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

Acceptable 5/29/12 MAY 29 2012

PRINTED: 05/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185144		C 05/04/2012

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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating #KY00018529, #KY00018248 and #KY00018104 was initiated on 05/01/12 and concluded on 05/04/12. Complaint #KY00018529 was substantiated with no deficient practice identified. Complaint #KY00018248 and #KY00018104 were unsubstantiated; however, deficiencies were identified and cited.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F225/N110 No residents were affected. Social Services identified and interviewed a sampling of residents from the units on which Residents #1 and Residents #2 live. All of the residents interviewed reported that he or she had not been treated in an abusive manner and none of the residents reported a loss of personal property. All staff received a written inservice on 5-25-12 through 5-28-12 by the DON, ADON, or QA Nurse on immediately reporting any signs and symptoms of abuse/neglect to their supervisor, to the Director of Nursing, or the Administrator. Any staff having not the inservice by 5-29-12 receive the inservice prior to working.	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Nancy Russell — Administrator — 5-28-12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure all allegations of abuse were reported immediately to the Administrator for one (1) of three (3) sampled residents (Resident #2). In addition, the facility failed to conduct a thorough investigation of an abuse allegation for two (2) of three (3) sampled residents (Residents #1 and #2). The findings include: Review of the clinical record revealed Resident #1 was admitted by the facility on 01/21/05 with diagnoses which included Hypertension, Anxiety and Depression. Review of the State Agency Intake Form, dated 03/29/12, revealed Resident #1 reported $200 to $250 was discovered missing from his/her personal belongings on 03/24/12. Review of the facility's investigation of the incident revealed Resident #1 was interviewed regarding the incident and a meeting was scheduled to interview the alleged perpetrator. However, no	F 225	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider 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.* Should an incident or suspected incident of resident abuse be reported, the Administrator, or his or her designee, will appoint a member of management to investigate the alleged incident. The individual conducting the investigation will interview all applicable witnesses, residents, and staff. An internal Abuse Investigation Tracking Log was created to be used with all abuse investigations to track and log dates, times, and responses of all appropriate people contacted including but not limited to, physicians, OIG, APS, residents, families, visitors, and staff. The Administrator, or his/her designee, will review all investigations for	

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F 225	Continued From page 2 additional residents were interviewed regarding any other missing monies. Continued review of the investigation revealed one staff member witnessed and reported an incident which raised suspicion regarding the alleged perpetrator. Further review, however, revealed no other residents or staff members were interviewed regarding additional concerns related to the alleged perpetrator. Review of the "Resident Abuse Reporting Policy", revised 10/01/10, revealed any alleged abuse should be reported immediately to the Administrator. Clinical record review revealed the facility admitted Resident #2 on 12/21/11 with diagnoses which included Schizophrenia and Dementia. Review of the State Agency Intake Form, dated 04/25/12, revealed the facility reported an alleged abuse involving Resident #2 occurred on 04/23/12. Review of the facility investigation revealed the alleged perpetrator and the staff member who reported the incident gave a written statement. There was no documented evidence any other residents or staff were interviewed regarding other incidents or concerns involving the alleged perpetrator. Review of the written statement by State Registered Nurse Aide (SRNA #1) revealed she was first informed of alleged verbal abuse toward Resident #2, by the resident's roommate, Unsampled Resident A, on 04/23/12 at approximately 1:30 PM. Continued review of the	F 225	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider 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.* thoroughness and present any issues to the Quality Assurance Committee for review and further recommendations for the next three months. Date of Compliance: 5-29-12	

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F 225	Continued From page 3 statement revealed Resident #2 reported the incident of verbal abuse to SRNA #1 about three (3) hours later, at approximately 4:30 PM. Interview with SRNA #1, on 05/03/12 at 11:30 AM, revealed Unsampled Resident A reported the alleged perpetrator was verbally abusive to Resident #2. The SRNA stated Resident #2 later reported the incident while the aide was providing care. SRNA #1 stated she did not report the allegation until after the second report. Continued interview revealed she meant to report it when Unsampled Resident A told her about it, but got sidetracked and forgot until Resident #2 reported it. The aide stated she had been inserviced related to abuse, and knew any allegation was to be reported "as soon as possible". Interview with the Assistant Director of Nursing, on 05/01/12 at 4:35 PM, revealed the staff member should have reported the alleged abuse immediately upon receiving the allegation. Interview with Social Worker (SW) #2, on 05/01/12 at 4:05 PM, revealed she was involved in the investigation. She stated she did not interview other residents or staff about possible additional incidents or concerns related to the alleged perpetrator. Interview with the Administrator and the Director of Nursing, on 05/01/12 at 4:10 PM, revealed they interviewed Resident #2 about the incident but couldn't remember exactly what the resident said, and they did not take any notes. They stated they did not interview other residents or staff regarding other incidents or concerns related to the alleged	F 225		

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F 225	Continued From page 4 perpetrator. The Administrator stated she was ultimately responsible for the abuse investigation. She further stated she was not sure what time she first heard about the allegation and acknowledged she was to be informed of all alleged abuse incidents immediately.	F 225	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider 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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop and implement an abuse policy which included the required seven components. The facility did not implement its policy related to notification of the Responsible Party and the physician for one (1) of three (3) sampled residents (Resident #2). The findings include: Upon request by the State Agency, the facility could not provide an abuse policy which contained the required seven components of screening, training, prevention, identification, investigation, protection and reporting. Review of the policy revealed the component related to investigation was not present. Review of the document titled "Resident Abuse Reporting Policy", dated 10/01/10, revealed any suspected abuse will be reported to the	F 226	F226/N105 No residents were affected. No other residents had the potential to be affected. An internal Abuse Investigation Tracking Log was created to be used with all abuse investigations to track and log dates, times, and responses of all appropriate people contacted including but not limited to, physicians, OIG, APS, residents, families, visitors, and staff. The Administrator, or his/her designee, will review all investigations for physician and responsible party notifications. Any issues will be presented to the Quality Assurance Committee for review and further recommendations for the next three months. Date of Compliance: 5-29-12	

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F 226	Continued From page 5 responsible party and the physician. Review of the State Agency Intake Form, dated 04/25/12, revealed the facility reported an alleged verbal abuse involving Resident #2 occurred on 04/23/12. Review of the clinical record revealed Resident #2 was admitted by the facility on 12/21/11 with diagnoses which included Schizophrenia and Dementia. Review of the facility investigation revealed no documented evidence the responsible party or the physician were notified of the abuse allegation. Interview with Registered Nurse #1, on 05/03/12 at 3:30 PM revealed she reported the abuse allegation to the Administrator as soon as she became aware of it. She stated she did not call the physician or the responsible party. She further stated she passed the information to administration and had no further involvement. Interview with the Director of Nursing, on 05/03/12 at 1:45 PM, revealed she was sure the responsible party had been called even though it was not documented. She stated she did not know if the physician had been called.	F 226		

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