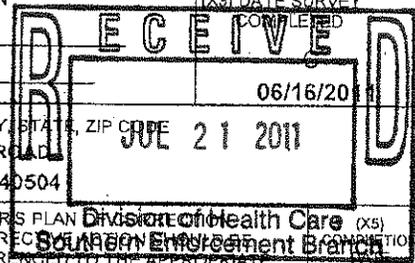


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 07/18/2011
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 06/16/2011
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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 (EACH CORRECTIVE ACTION MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) DATE OF CORRECTION
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F 000	INITIAL COMMENTS A standard health survey was conducted on June 14-16, 2011. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY15948, KY15960, KY15961, KY16137, KY16301) was also conducted at this time. KY15948, KY15961, and KY16301 were unsubstantiated with no related deficient practice. KY15960 and KY16137 were substantiated with deficient practice identified.	F 000		
F 174 SS=E	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents had reasonable access to the use of a telephone to make private telephone calls. Telephone calls could not be placed/received by residents without being overheard by staff and other residents. The residents were required to use a telephone in the dining room and at the nurses' station where other residents and staff were present. In addition, the facility's bedfast residents had no access to telephone use, other than the staff's cell phone. The findings include: The facility policies include a Privacy policy and a	F 174		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joni Gosser RN, Administrator</i>	TITLE Administrator	(X6) DATE 7/20/11
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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.

Received Time Jul. 21. 2011 11:27AM No. 0637

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F 174	<p>Continued From page 1</p> <p>Resident Telephone policy (no date noted). The Privacy policy stated the facility will ensure the residents have the right to personal privacy and confidentiality of personal and medical records. Personal privacy includes but is not limited to accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. The Telephone policy states the facility will provide the resident with reasonable access to the use of a telephone where calls can be made without being overheard. In this facility, there are two telephones in the dining room, a telephone at each nurses' station, and offices located throughout the facility. Staff cell phones may be used to assist residents who are bedbound with telephone calls.</p> <p>An observation of an unsampled resident during the initial tour on June 14, 2011, at 1:15 p.m., revealed the resident was using the telephone at the D Hall nursing station. The nursing station was full of staff working and talking and the resident was having difficulty hearing on the phone. The resident was observed covering the other ear in order to hear the conversation over the phone.</p> <p>An interview with the unsampled resident from the D Hall on June 14, 2011, at 2:00 p.m., revealed the resident used the telephone at the nursing station to make telephone calls as the telephone had been removed from the dining room for several weeks. The resident stated there was no place to talk in private on the telephone in the facility. The resident stated that when the telephone was in the dining room there was still no privacy.</p>	F 174	<p><u>F174</u></p> <ol style="list-style-type: none"> 1. We were not aware of any issues with the existing telephone arrangement until the day of the survey exit. Therefore, we were unable to correct the deficiency at that time. 2. Resident's were interviewed by Activities and Social Services staff on 7/18/ 2011 to ensure all resident's felt they had privacy when talking on the telephone. The facility identified some resident's who said they would like more privacy with their telephone conversations. 3. A telephone was installed in the facility conference room on July 11, 2011 for resident's usage only. Those resident's unable to go to the conference room by themselves for making or receiving telephone calls will be taken by the nursing staff. Resident's will be able to use the telephone in private. The staff was in serviced by the staff development and quality assurance nurses on July 11, 2011 to educate the staff on the new telephone procedure. 		

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Event ID: H89611

Facility ID: 100108

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Follow up to ensure the
resident's feel they have

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F 174	Continued From page 2 An observation of the dining room on June 14, 2011, at the evening meal service at 5:30 p.m., revealed no telephone in the main dining room. A group interview conducted with 20 alert and oriented residents on June 15, 2011, 10:00 a.m., revealed the only telephone for resident use was located in the dining area and each nursing station. Observation of the telephone on June 15, 2011, at 5:00 p.m., revealed the telephone was on a wall located across from the resident dining tables. Residents attending the meeting further stated the telephone calls were not private if residents/staff members were using the resident dining area. The residents stated bedfast residents did not have access to a telephone if the residents were to receive telephone calls. An interview with the Assistant Director of Nursing (ADON) was conducted on June 16, 2011, at 5:15 p.m. The ADON stated, "There is a phone in the dining room, but I realize it is not private and the bedbound residents are unable to use this phone." During an interview with the Licensed Practical Nurse (LPN) on the B Unit on June 16, 2011, at 5:30 p.m., the LPN stated, "They use the nurses' station to place and receive telephone calls and it is not private for them." During an interview with the Director of Nursing (DON) on June 16, 2011, at 5:40 p.m., the DON stated, "Well sometimes we let the bedbound residents use our cell phones."	F 174	adequate privacy while using the telephone will be done through Quality Assurance monitoring, by the Quality Assurance Nurse or designee, monthly for three months then quarterly thereafter. 4. The administrator will be responsible for ensuring compliance with this regulation. 5. Completion Date: 7/18/11	
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		

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F 225 SS=D	Continued From page 3 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. 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.	F 225	F225 1. No corrective action could be taken for Resident # 12 as the incident occurred in January 2011. The perpetrator was suspended and later terminated for the incident without ever encountering Resident # 12 or any other facility resident again. 2. The perpetrator in this incident was immediately suspended and terminated and had no further contact with any residents. All allegations of abuse and neglect reported to the administrator were audited to ensure the allegation was reported to the appropriate agencies immediately. 3. Any allegation of abuse will be reported immediately to the appropriate authorities. The suggested form from the Office of Inspector General (OIG) on reporting suspected abuse or neglect has been implemented in the facility. The staff will fill out the form immediately after reporting the incident to the administrator and fax it to the appropriate authorities. Facility staff will be serviced on Abuse and reporting abuse by the Social Services and the staff development nurse on July 11, 2011. The quality assurance	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H99611

Facility ID: 100108 nurse or designee will audit all abuse and neglect reports weekly
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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of abuse to the appropriate state agency timely. Resident #12 was involved in an alleged verbal abuse altercation on January 28, 2011; however, the facility failed to report one of three allegations of abuse to the State Survey and Certification Agency immediately. The findings include: A review of the Abuse policy dated October 1, 2010, revealed the facility was to notify the appropriate state agencies immediately of any allegation of abuse. A review of the investigation regarding a staff member verbally abusing resident #12 on January 28, 2011, revealed the incident was not reported to Adult Protective Services (APS) or the Office of Inspector General (OIG) until January 31, 2011, two days after the incident occurred. According to the investigation report, on January 28, 2011, two staff members overheard the incident with resident #12 and the perpetrator, and an investigation was initiated. The alleged perpetrator was suspended pending the investigation. The perpetrator was terminated on January 31, 2011, and the incident was then reported to the state agencies. The facility determined through their investigation that verbal abuse did occur. An interview with the Administrator on June 16,	F 225	for three months, then monthly thereafter to ensure the allegations were reported to the appropriate authorities in a timely manner. 4. The administrator or designee will ensure compliance with this regulation. 5. Completion Date: July 14, 2011	

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F 225	Continued From page 5 2011, at 3:00 p.m., revealed any allegation of abuse was to be reported immediately to the appropriate state agencies. The Administrator did not know why the incident had not been reported timely.	F 225			
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 record review and interview, it was determined the facility failed to implement a screening procedure related to abuse, neglect, mistreatment, and misappropriation of property for newly hired staff. The facility failed to provide evidence that the facility conducted or attempted to obtain work reference screening for one of five employee files reviewed. The findings include: The facility's policy (dated 2000) states the facility will not knowingly hire an individual who has a history of abusing other persons. This facility will conduct employment reference investigation checks on individuals making application for employment with this facility. A record review of five newly hired employees was conducted on June 16, 2011. An employee record review revealed no evidence of a work reference screening for one of five newly hired	F 226	<u>F226</u> 1. The employee involved in the deficient practice is no longer employed by the facility; therefore, no corrective action could be taken; 2. All current employee files were audited by the Payroll clerk to ensure that pre-employment reference checks were conducted before the employee was hired. 3. The Administrator or designee will audit the employee reference checks before the employee is able to enter orientation. Any employee without reference checks will not be hired by the facility. 4. The administrator or designee will be responsible for ensuring compliance with this regulation. 5. Completion Date: July 14, 2011		

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F 226	Continued From page 6 employees (a social worker). An interview conducted on June 16, 2011, at 2:50 p.m., with the Director of Nursing (DON) revealed he/she is responsible to perform work reference checks for all newly hired licensed staff. The DON added it is the responsibility of the Administrator to perform work reference screening for the newly hired social services staff (social workers). An interview conducted on June 16, 2011, at 4:40 p.m., with the Administrator revealed the facility's abuse policy states all newly hired employees are screened for work references. The Administrator further revealed he/she is responsible for performing work reference screening on newly hired social workers. The Administrator revealed he/she was unable to provide evidence of a work reference screening for the social worker. Further interview revealed he/she was not the Administrator at the time this employee was hired. The Administrator revealed this employee's father was a resident at this facility and was known by the former Administrator. In addition the Administrator stated employee reference screening is the facility's policy for protecting residents from abuse.	F 226			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 1. The medication that was left on the bedside table for resident #9 was destroyed and circled on the MAR as not taken by the resident. The fingernail polish and removal were removed from Resident #16's bedside and placed in the locked medication room on the day of the survey. 2. An audit of medication passes was done for three days after the medication of resident #9 was		

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found at the bedside to ensure no other medications were not taken
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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents' environment remained as free as possible of accident hazards. A medicine cup that contained liquid medication was left on resident #9's bedside table. In addition, nine bottles of nail polish and one bottle of nail polish remover were observed on resident #16's bedside table. The findings include: During the initial tour on June 14, 2011, at 1:30 p.m., a medication cup with 20 cubic centimeters (cc) of green liquid was observed on resident #9's bedside table. Interview with resident #9 on June 14, 2011, at 1:30 p.m., revealed the cup was filled with Enulose, and the resident's medication was left there overnight. Resident #9 stated, "I did not want to take the medication so I left it on the table." Interview with Certified Medication Aide (CMA) #1 at 1:40 p.m. on June 14, 2011, revealed no medications had been left on the bedside table on June 14, 2011, and stated resident #9 had taken all medications as prescribed. CMA #1 was unaware the medication had been left there from the night before, until the resident notified him/her at that time. Interview with the RN Supervisor for the D Unit on	F 323	by the residents. Resident's personal belongings were checked to ensure there was no fingernail polish or polish remover at the bedside. Other potentially harmful items were looked for as well and removed from the bedside to the medication room for safe storage. 3. Quality Assurance conducted in-services for all licensed nurses and KMA's June 15, 2011 on medication administration and not ever leaving medication at the residents bedside. A quality assurance audit of resident's rooms was done after the medication administrations daily for three days then one room daily every day for thirty days. This audit was done by the Quality Assurance Nurse. Resident's rooms were checked to ensure that nail polish and polish remover were not at the resident's bedside. Audits of resident rooms will be done monthly for three months then quarterly for three months. The audits for medicine at the bedside and fingernail polish and remover at the bedside will be discussed in monthly Quality Assurance meetings. 4. The administrator or designee will be responsible for ensuring	

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F 323	<p>Continued From page 8</p> <p>June 14, 2011, at 1:45 p.m., revealed medications should not be left unattended in any resident's room. The Supervisor did not know why the medication was left in resident #9's room.</p> <p>2. A review of the facility's policy titled "Personal Items at the Bedside" (not dated) revealed the facility encouraged residents to retain and use their personal possessions. The policy further revealed these items may be kept at the resident's bedside, in the resident's bedside table drawer, resident's bath pan, or other areas deemed necessary to meet the resident's needs.</p> <p>During the initial tour on June 14, 2011, at 1:45 p.m., one full bottle of 100% Acetone Nail Polish Remover was observed on resident #16's bedside table. The bottle contained a warning which read, "Keep away from children." Further observation revealed nine bottles of fingernail polish were observed sitting on the bedside table.</p> <p>A review of Medline Plus Medical Encyclopedia Online revealed a person should seek emergency medical care immediately if fingernail polish or nail polish remover was ingested.</p> <p>A review of the wanderer resident list provided by the facility and dated June 8, 2011, revealed there were two wandering residents on the C Station and four wandering residents on the D Station of the facility. All six residents' rooms were within a short distance from resident #16's room.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #5 on June 16, 2011, at 8:50 a.m., revealed residents were not</p>	F 323			

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F 323	Continued From page 9 permitted to have nail polish remover in their rooms. The SRNA further stated if he/she finds nail polish remover or fingernail polish, he/she would take it to the nurse to be locked up. An interview conducted with the Director of Nursing (DON) on June 16, 2011, at 8:55 a.m., revealed the DON stated the facility tried to keep the environment homelike and states chemicals should be kept in the resident's bedside table. Observation of the hallway outside resident #16's room on June 16, 2011, at 9:00 a.m., revealed four residents walking in the hallway.	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Second SOD

RECEIVED		DATE SURVEY COMPLETE
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Division of Health Care Southern Enforcement Branch		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185144	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	
F 205	<p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written information to one of twenty-four sampled residents (resident #22) that specified the duration of the bed-hold policy under the State plan. Resident #22 was transferred to the hospital on March 11, 2011, however, the facility failed to provide the resident with information concerning the duration of the bed-hold policy before transfer.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Bed-Hold Policy," which contained no date, revealed upon transfer to the hospital, if the resident is out of bed-hold days, a resident may choose to hold the bed by paying the self-pay room rate.</p> <p>A review of the medical record for resident #22 revealed the resident was admitted the facility on August 16, 2010, with diagnoses of Cerebral Vascular Accident (Stroke), Dementia, Agitation, and Confusion.</p> <p>A review of the nursing notes for resident #22 revealed the resident was transferred to St. Joseph East Hospital for evaluation on March 11, 2011, and was subsequently admitted to the hospital. A review of the transfer sheet dated March 11, 2011, revealed the resident was being sent to the hospital due to the resident being diagnosed with a venous thrombosis (blood clot) of the left lower extremity.</p> <p>An interview conducted with the responsible party (RP) for resident #22 on June 16, 2011, at 9:30 a.m., revealed he/she had not been notified at the time the resident was sent to the hospital, the resident was out of bed-hold days, and therefore the resident would lose his/her bed at the facility. The RP further revealed no one at the facility had discussed the bed-hold days with the family member prior to the resident being transferred to the hospital. The RP stated he/she had not been offered the chance to pay to hold the bed for the resident.</p> <p>Interview with the Administrator on June 16, 2011, at 10:00 a.m., revealed the facility was unable to provide documentation that resident #22 was provided information concerning the resident being out of bed-hold</p>	

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

The above isolated deficiencies pose no actual harm to the residents

031099

Event ID: H99611

If continuation sheet 1 of 3

Received Time Jul. 21, 2011 11:27AM No. 0637

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESAH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185144	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/16/2011
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 205	<p>Continued From Page 1</p> <p>days, before the resident's transfer to the hospital on March 11, 2011. The Administrator further revealed the facility does not send a notice to the resident or the family when a resident is out of bed-hold days. The Administrator revealed it is the responsibility of the Admissions Coordinator to call the family to inform them of the resident being out of bed-hold days.</p> <p>An interview conducted with the Admissions Coordinator (AC) on June 16, 2011, at 4:15 p.m., revealed the AC was responsible to call residents or the family if a resident was out of bed-hold days and to allow the resident or the family to hold the bed by paying the self-pay room rate. The AC further stated he/she could not recall if he/she had spoken with the family of resident #22. The AC revealed resident #22 was out of bed-hold days.</p>		
F 206	<p>483.12(b)(3) POLICY TO PERMIT READMISSION BEYOND BED-HOLD</p> <p>A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure one resident (resident #22) of twenty-four sampled residents was afforded the right to a bed-hold, and the opportunity to be readmitted to the facility immediately upon the first availability of a bed in a semi-private room when the bed-hold expired.</p> <p>The findings include:</p> <p>A review of the facility's policy (no date) revealed upon transfer to the hospital, if the resident is out of bed-hold days a resident may choose to hold the bed by paying the self-pay room rate. The policy further revealed if a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan, the resident will be readmitted to the facility immediately upon the first availability of a bed, if the resident chooses to be readmitted, requires the services of the facility, and is eligible for Medicaid facility services.</p> <p>Record review revealed resident #22 was admitted the facility on August 16, 2010, with diagnoses of Cerebral Vascular Accident (Stroke), Dementia, Agitation, and Confusion.</p> <p>A review of the medical record for resident #22 revealed the resident was transferred to Saint Joseph East Hospital for evaluation on March 11, 2011. A review of the transfer sheet dated March 11, 2011, revealed the resident was being sent to the hospital due to the resident being diagnosed with a venous thrombosis (blood clot) of the left lower extremity.</p>		

031099

Event ID: H99611

If continuation sheet 2 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESAH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185144	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/16/2011
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 206	<p>Continued From Page 2</p> <p>An interview conducted with the family member of resident #22 on June 16, 2011, at 9:30 a.m., revealed he/she had not been notified at the time the resident was sent to the hospital that the resident was out of bed-hold days and as a result would not be readmitted to the nursing home. The family member further revealed no one at the facility had discussed the bed-hold days with the family member prior to the resident being transferred to the hospital. The family member stated he/she had not been offered the chance to pay to hold the bed for the resident. The family member further stated he/she had requested a meeting with the facility to discuss resident #22 being readmitted to the facility and was told by the Director of Nursing (DON) there was no need for a meeting, it was a moot point. The family member further stated the DON told him/her the facility could not meet the resident's needs but, when asked why, the DON failed to give the family member a specific reason.</p> <p>An interview conducted with the Social Worker (SW) at Saint Joseph East Hospital on June 16, 2011, at 9:25 a.m., revealed the SW had contacted the facility on March 14, 2011, to inquire about the resident's bed-hold days remaining, and was told by the Admissions Coordinator that the facility would not be readmitting the resident. The SW further stated the resident's family member appeared shocked when told of the news by the SW. The SW further stated he/she had also spoken with the facility Administrator to try to resolve the issue and was informed the resident's family member had obtained an attorney and the facility would not be taking the resident back to the facility because the facility could not meet the resident's needs. The SW stated he/she had inquired from the Administrator as to what needs the facility could not meet and none were given.</p> <p>Interview with the Administrator on June 16, 2011, at 10:00 a.m., revealed the facility was unable to provide documentation that resident #22 was provided information concerning the resident being out of bed-hold days before the resident's transfer to the hospital on March 11, 2011. The Administrator further revealed the facility does not send a notice to the resident or the family when a resident is out of bed-hold days. The Administrator revealed it is the responsibility of the Admissions Coordinator to call the family to inform them of the resident being out of bed-hold days. The Administrator further revealed the resident was out of bed-hold days and the family member had not paid to hold the bed for the resident. The Administrator stated the facility does not send a written notice, the Admissions Coordinator just calls the family. The Administrator further stated the family member of resident #22 had obtained the services of an attorney and was going to sue the facility; therefore the resident was not taken back to the facility.</p> <p>An interview conducted with the Admissions Coordinator (AC) on June 16, 2011, at 4:15 p.m., revealed the AC was responsible to call residents or the family if a resident was out of bed-hold days and to allow the resident or the family to hold the bed by paying the self-pay room rate. The AC further stated he/she could not recall if he/she had spoken with the family of resident #22. The AC revealed resident #22 was out of bed-hold days and the family had not paid to hold the bed for the resident. The AC further revealed the facility did have available beds on the day the resident was discharged from the hospital on March 21, 2011.</p>		

031099

Event ID: H99611

If continuation sheet 3 of 3

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

PRINTED: 06/30/2011
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 06/16/2011
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 000	INITIAL COMMENTS K3 Building: 0101 K6 Plan Approval: 1971 K7 Survey under: 2000, existing K8 SNF Type of structure: one story Skilled Nursing Facility Type V unprotected. A Life Safety Code survey was initiated and concluded on June 6, 2011, 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. The following findings demonstrate noncompliance with the highest scope/severity at "F" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018 1. Trashcans were removed from in front of resident room doors. 2. An audit of all resident rooms was done July 8, 2011 by the Quality Assurance nurse to ensure there were no other trashcans in front of resident room doors. 3. The Quality Assurance nurse or designee will monitor the resident room doors weekly for one month then monthly thereafter to ensure trashcans are not in front of resident room doors. The administrator or designee will in service the facility staff on July 11, 2011 to ensure staff knows the reason for this regulation. 4. The administrator or designee will be responsible for ensuring compliance with this regulation. 5. Completion Date: July 15, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Margie Starnelle RN, D.O.N.* TITLE _____ (X8) DATE 7-8-11

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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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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in the corridor did not have any impediments to their closing, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three of six smoke compartments, 69 residents, staff, and visitors. The findings include: Observation on June 16, 2011, at 11:09 a.m., with the Maintenance Director, revealed resident room door 205 had a trash can placed in front of it, impeding the door from closing. Further observation revealed resident room doors 308, 405, and 406 had trash cans in front of them, preventing easy closure of the door. Resident room doors located in the corridor must be kept clear of impediments to their closing in case the door needs to be closed quickly to isolate a fire. Interview on June 16, 2011, at 11:09 a.m., with the Maintenance Director, revealed staff had been repeatedly warned not to place items in front of resident room doors. Further interview revealed the Maintenance Director believed staff placed the trash cans in front of the resident room	K 018		

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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 018	Continued From page 2 doors to make discarding of exam gloves easier. The facility did not have a written policy related to impeding the closing of resident doors.	K 018		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire sprinkler system was installed according to National Fire Protection Standards (NFPA). The deficiency had the potential to affect six of six smoke compartments, 134 residents, staff, and visitors. The findings include: Observation on June 16, 2011, at 9:34 a.m., with the Maintenance Director, revealed the Post Indicator Valve (PIV) located next to Versailles Road did not have an electronic tamper switch. The electronic tamper switch sends a signal to the facility to allow the facility to know if the water supply to the fire sprinkler system has been shut off. Interview on June 16, 2011, at 9:34 a.m., with the Maintenance Director, revealed he had never known of the PIV having an electronic tamper switch since he started working at the facility in	K 061 <u>K061</u> 1. The PIV valve will have an electronic tamper switch installed by Brown Sprinkler. Due to a heavy workload, Brown Sprinkler cannot install the switch until August 2011. The work order number for the project is LX-1109243 Aug. 2. All other valves have tamper switches. 3. The PIV valve will have an electronic tamper switch installed to alert the facility that the water supply to the sprinkler company has been shut off. 4. The administrator or designee will be responsible for ensuring compliance with this regulation 5. Completion Date: July 8, 2011		

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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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K 061	Continued From page 3 1995. Reference: NFPA 101 (2000 Edition). 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to inspect and maintain the fire sprinkler system according to NFPA standards. The deficiency had the potential to affect six of six smoke	K 062		

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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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K 062	<p>Continued From page 4 compartments, 134 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on June 16, 2011, at 9:59 a.m., with the Maintenance Director, revealed the sprinkler system riser had a total of four gauges. Gauges located in the fire sprinkler system must be recalibrated or replaced every five years.</p> <p>Interview on June 16, 2011, at 9:59 a.m., with the Maintenance Director, revealed two of the four gauges had been replaced within the last five years, but he was unsure of when the other gauges were replaced or recalibrated. Review of the Sprinkler inspection reports revealed no evidence the gauges had been replaced or recalibrated every five years as required.</p> <p>Observation on June 16, 2011, at 10:00 a.m., with the Maintenance Director, revealed the fire sprinkler system had one control valve located on the fire sprinkler riser. The control valve was supervised with an electronic tamper switch. Control valves that are supervised with an electronic tamper switch must be inspected monthly to ensure they function properly. Review of the Sprinkler inspection reports revealed no evidence the monthly inspections had been completed.</p> <p>Interview on June 16, 2011, at 10:00 a.m., with the Maintenance Director, revealed he did not perform a monthly inspection on the control valve because he felt like he had not been properly trained.</p> <p>Record review of the fire sprinkler system</p>	K 062	<p><u>K062</u></p> <ol style="list-style-type: none"> 1. Brown Sprinkler replaced all the gauges of the sprinkler system riser. 2. No other areas were affected by this practice. 3. Brown Sprinkler replaced the gauges in the sprinkler system riser and the control valves will be inspected monthly as well. 4. The administrator or designee will be responsible for ensuring this regulation is met. 5. Completion Date: July 1, 2011 	

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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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K 062	<p>Continued From page 5</p> <p>Inspection documents on June 16, 2011, at 11:30 a.m., with the Maintenance Director, revealed the facility last had an internal pipe inspection for the fire sprinkler system performed on June 23, 2003. Fire sprinkler systems must have an internal pipe inspection performed every five years to ensure the reliability of the fire sprinkler system.</p> <p>Interview on June 16, 2011 at 11:30 a.m., with the Maintenance Director, confirmed the facility last had an internal pipe inspection on the fire sprinkler system performed on June 23, 2003.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.</p> <p>9-3.3.1 All valves shall be inspected weekly.</p> <p>Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p> <p>Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised.</p> <p>9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible</p>	K 062		

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K 062	Continued From page 6 (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062		