interview with DA #2 on 04/21/10 at 10:00am revealed that food items should be covered, dated and timed when opened so that it does not become contaminated with bacteria. She stated she was rushed this morning, so she did not cover or date the sweet rolls prior to placing them into the refrigerator.</p> <p>Interview with DA #1 on 04/22/10 at 12:50pm revealed all open foods should be taped shut with plastic wrap. Foods are dated and timed when stored because food could go bad, and make someone sick.</p>	F 371			



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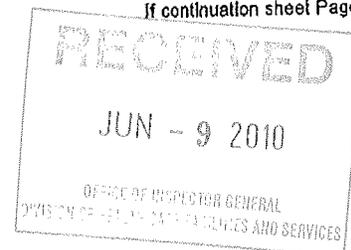
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2010
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40050	
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F 371	<p>Continued From page 19</p> <p>Interview on 04/22/10 at 1:15pm with the Assistant Dietary Manager (ADM) revealed that opened foods should be sealed and dated prior to placing in the freezer or refrigerators. She stated this was done so the facility staff would know how old the food was and so that outdated foods were not served to residents. Serving outdated food could possibly cause an illness or a resident to become poisoned. She stated it was everyone's responsibility to rotate and/or date opened frozen or refrigerated foods. She stated the facility did not track outdated foods, labeling of foods, or food rotation.</p> <p>Interview on 04/22/10 at 10:35am with the Dietary Manager (DM) revealed that all open food packages should be dated and labeled prior to placing into the freezer or the refrigerator. She stated food packages that had been opened could grow/contain bacteria that could make people very sick and possibly kill them. She stated placing foods back into refrigeration without labeling and dating was a bad practice.</p> <p>3. Review of the facility's Food Temperature policy, undated, revealed cold food should be at forty-five (45) degrees during preparation and service. Tray line food temperatures are checked and recorded before each meal.</p> <p>Observation on 04/21/10 at 11:00am revealed DA #2 placing individual cartons of milk into a large pan filled with ice to serve to the Residents with their noon meal. There was no observation of milk temperatures being obtained or recorded.</p> <p>Interview with DA# 2 on 04/21/10 at 11:00am revealed that she was unaware that the milk temperatures needed to be monitored. She</p>	F 371		



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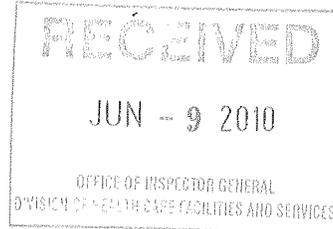
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F 371	<p>Continued From page 20</p> <p>revealed the residents should not be served foods or milk outside of safe temperatures because it can spoil, and cause the residents to become ill. She stated she had received training on monitoring food temperatures.</p> <p>Interview with the DM on 04/22/10 at 10:35am revealed that she was unaware of the facility's policy on monitoring the milk temperatures. She stated that she was unaware that milk temperatures needed to be monitored once removed from the refrigerator. She stated it was her responsibility to see to it that all food temperatures were monitored and logged.</p> <p>Interview with DA #1 on 04/22/10 at 12:50pm revealed that milk had to stay cold, at least forty one (41) degrees or less, or it could grow bacteria, and make the residents sick.</p> <p>Interview on 04/22/10 at 1:15pm with the ADM revealed that for every meal, every food temperature should be monitored, but this was not consistently done by the kitchen staff. She stated that she had received education on monitoring food temperatures in the past year.</p> <p>4. The facility did not provide a policy for hairnets even though requested by surveyors.</p> <p>Observation on 04/20/10 at 10:30am revealed a vendor in the kitchen food preparation area with a full mustache and beard, uncovered.</p> <p>Observation on 04/21/10 at 10:00am revealed one (1) employee with the front of her hair uncovered.</p> <p>Interview on 04/22/10 at 10:36am with the DM</p>	F 371		



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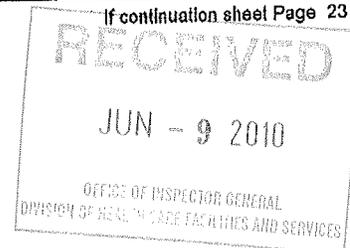
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F 371	<p>Continued From page 21</p> <p>revealed that beards and hair should always be covered to prevent hair from getting into the residents' food. She stated that it was her responsibility to assure all staff and vendors wear the appropriate hair restraints when in the kitchen area. She stated this particular vendor had not been the only one in the kitchen food preparation area without the proper hair restraint in place.</p> <p>Interview on 04/21/10 at 1:00pm with DA #2 revealed hair is to be kept in a hair net so that it does not get into the residents' food.</p> <p>5. Review of the facility's Hand Washing Policy, undated, revealed staff were to use a disposable hand towel to dry their hands after completing handwashing, then use a disposable hand towel to turn off the water faucet.</p> <p>Observation on 04/21/10 at 11:00am revealed two (2) employees incorrectly performed hand washing. Both employees were observed to use their bare hands to turn off the water after washing their hands and before drying them.</p> <p>Interview with DA #2 on 04/22/10 at 1:00pm revealed that she knew better than to turn off the water using her bare hands after she washed her hands. She was aware this practice could cause cross-contamination.</p> <p>Interview with the Dietary Manager on 04/22/10 at 10:35am revealed that touching the water faucet knob with bare hands after completing hand washing was incorrect because of infection control issues.</p> <p>Interview with DA #1 on 04/22/10 at 12:50pm revealed that she knew to rinse her hands, and</p>	F 371		



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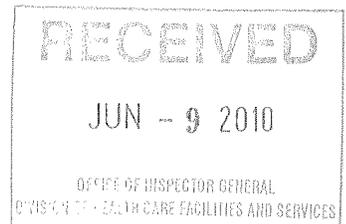
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F 371	<p>Continued From page 22</p> <p>then use a paper towel to turn the water off. She stated she knew better than to turn the water off with her bare hands and is not sure why she did it.</p> <p>6. Review of the facility's policy on Refrigerator/Freezer Temperatures dated 07/28/05, revealed temperatures were monitored daily and variations were reported to the DM. The temperature in the refrigerators was to be below forty (40) degrees and the freezer temperatures were to be maintained below zero (0) degrees.</p> <p>Review of the temperature logs from April 14th through April 20th, 2010 revealed temperatures were not recorded.</p> <p>Interview on 04/21/10 at 10:15am with the Dietary Manager revealed that the ADM was responsible to make sure the temperature log was maintained. She continued to state that it was the Dietary Manager's ultimate responsibility to assure all the refrigerator and freezer temperatures were checked and logged daily.</p> <p>Interview on 04/22/10 at 1:15pm with the ADM revealed that foods needed to be refrigerated/frozen at safe temperatures. She stated the refrigerator and freezer temperatures had not been monitored because she had been busy, and forgot to do it and checking the temperatures of the refrigerators and freezers daily was her responsibility. She stated there was no alternate plan in place for other employees to monitor the temperatures when she was busy or off work.</p> <p>7. Review of the facility's Food Temperatures Policy dated 07/28/05 stated the thermometer</p>	F 371			



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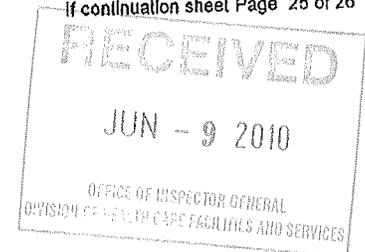
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F 371	<p>Continued From page 23</p> <p>must be cleaned and sanitized between each product that is tested using an appropriate sanitizer (100ppm (parts per million) bleach solution or 25 ppm iodine solution). The use of individual foil wrapped alcohol pads is acceptable for sanitizing probes; however, allow time for the alcohol to evaporate before inserting the probe into the food.</p> <p>Observation on 04/21/10 at 11:00am revealed DA #1 checked the temperature of a baked potato then checked the temperature of mashed potatoes on the tray line using the same food thermometer. No sanitation of the food thermometer was observed. She was then observed to pick up a rag from the hand sink in the dishwashing room and wipe the thermometer off then use the thermometer to check the temperature of the gravy.</p> <p>Interview with DA #1 on 04/22/10 at 12:50pm revealed that she had been trained in the past to clean the thermometer between testing each food item. She stated it was important to sanitize the thermometer between each use because it keeps potentially harmful bacteria from being spread from food to food.</p> <p>Interview with the Grill Cook, DA #1, and the Dietary Manager on 04/22/10 revealed that a disinfectant/sanitizer (Saniquat) had been applied to the rag to sanitize the food thermometers between each use. They were unable to state the solution strength that had been applied to the rag prior to use on the food thermometers.</p> <p>Review of the Saniquat Description published by National Chemical Laboratories, INC TDS-0126-0506 stated to sanitize immobile items</p>	F 371			



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F 371	<p>Continued From page 24</p> <p>Immerse in a two-hundred (200) ppm active quaternary solution for at least sixty (60) seconds making sure to immerse completely. Remove and let air dry. There was a precautionary statement- Causes severe eye and skin damage. Do not get in eyes, skin. Wear rubber gloves when handling.</p> <p>Interview with DA #1 on 04/21/10 at 12:30pm revealed that she referred to instructions written on the kitchen wall to mix the Saniquat. She stated the Saniquat needed to be diluted with water prior to use. She stated she did not know the chemical solution created when water was added needed to be tested using approved test strips to check the potency of the chemical solution.</p> <p>Interview on 04/22/10 at 10:35am with the Dietary Manager revealed the Saniquat should have been put in a pan, and diluted with the proper amount of water per manufacturer's instruction. She stated using a rag with an unknown amount/dilution of Saniquat sanitizer was not the correct way to sanitize the food thermometers between each use. She stated the solution was not tested with chemical test strips to ensure proper strength.</p> <p>Interview on 04/22/10 at 1:15pm with the Assistant Dietary Manager revealed that the food thermometers should be sanitized between each use using the Saniquat disinfectant diluted in water; however, a rag lying on a sink should not have been used to sanitize the food thermometers. She stated the test strips are not usually used, and she was unaware of where the test strips were located. She stated the test strips need to be utilized to determine if the chemical</p>	F 371		



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F 371	Continued From page 25 was properly working to sanitize the thermometers. She revealed that she had been educated on proper use of the test strip in the past. Interview with Dietary Assistant #1 on 04/22/10 at 12:50pm revealed that she had not seen a policy on cleaning the food thermometers. She also revealed that she was not familiar with a chemical test strip, or what it was used for. The facility was unable to produce a Policy or Procedure related to the use of Saniquat Disinfectant/Sanitizer/Deodorizer, or the use of test strips.	F 371			



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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY.	STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050
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K 000	INITIAL COMMENTS A Life Safety Code survey was Initiated and conducted on 04/28/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) 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.	K 000		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview conducted on 04/28/10, it was determined the facility failed to ensure that electrical wiring and standards met NFPA requirements. The findings include: Observation during the Life Safety Code tour conducted on 04/28/10 at 2:30pm with the Maintenance Director revealed the facility did not have an annunciator alarm for the emergency generator. An interview with the Maintenance Director on 04/28/10 at 2:35pm revealed the facility was aware of the need for the alarm annunciator for the generator and had been trying to find a contractor to install the alarm annunciator. An interview with the Administrator revealed that	K 147	1. A generator enunciator panel alarm, to be located in an area that can be centrally observed will be installed upon hiring of a contractor. 2. Calls have been placed to area contractors to install this equipment. Once contractors respond we will ask for bids and hire a contractor to expedite and complete the work. 3. A procedure will be written for it's operation and on installation of the panel staff will be educated on its purpose, functions and actions to be taken in accordance with the procedures. 4. The Maintenance Director will audit the panel monthly as part of his preventative maintenance rounds. 5. The Director of Maintenance is responsible for compliance.	6-6-2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *5/25/10*

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.

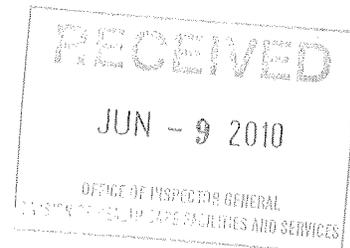
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OFFICE OF INSPECTOR GENERAL
DEPT. OF HEALTH CARE FACILITIES AND SERVICES

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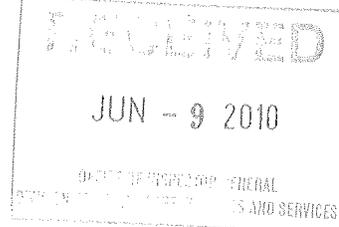
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K 147	Continued From page 1 due to the age of the forty year old generator the facility was having difficulty finding a contractor. Reference to: NFPA 99, 1999 Edition 3-4.1.1.15 Alarm Annunciator. A remote annunciator, storage battery-powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12). The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follow: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel- when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement	K 147		



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K 147	<p>Continued From page 2</p> <p>signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. {110:3-5.5.2}</p> <p>Reference: NFPA 110 1999 edition</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 101 2000 edition</p> <p>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.</p> <p>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</p>	K 147		



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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40060		
(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 147	Continued From page 3 inspection is performed at 30-day intervals.	K 147			

