Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
{P 000}	Initial Comments Based upon implementation of the acceptable Plan of Correction (PoC), the deficiency was corrected on 02/19/2024.	{P 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

PRINTED: 02/07/2024
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 000	Initial Comments A Complaint Survey investigating KY41731 was initiated on 01/23/2023 and concluded on 01/24/2024. Regulatory violations were identified with complaint KY41731.	P 000		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined the facility failed to admit only residents whose supervision and monitoring of health care needs could be met	P 185		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 3/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 185	Continued From page 1 for one (1) of four (4) sampled residents (Resident #1). Interviews with facility staff revealed Resident #1 expired shortly after returning to the facility from a hospital stay on 01/17/2024, however, staff felt the resident required a higher level of care. The findings include: Review of the facility's policy, "Abuse Prevention and Reporting", undated, revealed the facility prohibited all forms of abuse, neglect, involuntary seclusion, and misappropriation of property of all residents. This could include the deprivation by an individual including a caretaker, deprivation of goods, and deprivation of services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Review of Resident #1's Admission Record revealed the facility admitted Resident #1 on 11/08/2023, with diagnoses which included Schizophrenia, Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). In an interview with Nurse Aide (NA) #1 on 01/23/2024 at 9:56 AM, she stated Resident #1 came back to the facility on 01/17/2024 around 3:30 PM from the hospital. She stated it took about fifteen (15) minutes to get the Resident #1 off the transportation bus and back into the facility. She stated the resident was taken to the shower room and she checked on the resident twice. NA #1 stated Resident #1 did not want to be taken out of the shower room. She stated she continued to do work and went back to check on Resident #1 a third time and found the resident unresponsive. NA #1 stated she called for help from MedTech #1. She stated neither she or	P 185	P 185 Administrator has informed Medication Technician (Med. Tech.) staff via written notice that was signed by the staff member indicating they understood the information being conveyed and provided an opportunity to ask any questions, that any and all admissions or readmissions must be forwarded directly to the administrator or the person acting on the administrator's behalf in the administrator's absence. Further, the importance of relaying this information to the individual contacting the facility was emphasized. That they themselves could not make the decision to admit/readmit any resident and that they would have the administrator or the person acting on the administrator's behalf in the administrator's absence contact them directly to discuss the admission/ readmission or the reasoning for not doing so.	2.19.2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 185	Continued From page 2 MedTech #1 initiated cardiopulmonary resuscitation (CPR) on Resident #1. NA #1 stated staff called 911 immediately when realizing the resident was unresponsive. NA #1 stated she did not witness Emergency Medical Services (EMS) perform CPR on Resident #1. She stated Resident #1 did not seemed distressed and was talking when she returned to the facility. NA #1 stated Resident #1 did not ask to be taken back to the hospital and was not acting like he/she had any problems. She stated MedTech #1 had assisted Resident #1 to the shower room upon his/her return from the hospital. NA #1 stated MedTech #1 had instructed her to check on Resident #1 after leaving him/her in the shower room. She stated she was not CPR certified and did not perform any life saving measures for Resident #1. In an interview with MedTech #1 on 01/23/2024 at 11:07 AM, he stated that on 01/17/2024 around 11:00 AM he spoke with hospital staff about Resident #1 needing a higher level of care. He stated the hospital staff member stated they would "put a bug out there" to see if Resident #1 could be admitted somewhere else. MedTech #1 stated Resident #1 had to be returned to the facility that day without a change in facility admission from the hospital. He stated he wanted to get in touch with the Assistant Administrator about suggesting Resident #1 be sent to a higher level of care. MedTech #1 stated around 3:00 PM a transportation van pulled into facility parking lot, without an updating the facility staff on the resident's return. MedTech #1 stated he talked Resident #1 into getting out of the van even though the resident insisted on being returned to the hospital immediately. He stated Resident #1 was in a gown and he rolled Resident #1 straight to the bathroom and instructed Nurse Aide #1 to	P 185	P 185 A copy of the -- Notice to Med Tech Staff Re: Admission/Readmission of Residents is attached to this reply (or to the email used to send this reply). In addition the admin will consult with the medical director before somebody is readmitted from the hospital to make sure they are not above our level of care.	

unacceptable

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 000	Initial Comments A Complaint Survey investigating KY41731 was initiated on 01/23/2023 and concluded on 01/24/2024. Regulatory violations were identifed with complaint KY41731.	P 000		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined the facility failed to admit only residents whose supervision and monitoring of health care needs could be met	P 185		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 185	Continued From page 1 for one (1) of four (4) sampled residents (Resident #1). Interviews with facility staff revealed Resident #1 expired shortly after returning to the facility from a hospital stay on 01/17/2024, however, staff felt the resident required a higher level of care. The findings include: Review of the facility's policy, "Abuse Prevention and Reporting", undated, revealed the facility prohibited all forms of abuse, neglect, involuntary seclusion, and misappropriation of property of all residents. This could include the deprivation by an individual including a caretaker, deprivation of goods, and deprivation of services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Review of Resident #1's Admission Record revealed the facility admitted Resident #1 on 11/08/2023, with diagnoses which included Schizophrenia, Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). In an interview with Nurse Aide (NA) #1 on 01/23/2024 at 9:56 AM, she stated Resident #1 came back to the facility on 01/17/2024 around 3:30 PM from the hospital. She stated it took about fifteen (15) minutes to get the Resident #1 off the transportation bus and back into the facility. She stated the resident was taken to the shower room and she checked on the resident twice. NA #1 stated Resident #1 did not want to be taken out of the shower room. She stated she continued to do work and went back to check on Resident #1 a third time and found the resident unresponsive. NA #1 stated she called for help from MedTech #1. She stated neither she or	P 185	P 185 Administrator has informed Medication Technician (Med. Tech.) staff via written notice that was signed by the staff member indicating they understood the information being conveyed and provided an opportunity to ask any questions, that any and all admissions or readmissions must be forwarded directly to the administrator or the person acting on the administrator's behalf in the administrator's absence. Further, the importance of relaying this information to the individual contacting the facility was emphasized. That they themselves could not make the decision to admit/readmit any resident and that they would have the administrator or the person acting on the administrator's behalf in the administrator's absence contact them directly to discuss the admission/ readmission or the reasoning for not doing so.	2.19.2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 185	Continued From page 2 MedTech #1 initiated cardiopulmonary resuscitation (CPR) on Resident #1. NA #1 stated staff called 911 immediately when realizing the resident was unresponsive. NA #1 stated she did not witness Emergency Medical Services (EMS) perform CPR on Resident #1. She stated Resident #1 did not seemed distressed and was talking when she returned to the facility. NA #1 stated Resident #1 did not ask to be taken back to the hospital and was not acting like he/she had any problems. She stated MedTech #1 had assisted Resident #1 to the shower room upon his/her return from the hospital. NA #1 stated MedTech #1 had instructed her to check on Resident #1 after leaving him/her in the shower room. She stated she was not CPR certified and did not perform any life saving measures for Resident #1. In an interview with MedTech #1 on 01/23/2024 at 11:07 AM, he stated that on 01/17/2024 around 11:00 AM he spoke with hospital staff about Resident #1 needing a higher level of care. He stated the hospital staff member stated they would "put a bug out there" to see if Resident #1 could be admitted somewhere else. MedTech #1 stated Resident #1 had to be returned to the facility that day without a change in facility admission from the hospital. He stated he wanted to get in touch with the Assistant Administrator about suggesting Resident #1 be sent to a higher level of care. MedTech #1 stated around 3:00 PM a transportation van pulled into facility parking lot, without an updating the facility staff on the resident's return. MedTech #1 stated he talked Resident #1 into getting out of the van even though the resident insisted on being returned to the hospital immediately. He stated Resident #1 was in a gown and he rolled Resident #1 straight to the bathroom and instructed Nurse Aide #1 to	P 185	P 185 A copy of the -- Notice to Med Tech Staff Re: Admission/Readmission of Residents is attached to this reply (or to the email used to send this reply).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 185	Continued From page 3	P 185		

check on the resident. MedTech #1 stated Nurse Aide #1 found the resident unresponsive and 911 was called at 3:43 PM. He stated he did not attempt CPR and the fire department showed up three minutes after the call. MedTech #1 stated that he did not see CPR attempted by anyone, but a defibrillator was placed by EMS. MedTech #1 stated that he has an active CPR certification but did not perform CPR on the Resident #1. He stated that he planned to return Resident #1 to the hospital but had to get him/her inside because the van transportation would not drive him/her back to the hospital. Resident #1 was not in apparent distress at that point. MedTech #1 stated his plan was to get resident settled and then start talking with him/her about potentially going back to the hospital. He stated he was personally upset because Resident #1 had been discharged back to the facility and the Resident clearly was not ready to come back.

In an interview with Assistant Administrator on 01/23/2024 at 8:30 AM, she stated facility staff had not attempted to perform CPR on Resident #1 on 01/27/2024.

In an interview with MedTech #2 on 01/23/2024 at 2:07 PM, he stated he revealed that if a resident were unresponsive, he was trained to check the resident's pulse and call 911. He stated he had no CPR training and had not been advised that he should provide CPR to a resident if he felt it was needed.

In an interview with the Administrator on 01/23/2024 10:30 AM, she stated Resident #1 was admitted to the hospital on 01/14/2024 and returned to the facility on 01/17/2024. She stated MedTech #1 was asking the hospital staff to assist in obtaining a referral for a higher level of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100182	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD	384 THOMPSON AVENUE MADISONVILLE, KY 42431

(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) COMPLETE DATE
P 185	Continued From page 4 care, but received no assistance. And by this time Resident #1 was on his/her way back to the facility. The Administrator stated it took staff about fifteen minutes to get the resident out of the van and she wasn't sure if the resident stated why he/she didn't want to get out of the van. She stated MedTech #1 placed Resident #1 in a wheelchair and assisted him/her to the restroom (shower room). The Administrator stated staff checked on the resident three times and on the third check found the resident to be unresponsive. She stated staff called 911. The Administrator stated she believed EMS staff had initiated CPR on Resident #1 and that MedTechs are not required to be CPR certified. She stated facility staff had not performed CPR and no one reported that Resident #1 was requesting to be sent back to the hospital.	P 185		