Received Time Jul. 2. 2012 3:55PM No. 8999

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

FORM APPROVED
OMB NO. 0938-0391

RECEIVED JUL - 2 2012 Division of Health Care Compliance Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/14/2012
NAME OF PROVIDER OR SUPPLIER: EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE: 195 BERRYMAN ROAD FRENCHBURG, KY 40322	

(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 06/12-14/12. Deficient practice was identified at "D" level. An abbreviated standard survey (KY18530) was also conducted at this time. The complaint was substantiated with no deficient practice identified.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure services were provided in accordance with the resident's plan of care for one of fifteen sampled residents (Resident #5). On 06/13/12, facility staff failed to ensure Resident #5 had been turned and repositioned in accordance with the resident's plan of care. The findings include: A review of the facility's policy titled, "Comprehensive Plan of Care Policy" and dated June 2012, revealed it was the responsibility of all interdisciplinary team members to ensure all interventions are followed. A review of the medical record for Resident #5 revealed the facility admitted the resident on	F 282	**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** ***The facility has ensured the following corrective action:*** • On June 13, 2012, the Director of Nursing revised the resident Nurse Aide Care Plan for Resident #5 to correctly correspond to the Comprehensive Plan of Care. (Attachment #1) • The staff assigned to Resident #5 [SRNA #5, SRNA #6 & RN #1] were provided verbal counseling on the facility policy regarding Care Plans by the Director of Nursing on 6/15/12. (Attachments # 2a, 2b, 2c)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Hill, NHA — TITLE: Administrator — (X6) DATE: 7/2/12

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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	185423		C 06/14/2012

NAME OF PROVIDER OR SUPPLIER: EDGEWOOD ESTATES

STREET ADDRESS, CITY, STATE, ZIP CODE: 195 BERRYMAN ROAD, FRENCHBURG, KY 40322

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F 282	Continued From page 1 08/02/96, with diagnoses that include Cerebral Vascular Accident, End Stage Chronic Obstructive Pulmonary Disease, and Psychosis. A review of the most recent quarterly Minimum Data Set (MDS) dated 04/11/12, revealed the facility had assessed Resident #5 to require the total assistance of two persons for bed mobility. The MDS also revealed the resident was incontinent of both bowel and bladder and was at risk for the development of pressure sores. A review of the comprehensive plan of care developed on 08/17/11, revealed staff was to turn and reposition Resident #5 every two hours and as needed. Observation of Resident #5 on 06/13/12, at 2:00 PM, 3:00 PM, 4:00 PM, 4:15 PM, and 4:55 PM, revealed the resident was left lying in the same position, on his/her right side, for a timeframe of two hours and fifty-five minutes, fifty-five minutes longer than the planned turn and reposition schedule of every two hours. An interview conducted on 06/13/12, at 5:05 PM, with State Registered Nursing Aide (SRNA) #5 revealed she had been assigned to provide care/assistance for Resident #5 on 06/13/12, was required by the facility to check the resident's care plan at the beginning of every shift, and was aware the resident should have been turned and repositioned every two hours. The SRNA stated she and SRNA #6 had been responsible to ensure Resident #5 was turned and repositioned every two hours, and they had gotten behind and failed to ask the nurse for assistance.	F 282	***The facility has taken the following action to prevent this practice from affecting other residents:*** • A complete Care Plan audit review was conducted by the Director of Nursing and Assistant Director of Nursing to ensure that facility residents' Comprehensive Care Plan was correctly documented on their Nurse Aide Care Plan on June 15, 2012. (Attachment #3, pages 1-5) • Nursing Department Staff received in-service training on 6/15/12 and 6/22/12 (Nurses, SRNAs, CMAs) regarding a review of the *revised* Comprehensive Plan of Care policy. Staff received direct instruction for daily review of, and adherence to, the Resident Care Plans. (Attachments #4, pages 1-4) ***The facility has initiated the following systemic changes to prevent this practice from recurring:*** • A revision was made to the Comprehensive Care Plan Policy to outline responsibility	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/14/2012
NAME OF PROVIDER OR SUPPLIER: EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE: 196 BERRYMAN ROAD FRENCHBURG, KY 40322	

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F 282	Continued From page 2 An interview conducted on 06/13/12, at 5:00 PM, with Registered Nurse (RN) #1 revealed she was responsible for the care of Resident #5 on that date. The RN stated Resident #5 was unable to turn and reposition him/herself in bed and required the total assistance of two persons for this. The RN stated Resident #5 should have been turned and repositioned every two hours as indicated in the plan of care. In addition, RN #1 stated she conducted observations of residents every "couple of hours" in an attempt to ensure the residents were getting the care they required, but had failed to observe staff had not turned and repositioned Resident #5 in accordance with the plan of care. The RN stated she had thought the resident had been turned and repositioned. An interview conducted with the Director of Nursing (DON) on 06/14/12, at 5:50 PM, revealed staff was required to check the comprehensive plan of care at the beginning of every shift to see what care needs were required by the residents. The DON acknowledged Resident #5 should have been turned/repositioned every two hours in accordance with the plan of care. The DON stated she makes rounds at least once daily to ensure the residents were receiving the care they required and had failed to identify the resident had not been turned timely.	F 282	for notating any change of physician orders to the Comprehensive Care Plan and the SRNA care plan (Charge Nurse); and next-working-day monitor of notated changes (MDS Coordinator). (Attachment # 5) ***The facility will sustain performance through the following monitoring practice:*** • In addition to the scheduled Care Plan review conducted quarterly by the Multidisciplinary team, a revision was made to the facility Monthly Care Plan Audit form to include a 33% sampling per month (23 residents) of resident Care Plans for comparison accuracy. This practice will ensure that all resident care plans will receive review supervision within each quarter. (Attachment # 6) Results of the monthly chart audit will be included as part of the on going Quality Assurance report for nursing. (Attachment # 7).	
		F 282	Completion Date:	6/22/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185423	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD ESTATES	195 BERRYMAN ROAD FRENCHBURG, KY 40322

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1997 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (111) SMOKE COMPARTMENTS: 3 FIRE ALARM: Complete automatic fire alarm system. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II natural gas generator. A life safety code survey was initiated and concluded on 06/13/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	K 000		

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

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