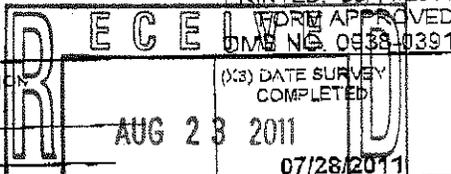


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2011



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED AUG 23 2011 07/28/2011
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	Division of Health Care Southern Enforcement Branch
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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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	See Attached	
F 225 SS=E	<p>A standard health survey was conducted on 07/26-28/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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</p>	F 225	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Zech TITLE: Administrator (X6) DATE: 8/23/11

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.

Received Time Aug. 23. 2011 4:31PM No. 1617

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, policy review, and a review of grievance reports, it was determined that the facility failed to ensure all allegations of alleged misappropriation of resident property were reported to the appropriate state agencies for three of sampled residents (Residents #16, #17, and 18).</p> <p>The findings include:</p> <p>The facility's Abuse Policy (no date) revealed when the facility received a report of suspected abuse, neglect, or misappropriation of property the facility would report the incident to the Office of Inspector General (OIG) and the Department for Community Based Services (DCBS).</p> <p>1. A review of a grievance report, "Resident Family Concern," dated 11/06/10, revealed Resident #16 had reported to facility staff that \$35.00 was missing from his/her wallet. Based on documentation, the report of the missing money was given to the facility's Social Services Department and to the Administrator of the facility. Although the alleged misappropriation of the resident's property (\$35.00) had been recorded, the facility failed to provide evidence the allegation had been reported to the appropriate state agencies.</p>	F 225	<i>See Attachment</i>	

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(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 225	Continued From page 2 2. A review of a grievance report, "Concern/Grievance," dated 11/25/10, revealed on 11/24/10, the spouse of Resident #17 reported to facility staff that the resident had placed \$50.00 in a drawer of the resident's bedside table and the money could not be found. Although the alleged misappropriation of the resident's property (\$50.00) was documented, the facility failed to provide evidence that the allegation had been reported to the appropriate state agencies. 3. A review of a grievance report, "Concern/Grievance Follow Up," dated 12/28/10, revealed on 12/26/10, Resident #18 reported to facility staff he/she had placed \$51.00 dollars in a wallet, placed the wallet under a pillow on the bed, and the money could not be found. Documentation revealed the Administrator was made aware of the resident's allegation on 12/27/10. Although documentation revealed the resident's allegation had been recorded, the facility failed to provide evidence the alleged misappropriation of the resident's property (\$51.00) had been reported to appropriate state agencies. An interview conducted with the Administrator on 07/26/11, at 9:00 AM, revealed if a resident reported an item could not be found, facility staff would conduct a search for the item and an investigation would be completed if the item could not be found. The Administrator stated the facility was not responsible to replace any lost or missing items (including money), and the facility would not report the allegation if a "minimum" amount of money was missing.	F 225	<i>See Attachment</i>		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	<i>See Attachment</i>		

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(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 253	Continued From page 3 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, interview, and record review, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. Observations revealed resident fall mats, wheelchair arms, and wheelchair cushions/seats had tom edges, commode anchor screws were exposed, floor tiles in a resident shower room were chipped, a section of the baseboard was missing in a resident's bathroom, a closet door in a resident's room had a hole in it, and drywall was chipped and marred. The findings include: During the environmental tour of the facility on 07/26-28/11, the following items were observed in need of repair: -The bedside chair arms in resident room 321 were observed to be chipped with rough edges exposed. -Wheelchairs in resident rooms 114 and 320 were observed to have tom armrests and the wheelchair seats/cushion in resident rooms 302 and 320 were tom. Blue tape was observed on the armrest of the geri-chair in resident room 204 and on the corner of a wheelchair seat in resident	F 253	<i>See Attachment</i>		

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(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 253	Continued From page 4 room 211. -The bedside table in resident room 308 was observed to be scraped/scarred and rough edges were exposed. -A hole was observed in the folding closet door in resident room 317 and the drawers in the dresser would not completely close. -The drywall in resident rooms 110 and 307 and the bathroom wall in resident room 204 were observed to be marred. -The bathroom door in resident room 204 had rough edges that exposed splintered wood. -A section of the baseboard was missing in the resident's bathroom in room 313. -Commode anchor screws were protruding one to three inches in the bathrooms located in rooms 102, 106, 111, 201, 204, 210, 216, 217, 307, and 308. -Fall mats in resident rooms 106, 210, and 301 were observed to have torn edges. -The ceiling in resident room 301 was observed to be soiled with a tan substance -A shower chair stored in the bathroom of resident room 217 was soiled and in need of cleaning/disinfecting. -The floor tiles at the shower threshold on the North Hall were observed to be chipped and sharp edges were exposed.	F 253	<i>See Attachment</i>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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 253	Continued From page 5 An interview conducted with the Maintenance Supervisor (MS) on 08/22/11, at 2:15 PM, revealed the facility utilized a work order system. The MS stated any staff member could obtain a Repair Requisition at the nurses' station to inform the Maintenance Department of anything that needed to be repaired. The MS stated staff also informed him verbally or by phone of items in need of repair. The MS revealed daily rounds were conducted by the department heads and a Quality Improvement (QI) monitoring sheet was completed. The MS stated if items in need of repair were identified during the weekly QI monitoring rounds, the department heads forwarded a Repair Requisition to him. A review of facility work orders revealed the above concerns had not been identified by the facility. In addition, the MS confirmed work orders had not been completed for the identified concerns and had not been identified during the room checks.	F 253	<i>See Attachment</i>	
F 371 SS=D	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 This REQUIREMENT is not met as evidenced by:	F 371	<i>See Attachment</i>	

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(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 371	<p>Continued From page 6</p> <p>Based on observation, interview, and record review, it was determined the facility failed to maintain the kitchen under sanitary conditions. The facility failed to ensure the grease drip pan underneath the range top was clean of grease and burned food debris.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure for cleaning the kitchen range revealed the grease drip pan was to be removed from the range and washed in hot detergent water. In addition, according to the policy, if a spill in the drip pan was difficult to cleanse/remove, a stiff bristled brush was to be used to remove the spills.</p> <p>A sanitation tour of the kitchen was conducted at 1:10 PM on 07/28/11. During the tour, the surveyor attempted to pull out the grease drip pan from underneath the range top to observe for cleanliness. However, the grease drip pan would not pull out from underneath the range top. Observation underneath the range top burners revealed the entire grease drip pan was completely covered with grease and burned food debris. The grease and burned food debris prevented the grease drip pan from being removed from underneath the range top to be cleaned. Continued observation at 2:00 PM on 07/28/11, revealed Maintenance staff removed the grease drip pan that the surveyor had been unable to remove, and the drip pan was completely covered with grease and burned food debris.</p> <p>A review of the kitchen cleaning schedule dated 07/10/11-08/06/11, revealed the range had been</p>	F 371	<i>See attachment</i>	

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 223 WEBSTER AVENUE CYNTHIANA, KY 41031
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F 371	Continued From page 7 signed off as cleaned. However, there was no indication the grease drip pan had been cleaned. An interview was conducted with the Dietary Manager and three dietary staff members at 1:25 PM on 07/28/11. The Dietary Manager and dietary staff stated they had never known of the grease drip pan being removed from underneath the range top to be cleaned. Furthermore, the Dietary Manager stated that the dietary staff was not aware the grease drip pan could be removed from underneath the range top to be cleaned.	F 371	<i>See Attachment</i>	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	<i>See Attachment</i>	

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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 425	<p>Continued From page 8</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to provide emergency drugs to its residents in accordance with currently accepted professional principles. The facility's emergency medication box contained twenty-eight expired tablet medications available for resident use.</p> <p>The findings include:</p> <p>An observation conducted on 07/28/11, at 3:00 PM, of medications in an emergency medication box located in Station 1's medication room revealed numerous medications available for use that exceeded the manufacturer's recommended expiration dates. Based on observation, seven Lisinopril tablets expired April 2011, one Lisinopril tablet expired February 2011, eight Carvedilol tablets expired 06/10/11, six Diltiazem capsules expired May 2011, and six Clarithromycin tablets expired 06/09/11, and were available for resident use.</p> <p>An interview conducted on 07/28/11, at 3:00 PM, with a Kentucky Medication Aide (KMA) revealed the facility's emergency medication box was exchanged by the facility's pharmacy every day except Sundays. The KMA stated expired medications and discontinued medications were to be returned to the pharmacy daily, except on Sundays.</p> <p>An interview conducted on 07/28/11, at 3:25 PM, with the facility's Pharmacy Manager revealed the emergency medication box was picked up daily from the facility except on Sundays, was taken to the pharmacy, and the medications were counted</p>	F 425	<i>See Attachment</i>

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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F 425	Continued From page 9 and examined for expiration dates. The Manager stated a new emergency medication box was sent to the facility on a daily basis, except Sundays. The Manager stated the policy was to remove medications from the emergency medication box prior to the medication's expiration date, and stated he/she could not determine if a resident could be harmed from the use of an expired medication.	F 425	<i>See Attachment</i>	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	<i>See Attachment</i>	

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
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F 431	<p>Continued From page 10</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to store all drugs and biologicals in accordance with current accepted professional principles. Observation of the East Wing medication room revealed the facility failed to monitor medication room temperatures to ensure medications were stored at proper temperatures.</p> <p>The findings include:</p> <p>Review of the facility policy Storage of Medications (not dated) revealed medications that required storage at "room temperature" were to be kept at temperatures in accordance with the manufacturer's specifications. The policy revealed medication storage areas were to be kept clean, well-lit, and free of clutter and extreme temperatures.</p> <p>Observation on 07/28/11, at 2:55 PM, of the East Wing medication room revealed the room temperature was 84 degrees Fahrenheit. Further observation revealed ten containers with multiple individual doses of Ipratropium Bromide and Albuterol ampules (used in nebulizer treatments) were stored in the treatment cart that was</p>	F 431	<i>See Attachment</i>	

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F 431	<p>Continued From page 11</p> <p>positioned in the medication room. Further observation revealed five containers that held multiple individual doses of Albuterol 0.083% (used for nebulizer treatments) stored in the treatment cart. The manufacturer's label on the nebulizer medications directed staff to store the medication at 36-77 degrees Fahrenheit.</p> <p>Interview on 07/28/11, at 3:00 PM, with Licensed Practical Nurse (LPN) #3 (Charge Nurse) revealed the medication room was not vented for air conditioning. LPN #3 stated as long as staff was at the nurses' station to monitor the room, the door to the medication room was propped open, and a fan was used in an attempt to cool the room. LPN #3 stated the medication room remained too warm.</p> <p>Interview on 07/28/11, at 3:10 PM, with the Director of Nursing (DON) revealed the facility did not routinely monitor the medication room air temperatures. The DON stated she had been informed by the Pharmacist monthly monitoring reports, and was aware, the room was too warm. The DON also stated she was knowledgeable of the manufacturer's recommendation for storing nebulizer treatments. The DON stated when staff was available to supervise the medication room, the door to the medication room was propped open, and a fan was used in an attempt to cool the room.</p> <p>Interview on 07/28/11, at 3:40 PM, with the Pharmacy Manager revealed the pharmacy conducts a monthly inspection and issues the facility a report of items that required correction. The Manager stated manufacturer's recommendations should always be followed</p>	F 431	<i>See attachment</i>

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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 431	Continued From page 12 related to storage of medications.	F 431	<i>See attachment</i>	
F 441 SS=D	Review of the pharmacy monthly inspections dated 06/10/11 and 07/13/11, revealed the medication room temperature was 80 degrees Fahrenheit. A notation was included with the report dated 07/13/11, that the medication room was extremely warm. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	<i>See Attachment</i>	

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

PRINTED: 08/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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)
F 441	<p>Continued From page 13 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. Observation of wound care treatment provided for one of eighteen sampled residents (Resident #1) revealed staff failed to prevent cross-contamination during treatment. In addition, observation revealed staff left an ice scoop in the ice cooler after use. Observation revealed the handle of the ice scoop was in contact with the ice.</p> <p>The findings include:</p> <p>1. Review of the facility's policy Infection Control: Prevention of Cross Contamination (dated 07/14/09) revealed clean items should not come in contact with non-clean items. In addition, staff was to assure a clean surface/environment was available to place clean items on and items were not to be placed on the floor or against unclean/unsanitary conditions.</p>	F 441	<i>See Attachment</i>

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F 441	<p>Continued From page 14</p> <p>Record review of Resident #1's physician's orders revealed the resident was discharged from the hospital on 07/11/11, with diagnoses of Stage IV decubitus ulcer on the right hip, Stage III decubitus ulcer on the coccyx, Stage II decubitus ulcer on the inner ankle, and Stage I decubitus ulcer on the left hip. Continued record review revealed a physician's order dated 07/21/11, for wound care treatment for the decubitus ulcers.</p> <p>An observation of wound care for Resident #1 was conducted on 07/28/11, at 5:00 PM, and revealed Licensed Practical Nurse (LPN) #1 obtained supplies to perform wound care to the Stage IV decubitus ulcer located on Resident #1's right hip. Observation revealed the LPN placed a plastic bag of dressing supplies on a fall mat that was on the floor beside the resident's bed. There was not a clean surface to place clean items on the fall mat. LPN #1 knelt on her knees beside the bed, obtained dressing supplies (gauze dressings and normal saline) from the plastic bag on the mat, and opened/moistened the gauze with the normal saline. Continued observation revealed after the wound had been cleansed the LPN removed the soiled gloves worn during the treatment, washed her hands, applied new gloves, and knelt on the floor beside the resident's bed to continue the wound care treatment. However, based on observation, the LPN failed to provide a clean surface on which to place clean wound care supplies. LPN #1 was observed to remove wound care supplies from the plastic bag lying on the mat on the floor, drop a tube of ointment from the bag onto the floor, pick the tube up, place it on the mat on the floor, and continue to obtain supplies from the plastic</p>	F 441	<i>See attachment</i>	

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

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F 441	Continued From page 16 bag in order to complete the wound care. The LPN was observed to cleanse the resident's wound with moistened gauze three separate times during the wound care and cross from a dirty area to a clean area, and back to a dirty area each time. An interview conducted on 07/26/11, at 5:15 PM, with LPN #1 confirmed the LPN had moved supplies from a dirty area to a clean area, and back to a dirty area. In addition, continued interview with the LPN revealed she should have provided a clean surface for the wound care supplies, should have arranged the supplies on a clean surface when she began the treatment, and should not have obtained supplies from the plastic bag throughout the treatment. An interview with the DON on 07/26/11, at 6:15 PM, revealed wound care supplies should be placed on a clean surface to prevent contamination of the supplies during treatments. 2. A review of the facility's untitled policy and procedure (dated 06/23/09) related to passing ice to residents revealed standard precautions would be observed while dispensing the ice. Observation on 07/27/11, at 10:30 AM, revealed CNA #4 entered resident room 217 while wearing gloves, obtained a resident's ice pitcher from the room, and took the ice pitcher to the ice chest. The CNA was then observed to obtain the ice scoop with her gloved hand from the ice chest, fill the pitcher with ice obtained from the ice chest, place the ice scoop back in the ice chest with the handle of the ice scoop in contact with the ice, place the pitcher on the resident's overbed table.	F 441	<i>See Attachment</i>		

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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F 441	Continued From page 16 and arrange the resident's table closer to the resident's bed. The CNA was then observed to proceed to obtain the ice pitcher from the other resident in the room, take the ice pitcher to the ice chest, obtain the ice scoop from the ice, and fill the resident ice pitcher with ice before returning the pitcher to the resident's bedside table. Interview on 07/27/11, at 10:40 AM, with CNA #4 revealed the CNA was knowledgeable of the requirement to store the ice scoop in the separate container beside the ice chest when the ice scoop was not in use. However, the CNA confirmed she failed to follow the procedure and had placed the ice scoop in the ice chest with the handle of the scoop in contact with the ice.	F 441	<i>See Attachment</i>	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide firmly secured handrails in the corridors. The handrail located between resident rooms 303 and 307 was loose and not secured at one end. The handrail across from the North Wing nurses' station was also observed to be loose and not firmly secured to the wall. The findings include: Observations conducted during an environmental	F 468	<i>See Attachment</i>	

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F 468	Continued From page 17 tour of the facility on 07/27/11, at 10:30 AM, revealed the handrail between resident rooms 303 and 307 was not secured. Further observation revealed a screw was missing from the handrail that would be used to secure the handrail to the wall bracket. Continued observation revealed the handrail across from the North Wing nurses' station was loose and not firmly secured to the wall. An interview conducted on 07/28/11, at 2:16 PM, with the facility's Maintenance Supervisor revealed the Supervisor conducted rounds once a month to assess the handrails. According to the Maintenance Supervisor, staff was required to fill out a repair request form when a problem was identified to require maintenance. However, the Supervisor stated no requests had been made for repairs of the handrails and the Supervisor had not observed the loose handrails in the monthly rounds.	F 468	<i>See attachment</i>		

POC Allegation of Compliance for F225 Investigate/Report Allegations/Individuals

#1- R16& R17 no longer reside at Facility and investigation revealed locating of said property but dated investigation after reporting timelines with typed official investigation.

R18 continues to reside at the Facility. No further incidents have been reported as of this date and was corrected prior to survey exit.

#2- All residents have potential to be affected by said practice, but no additional reporting required as of this date after Administrator/Social Services Director reviewed grievance reports as of 7/28/11 and reviewed ongoing as noted below for monitoring/reporting. All said incidences were corrected prior to survey at time of occurrence and were not adversely affected. Ombudsman and Social Services Director held Resident Council meeting on 8/5/11 no other residents have been affected by said practice with no additional concerns at that time.

#3/4- Ombudsman and Social Services Director conducted Resident Council meeting on 8/5/11 to educate/re-educate resident rights. Residents were reminded of facility policy on reporting/investigating, the importance of reporting promptly and accurately. Residents voiced understanding of facility policy and regulations. SS Director/designee sent letters to family members dated 8/3/11 informing them of facility policy in addition. Family members were also informed that resident funds were available through the trust account 24 hours a day 7 days a week. No family members/residents voiced any concerns regarding these issues.

Reporting/investigation shall be initiated and completed according to facility policy and regulatory guidelines. Staff who are informed/aware of grievance shall inform SS Director/designee to initiate process accordingly in addition to assisting with any missing items as of 7/29/11. Administrator/designee shall be notified as well by reviewing grievances requiring reporting during Dept. head meetings weekly basis as detailed below.

Multiple in-services regarding policy/reporting regulations were initiated by SS Director and D.O.N. beginning 7/28/11 and repeated to all staffing departments to assure compliance including on 8/5/11, 8/10/11. Discussed policy on misappropriation of resident property, importance of assisting with locating belongings/investigation and reporting to appropriate personnel, and to document date of finding said belongings (outcome) vs. date of typing official report.

RN Consultant and Administrator in-serviced all Department managers on facility policy, State and Federal reporting requirements including timelines and procedures for reporting on 7/28/11 and 8/10/11. Discussed documentation requirements for reporting as well as the importance of documented evidence that the allegation has been reported to the appropriate state agencies per regulatory guidelines when property cannot be located prior to reporting timelines.

QA: Grievances/complaints shall be reviewed from prior working day at morning clinical meetings by SS Director/designee (if any received that week) times 60 days. Admin/designee will oversee investigation and review/send report to state agencies ongoing. Grievance logs shall be reviewed by Administrator/designee on at least a weekly basis times 60 days in addition and shall document on QA form any noted concerns/grievances not followed up on and shall notify Executive Director/designee for additional checks/balances and assure proper investigation/reporting requirements fulfilled. Issues/concerns will be discussed/reviewed at Quarterly QA meeting for additional follow up and to ensure compliance.

Date of Compliance: 8/11/11
Responsible: Administrator

Plan of Correction/Allegation of Compliance for F253 Housekeeping and Maintenance Services

#1- all areas identified in the 2567 have been corrected as of 8/19/11 for:

Chair in 321 was sanded and painted, w/c arm in room 114 replaced, wheelchair cushion and armrests in room 320 replaced, w/c cushion in 302 replaced, geri chair in room 204 replaced, bedside table in room 308 replaced, hole in closet door in room 317 repaired as well as the drawers in the dresser, drywall in resident rooms 110, 307, and 204 repaired, bathroom door room in 204 corrected, baseboard 313 bathroom replaced. Commode anchor screws: 102, 106, 111, 201, 204, 210, 216, 217, 307, and 308 have been capped. Fall mats in resident rooms 106, 210, and 301 have been corrected. The ceiling in resident room 301 has been painted. Shower chair in bathroom 217 cleaned and disinfected. Floor tiles at the shower threshold on the North Hall bathroom have been repaired.

#2- All residents have the potential to be affected by said practice. QI audits have been conducted by designated department managers assigned areas of building/rooms as of 8/1/11 by making rounds and noting on checklist for any additional areas as noted in 2567 needing repairs. Any audits that noted issues found have been identified and have been corrected as of 8/19/11 by maintenance supervisor. No adverse affects have been noted by said practice.

#3/4 In addition to maintenance supervisor making rounds daily of building, QI members are designated specific rooms and common areas to inspect for issues on a weekly basis and will document any concerns needing repaired. Items will be corrected/replaced based on findings ongoing accordingly to QI rounds performed (painting, cleaning, torn cushions, any environmental concerns, etc). QI members shall turn in QI rounds audit forms for Admin/designee review at least 2 times weekly times 60 days to assure compliance/corrections are done for QA. QI rounds form has been changed as of 8/11/11 to include items not already listed for department managers to monitor on weekly basis in addition to staff being inserviced to report and complete work order request. Admin/designee shall review work orders as well weekly times 60 days to assure being completed.

Administrator in-serviced Maintenance Supervisor, Department Managers/QI members on 8/2/11 to identify issues/procurement related to maintenance/upkeep of the facility, and to ensure compliance with identified issues/procedures and timeliness of work orders being performed. In addition all staff meeting was given by Department managers as of 8/11/11 regarding importance of notifying management of needed work repairs and to complete work orders.

Audits and concerns with QI rounds shall be discussed at next scheduled QA meeting to review outcomes as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 8/19/11 (for final item to be received/corrected)

Responsible: Maintenance Supervisor

Plan of Correction/Allegation of Completion for F371 Food Procure, Store/Prepare/Serve-Sanitary

#1- The grease drip pan was removed/corrected on July 28, 2011 and then ongoing per policy. In-service was conducted by Dietary manager 8/1/2011 with dietary staff to inform of the grease drip pan and the procedure for cleaning it per policy. Dietary Manager added the grease drip pan to the weekly cleaning schedule on 8/1/11. Cleaning of grease drip pan will be done weekly.

#2- No residents have been adversely affected by said practice as there have been no grease fires, etc. related to said practice. No additional issues have been noted since new procedures have been put into place. No other stoves in facility.

#3/4- Cleaning schedule updated on 8/1/11 by Dietary Manager and reviewed by Administrator to include weekly cleaning of grease drip pan. Dietary Manager to assure cleaning schedule and sanitary requirements are met weekly by reviewing cleaning checklist and inspecting kitchen/drip pan. Dietician added grease drip pan to her routine inspection sheet as of this date and will inspect the drip pan on monthly basis as well. QI members responsible for additional oversight to perform inspections on at least weekly basis and document on audit report form/checklist and note concerns for Administrator/Dietary Manager to address times 60 days for quality assurance in addition to dietary manager. In addition to Administrator/designee checking audits weekly times 60 days to assure performed, QA team will discuss at next scheduled QA meeting for any additional concerns.

Date of Compliance: 8/2/11

Responsible: Dietary Manager

Plan of Correction/Allegation of Compliance for F425 Pharmaceutical Svc. Accurate Procedures

#1- Pharmacy was contacted by phone and e-mail as well as letter sent informing them of expired meds. on July 29 and Aug. 1 2011 by D.O.N. New ebox has been sent out on daily basis with assurance that medications were examined prior to putting into locked box that is not routinely used but is being exchanged with new one weekly. Discontinued meds were removed same day after being notified.

#2- No resident's were effected by said practice as medications were not utilized and nurses would have also checked for expiration dates if Ebox would have been opened. There is only one emergency box in use and it is replaced daily except on Sundays. Only one ebox utilized in facility at any given time.

#3/4- Pharmacy to assure emergency box checked prior to sending to facility being locked and restock the ebox with current medications as ebox is replaced and have inserviced their staff as well. Medication box is exchanged on a nightly basis and restocked daily by Pharmacy. In-service was conducted with nursing personnel on 8/2/11 by pharmacy staff on checking medication expiration dates before administering the medication to the resident and to notify pharmacy of any noted problems for replacement as additional checks/balances. Director of Nursing in-serviced nurses and KMA's on 7/29/11 on medication storage policy as well as the expired medication policy.

The emergency box medications and expiration dates monitored monthly by the nursing staff and Pharmacy staff jointly times 60 days to assure that contracted vendor is adhering to regulations as a random audit to the exchanged Emergency Medication boxes. Issues/concerns will be documented on audit report form and reported to Pharmacy and Administrator/designee and shall be addressed promptly for quality assurance. (see attachment from/to pharmacy for additional information of their policy). Issues/concerns will be discussed/reviewed at next QA meeting for additional follow up and to ensure compliance. (This is all in addition to the pharmacist who shall continue to inspect/review all areas of quality assurance for medication administration and suggestions)

Date of Compliance: 8/3/11

Responsible: Director of Nursing

Plan of Correction/Allegation of compliance for F431 Drug Records, Label/Store Drugs

#1- On 7/28/11 the medication carts were temporarily moved from room identified and placed in other locked location temporarily until air temperature corrected. Temperatures being monitored to ensure compliance with manufacturer's recommendations where carts maintained when not in use. Area has been corrected as of 8/3/11 with monitoring temperatures and/or assuring medications stored in appropriate temperatures on a daily basis. 7/29/11 a Kuulaire air conditioning system was ordered.

#2- No residents have been affected by said practice as there have been no issues related to said practice. Medications have been maintained in appropriate room temperatures as of survey exit. No other areas identified and only other medication room/carts have been checked and in compliance for storage of medications.

#3/4- Monitoring of medication room temperatures as well as refrigerator temperatures are done daily by nursing staff to ensure medications are stored at proper temperatures. Director of Nursing monitoring temperature logs at least weekly after being corrected and will continue times 60 days. Pharmacy staff to continue to monitor medication room and refrigerator temperatures monthly with tour and shall notify issues/concerns to DON on recommendations sheet.

DON conducted in-service to nurses/KMAs on 7/29/11 to include expired medications, medication storage/refrigeration, temperatures per recommendations/policy in addition to pharmacy staff on 8/2/11.

Monthly pharmacy recommendations/notes shall be also reviewed by Administrator/designee to ensure/maintain compliance. Issues/concerns will be reviewed/discussed at quarterly QA meetings for additional follow up.

Date of Compliance: 8/3/11

Responsible: Director of Nursing

Plan of Correction/Allegation of compliance for F441 Infection Control

#1- Resident #1 continues to reside at the facility and has had no adverse effects from said practice as there has been no adverse effects related to said practice. LPN #1 in-serviced 1:1 by DON regarding importance of infection control and prevention. No further concerns noted after monitoring nurse(s) with said practice and performed without any infection control concerns as of this date.

CNA#4 in-serviced 1:1 by DON regarding ice passing policy including ice scoop should not be left in ice chest where handle of scoop could contact ice on 7/27/11 and voiced understanding of policy and procedures regarding passing ice to residents. (In addition to other interventions as noted below). No further non-compliance has been noted by employees.

#2- All residents have potential to be affected by said practice but no residents have been affected as of compliance date by monitoring infections/common bacteria reports from labs, passing of ice, monitoring wound care, and general infection control monitoring with items.

#3/4- Multiple in-services given to address infection prevention/control per policy to general all staff. As well as in-services/policies on cross contamination/infection control given by Director of Nursing to nursing staff (CNA's, KMA's Nurses) on 7/29/11 and wound cleaning/infection control given by DON to nurses on 8/12/11. Staff voiced understanding of the policies and voiced no concerns regarding these issues. DON in-serviced CNA's, KMA's and nurses on 7/29/11 regarding ice passing procedures/policy

specifically that the ice scoop should not be left in the ice chest where handle of scoop could contact ice. Staff voiced understanding of the policy/procedure and voiced no concerns regarding these issues.

In addition to in-services DON/designee are randomly monitoring licensed nursing staff on wound care to assure/remind of proper wound care procedures/infection control starting 8/1/11 weekly times 60 days. Which will have allowed to review nurses performing wound care by end of QA audits. Any ongoing issues shall be documented on QA Audit report form to be discussed for additional in-services needed or additional monitoring at that time and along with next QA meeting.

DON /designee are also randomly monitoring staff passing ice as of 8/1/11 weekly, then weekly times 60 days. Any ongoing issues are documented on Audit report form to be discussed for additional in-services needed or additional monitoring. Issues/concerns will be discussed/reviewed at next quarterly meeting and ongoing for additional follow up and to ensure compliance.

Date of Compliance: 8/13/11

Responsible: Director of Nursing

Plan of Correction/Allegation of compliance F468 Secured Handrails

#1- The handrail located between resident rooms 303 and 307 as well as the handrail across from the north wing nurses station were repaired on 7/27/11. No residents were affected by said practice. Administrator and Executive Director met with Maintenance Supervisor as of 7/29/11 to review policies/procedures regarding monitoring handrails.

#2- All residents have potential to be affected by said practice. On 8/1/11 all handrails were audited with no issues or concerns noted. No residents were affected by compliance date as no injuries/issues noted by monitoring resident incident/tracking log.

#3/4- Handrails added to department managers QI rounds sheet to be done at least weekly times 90 days in addition to maintenance adding to monthly rounds checklist for inspection. Any issues/concerns are followed up with a maintenance work order and copy given to Administrator for follow up. General All staff in-service was conducted by Executive Director with final one being 8/12/11 to educate staff on importance of reporting issues/concerns to Maintenance Supervisor and informed it is the responsibility of all staff to identify safety issues and fill out work orders. Issues/concerns will be documented on audit report form and reported to Administrator for follow up. Issues/concerns will also be discussed/reviewed for additional follow up and to ensure compliance with next scheduled QA meeting.

Date of Compliance: 8/13/11 Responsible: Maintenance Supervisor, Administrator

Edgemont Healthcare
In-Service Attendance

Topic: Abuse

Date: 8-12-11

Kelly Hagen, L.S.

~~Adly Rice~~
~~Kathy Thompson~~
~~Lacey Buckley~~
~~Therese Prater~~
~~Ronald Gammie~~
~~James Camp~~
~~Jessie Lopez~~
~~Robyn Murphy~~
~~Deborah~~
~~J. Collins Jr~~
~~Ann Frederick~~
~~Deborah Hatter~~
~~Debra Cox SRNA~~
~~Melissa~~
~~Christina~~
~~W. H. H.~~
~~Janette Randall CNA~~
~~Rita Smith SRNA~~
~~Debra Ferguson CNA~~
~~Melanie R. M. Williams~~

~~Rita CNA~~
~~Debra CNA~~
~~Michelle Moore~~
~~Debra CNA~~
~~Jessie CNA~~
~~Debra CNA~~
~~Amie CNA~~
~~Cassandra Attorney~~
~~Carl~~
~~E. Dickerson~~
~~Alon~~
~~Robert Fulton KMA~~
~~M. Wolman~~
~~Powder~~
~~J. Conn CNA~~
~~Betty Meyer~~
~~Betty Choy~~
~~Monica~~
~~Yun Jung~~

~~Debra CNA~~
~~Debra CNA~~
~~Shandra Edward~~

Comments:

See Attached Abuse Policy

F 2

Edgemont Healthcare
In-Service Attendance

Topic: abuse

Date: 8-12-11

Debby Berna	Roci Allen SRNA
M. Woodman	Bartone Mary
Kim Kelly	Shirley W. Johnson SRNA
Cassandra McNepp	Amanda Burns SRNA
Jessica WASSER	Cherise L. By
William Richardson SRNA	Monica Lee
Renee Doss - Dutay	
Janet L. ...	
Marilyn Walter	
Laura K. ...	
R. B. ...	
Robert L. ...	
Amber Green SRNA	
Deq. A. ...	
Ruth Meyer	
Anna ...	
Ann Stevens	
Alton	
L. Phillip	

Comments: See Attack Abuse Policy

ABUSE REPORTING

POLICY STATEMENT

It is the policy of this facility that all personnel promptly report any incident or suspected incident of resident abuse, neglect, or misappropriation of property.

PROCEDURES

1. Our facility will not condone resident abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals.
2. Any alleged violations involving neglect, abuse, or misappropriation of resident property, must be reported to the administrator or designee as soon as possible.
3. All personnel, resident, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff.
4. To assist our facility's staff members in recognizing incidents of abuse, the following definitions of abuse are provided:
 - a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.
 - b. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.
 - c. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
 - d. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.
 - e. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommate) against the resident's will, or the will of the resident's legal guardian or representative (sponsor). (Note: Temporary monitored separation from other residents will not be considered involuntary seclusion and may be permitted when used as a therapeutic intervention to reduce agitation as determined by the medical director, and/or the director of nursing services, and such action is consistent with the resident's plan of care.)
 - f. Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment services.

F225

Incident Reporting Policy

- g. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident lacks care in one or more areas (e.g., absences of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces).
 - h. Misappropriation of resident property is defined as patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
5. The person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the charge nurse who will report to the Administrator or designee as soon as practicable. The following information should be reported.
- a. The name of the resident involved;
 - b. The date and time that the alleged incident occurred;
 - c. Where the incident took place;
 - d. The name(s) of the person(s) committing the alleged incident, if known;
 - e. The name(s) of any witnesses to the incident;
 - f. The type of abuse that was allegedly committed (i.e. verbal, physical, sexual, etc.); and
 - g. Other information that may be requested.
6. Upon receiving a report of suspected abuse, neglect, or misappropriation of property, the charge nurse shall examine and interview the resident. Findings of the examination/interview will be recorded in the resident's medical record. The resident's physician and representative will be notified. (Note: If sexual abuse is suspected, DO NOT bathe the resident or wash the resident's clothes or linen);
7. Upon receiving suspected reports of abuse, misappropriation of property, or neglect, the Administrator or designee will report the incident to the following agencies:
- Office of the Inspector General
 Department of Community Based Services
 Law Enforcement Agency (if appropriate)
8. The charge nurse must complete an Incident Report Form and obtain a written, signed, and dated statement from the person reporting the incident.
9. A completed Copy of the Incident Report Form will be given to the Administrator/designee. An investigation will be made and a copy of the findings of such investigation will be provided to the administrator within five (5) working days of the occurrence of such incidents. This investigation will be reported to the Office of the Inspector General and DCBS.
10. When an incident of resident abuse is suspected or determined such incident must be reported to the Administrator or designee regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy.

Edgemont Healthcare
In-Service Attendance

Topic: Reporting of Abuse, Neglect and Misappropriation of resident property
Date: 8/10/11

- Deborah Zed
- Debra Taylor
- Kelly Haggard
- Linda Wright
- Paula Hill
- Barbara Butler
- Melissa Parker
- Melvin Jones
- Mike Logan
- Karen Brown
- Rosemary Christy
- Kathy Thompson

Comments: Discussed policy/documentation requirements for reporting allegations of abuse, neglect and misappropriation of resident's property, no matter the amount. Evidence that the allegation has been reported to the appropriate state agencies. Investigation to begin immediately with proper documentation and reporting per facility policy.

Edgemont Healthcare
In-Service Attendance

Topic: Abuse Reporting / Dept head
Date: 7-28-11 in-service

- Laetia Healy
- Michelle
- Sari Hill
- William Hill
- Deborah Zell
- William D'Amico
- Emma Brown
- Mary Hagan
- Harold
- David
- Kathy Thompson

Comments:

Department managers and Administrator were in-service by owner Bonnie Laetia regarding investigating/reporting requirements for allegations of misappropriation of funds, neglect, and state and federal requirements including timelines, policy and grievance forms.

Department managers also reminded that they are managers on duty for holidays and weekend and to follow policy on investigations/reporting.

ABUSE REPORTING

POLICY STATEMENT

It is the policy of this facility that all personnel promptly report any incident or suspected incident of resident abuse, neglect, or misappropriation of property.

PROCEDURES

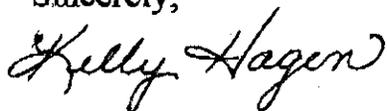
1. Our facility will not condone resident abuse by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals.
2. Any alleged violations involving neglect, abuse, or misappropriation of resident property, must be reported to the administrator or designee as soon as possible.
3. All personnel, resident, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff.
4. To assist our facility's staff members in recognizing incidents of abuse, the following definitions of abuse are provided:
 - a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.
 - b. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.
 - c. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
 - d. Physical abuse is defined as hitting, slapping, patching, kicking, etc. It also includes controlling behavior through corporal punishment.
 - e. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommate) against the resident's will, or the will of the resident's legal guardian or representative (sponsor). (Note: Temporary monitored separation from other residents will not be considered involuntary seclusion and may be permitted when used as a therapeutic intervention to reduce agitation as determined by the medical director, and/or the director of nursing services, and such action is consistent with the resident's plan of care.)
 - f. Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment services.

F205

To: Family Members
Date: 8-3-11
From: Edgemont Healthcare
323 Webster Ave.
Cynthiana, KY 41031

It is our priority to ensure that your loved ones belongings and money are kept safe at all times. However, we need your cooperation at all times to aid us with this. Once again, we are asking that any money you bring in, please do not leave with the resident. Money can be deposited into resident trust account in the business office. If it is after hours, money can be left with the charge nurse and then deposited the next day. If you would like to send your loved one money in the mail, please send it separately to the business office to be deposited into their account. It is not facility policy to replace any misplaced money or personal items. Many of our residents simply do not remember spending money or where they placed their money. Some remember money from a time long ago. These situations then become stressful for the resident and the facility. This happens frequently and can be minimized by utilizing the resident trust account. Residents have access to their money 24/7. We also do not encourage cell phones and any items of value to be brought in. Please be sure resident name is on all clothing and personal items. Please be sure to give charge nurse or social services a list of items brought in for the resident to be added to their inventory list. If you have any questions please call the facility. Thank you for your cooperation.

Sincerely,



Kelly Hagen, S.S.

F285

Edgemont Healthcare
In-Service Attendance

Topic: Resident's Rights

Date: 8-5-11

- | | | |
|------------------------|-------------|-------------------------------------|
| <u>Donna Hill</u> | <u>ADON</u> | <u>Benny White</u> |
| <u>Sheila Smith</u> | | <u>Lona Winkle</u> |
| <u>Donna Hill</u> | | <u>James Westfall</u> |
| <u>Benny White</u> | | <u>Michael Mordock</u> |
| <u>Kenneth Smith</u> | | <u>David Todd</u> |
| <u>Enich Stidham</u> | | <u>Dorothy Bell</u> |
| <u>Charles Beasley</u> | | <u>Buck West</u> |
| <u>Roger Stoves</u> | | <u>Edith Reed</u> |
| <u>Kelly Vaughn</u> | | <u>Benny Pies</u> |
| <u>Imed Outley</u> | | <u>Arnd Whalen</u> |
| <u>Clara McKenzie</u> | | <u>Martha LaShane</u> |
| <u>Sharon Horn</u> | | <u>Neal Lewis</u> |
| <u>Marcella Atkins</u> | | <u>Etta Richardson</u> |
| <u>Alie Huguey</u> | | <u>Robert Mergard</u> |
| <u>Randy Turner</u> | | <u>Sandy Spiker</u> |
| <u>Shirley Lyman</u> | | <u>Naomi Small</u> |
| <u>Elizabeth Kider</u> | | <u>Virginia Jones</u> |
| <u>Dee Johnson</u> | | <u>Margaret Hill</u> |
| <u>Phyllis Hannah</u> | | <u>Coral C. Osterman, Ombudsman</u> |
| | | <u>Kelly Hagen</u> |

Comments:

How did do.
Melinda MK

see attached

Residents Rights Reviewed. Res Trust & Personal
Time Reviewed.

F825

Initial Report of Incident/Allegation

To: Department of Community Based Services
 Office of the Inspector General

From: EDGEMONT HEALTHCARE
323 WEBSTER AVENUE
CYNTHIANA, KY 41031

RE: Initial Report of Incident/Allegation

Resident Name: _____
DOB: _____ SSN: _____
Date of Incident: _____ Time of Incident: _____

Description of Incident: _____

Description of Injury: _____

The aforementioned incident/allegation is under facility investigation, per facility policy. Investigation findings will be reported to the Office of the Inspector General within five (5) days as applicable, per statute.

Printed name of reporting person

Signature of reporting person

Date/Time

Fax completed report immediately to:
OIG# 859-246-2307
DCBS # 859-245-7136

F825

Administrative Investigation Report

Re: _____

Date _____

Report by: _____

Title _____

To Whom _____

Title _____

Incident Date _____

Time _____

Name of Resident Involved

1. _____

Room _____

2. _____

3. _____

Staff Involved

1. _____

Title _____

2. _____

3. _____

Nature of Occurrence

Time _____

Place _____

Investigative Action

FA25

Administrative Investigation Report

Re: _____

Date _____

Resolution:

Is a Five-Day Follow-up Required?

Additional Comments:

Signature _____

Date _____

FD25

Administrative Investigation Report

Re: _____ Date: _____

Other Persons or Agencies Notified of the Occurrence:

_____ Date/Time _____

Plan of Action/Prevention:

Method to Monitor Intervention:

08/17/2011 10:50:19 AM -0500 Direct Supply, Inc

PAGE 2 OF 2 *F25*CORPORATE OFFICES
414-358-2805SALES OFFICES
800-634-7328
FAX 800-770-1707

Aug-17-2011

Order #: 17299315

Purchase Order #: VERBAL LORI

Ms. Lori Giles
Payroll
Edgemont Healthcare-AMT
323 Webster Ave
Cynthiana, KY 41031

Dear Lori:

Thank you very much for your order today. To help with your records, I am providing you with confirmation of your order. You will find an area to note when each item has been delivered.

Please call me if you have any questions. I can be reached on my toll-free line at 866-339-1602. The Direct Supply Network allows you to build quotes and track orders online. Call me or log on to www.DirectSupply.net for more details.

Sincerely,

Ryne Kunce
Account Manager

Item #	Item Description	Qty	Price Each	Delivery By	Arrived Notes
0-19121	PROMO Alarm, Attendant, Deluxe and 45-Day Bed Pad, Six30i	1	\$0.00	8/26/2011	
0-19123	PROMO Alarm, Attendant, Voice and 45-Day Chair Pad	1	\$0.00	8/26/2011	
0-94007	Alarm, Attendant Economy Pull String Magnet Monitor	1	\$0.00	8/26/2011	
0-93152	Direct Choice Bedside Mat, Bi-Folding, 36iWx68iLx2iH	3	\$104.99	8/25/2011	

Order Online at www.DirectSupply.net
6767 North Industrial Road • Milwaukee, WI 53223

Received Time Aug. 23. 2011 3:59PM No. 1607

FA53
F468

Edgemont QI Rounds to be completed by QI members. Please complete at least 2 times daily after 10:00 to allow for am care rounds.

Name _____ Title _____
List RM#s/Area _____

Room # and Action Needed	Area/Misc	OK	Area and Action Needed-Additional Comments in General
Room # and Action Needed	Area/Misc	OK	Area and Action Needed-Additional Comments in General
Hand hygiene needs met-shaven, hair groomed, nails clean, appropriate/clean attire, no odors, eyes not matted, had good oral care, (what you would want)	East/North (circle) Hall/Unit; Floors clean (not sticky. Nothing on Floors and free of clutter		
Special need equipment in place (see chart Plan for specifics) bed/body alarms in place, mat on floor, respiratory equip. in place/clean, splints, special therapy positioning devices, etc. Side Rails per order (properly positioned at all times)	All equipment cleaned according to schedule shower chairs, w/c geri-chairs, pumps, hoover lifts, ice coolers etc./No ext. Cords		
Linens clean and bed made - free of crumbs/food crumbs (no frayed linens)	All items on one side of hallway-safe pass.		
Center Free-nothing on floor-trash cans in room does not contain diapers/ect. Room looks tidy overall.	Trash can/sharps containers not more than 3/4 full		
Water pitcher/ice and water - unless NPO	Dining Rms clean		
Suction machine covered and emptied - O2 tubing dated and bagged when not in use	Nsg stations/clean and HIPPA maintained		
Call-light within reach-working	Housekeeping carts locked		
Tables/Misc. clean including under bed and furniture.	No equip. in hallway free of hazards-carts/lifts		
Food in appropriate containers-no food left if needing refrigerated	Maintaining of hand-washing/knocking on doors		
Bathroom-clean and odor free.	Call lights being answered quickly		
Commode-base/bowl clean	STAFFING: name badges/gait belts on		
Privacy curtain clean and neat-privacy provided in/out of rooms	Appropriate attire/clean jewelry not appr.		
Other environmental issues, please list	Professional to others		
Maintenance request form filled out for: (please complete)	Not C/O staffing etc.		
Torn or marred equipment/furniture (ie. wheelchairs, cushions, mats, etc.)	Staying busy, talking with resident, not each other.		
Handrails light.			

F25

Edgemont Healthcare
In-Service Attendance

Topic: Housekeeping and Maintenance procedures
Date: August 2, 2011
Department managers

Deborah Zeeh
Kelly Hagen
Melissa
Barbara
William
David
Janet
John
...

Comments:

Discussed housekeeping and maintenance procedures with department managers.
Discussed importance of monitoring/repairing handrails to ensure the safety of everyone at the facility. Make recommendations on going. Please fill out work orders and turn them into maintenance promptly.

F253

Edgemont Healthcare
In-Service Attendance

Topic: Housekeeping and Maintenance
Date: August 2, 2011
procedures
Department managers

Deborah Zech
Kelly Hagan
Melissa Ann
Erin Smith
Missy Miller
Kari Smith
Karen Brown
Debra J. Smith
Phil

Comments:
Discussed housekeeping and maintenance
procedures with department managers.
Discussed importance of monitoring repairing
problems to ensure the safety of
everyone at the facility. Make recommendations
on going. Please fill out work orders on
issues identified and turn them in to
maintenance promptly.

F853

Edgemont Healthcare
In-Service Attendance

Topic: Hand Rails / Drywall / Form-tilt Chaco
Chair Chair

Date: 8/12/11

~~Steve Tuley~~
~~Castello Pletty~~
~~Kahe Moele~~
~~Ann Frederick~~
~~Susan Quereby~~
~~Jessica SRNA~~
~~R. Hagen SS~~
~~M. Uchmanen~~
~~S. S. Wilton~~
~~Christina Toney~~
~~Curt Carstard~~
~~Deanna Probst~~
~~Ashley Lipe~~
~~Matt Mack~~
~~Anna Beth Rimontas~~
~~Lacey Buckley~~
~~Laura S. Thomas~~
~~Dee S. Smith~~
~~Cheryl Kitcher~~
~~Alory~~

~~Adam Wherick~~
~~Robyn Elemen RN~~
~~Blair H. H. H.~~
~~Barbara L. L.~~
~~Michelle Peck~~
~~Rita Smith SRNA~~
~~Deborah J. J.~~
~~Michelle J. J.~~
~~Dianna E. E.~~
~~Christina T.~~
~~Shirley L.~~
~~R. Callan~~
~~R. J.~~
~~W. J.~~
~~Mandy W.~~
~~Amanda Burns SRNA~~
~~Ann C. C.~~
~~Ann C. C.~~
~~E. G. E.~~
~~W. J. W.~~

~~Shaunara Edwards~~
~~Jessica J. J.~~
~~Cara W.~~
~~R. Fulton~~
~~H. Bullenger~~
~~Ricardo SRNA~~
~~Meaia~~
~~Amber Jones SRNA~~
~~Christina J. J.~~
~~Symona C. C.~~
~~Patty Meyer~~
~~Betty J. J.~~
~~Emilia L.~~
~~W. J. W.~~
~~W. J. W.~~

Comments:

Hand rails checked randomly by
employees. Handrails, signals, will
be done on report to Department study
Maintenance Dept.

all ^{fire} will be reported to maintenance /
department head.

Sign or drywall issues will be reported
to maintenance

F 253

Edgemont Healthcare
In-Service Attendance

Topic: Housekeeping and Maintenance issues
procedures

Date: 8/2/11

Maintenance
Supervisor

Mita Hagan

Comments:

F805

Edgemont Healthcare
In-Service Attendance

Topic: Housekeeping/Maintenance procedures/
procurement
Date: 8/2/11
Maintenance

Geetha M. K. P.
Michelle Hager

Supervisor
and
Executive
Director

Comments:

SquirrelMail

F253

Shipping and Pickup Information

Site to Store

Pickup Person:

~~2160101010101~~

The person(s) listed above will receive an email when the order is ready for pickup

To add another pickup person, click this link:

https://www.walmart.com/cservice/add_pickup_person_post_order.do?order_id=267780742

Remember, you can edit the pickup person information from the Order Details page under Your Account.

Walmart.com

Order Number: 2677807-423443

Shipping Method: Store Pickup

ITEM	QTY	ARRIVAL DATE	PRICE
Night Stand with Door; Color: Natural Sep 1 \$45.00	2	Ready for pickup starting Thu.,	

Pick up this item at: Wal-Mart Supercenter #591 805 Us Highway 27 S ,
Cynthiana KY 41031 (859) 234-3232

Subtotal: \$90.00

Shipping: Free

Tax: \$5.40

Walmart.com Total: \$95.40

Learn more about our Returns Policy:

<http://www.walmart.com/catalog/catalog.gsp?cat=535459>

Contact Customer Service:

http://www.walmart.com/cservice/cu_comments_online.gsp?cu_heading=9

ORDER SUMMARY

Order Date: 08/19/2011
 Subtotal: \$90.00
 Shipping: Free
 Tax: \$5.40

Order Total: \$95.40
 Credit card: \$95.40

BILLING INFORMATION

F371

Cleaning Ranges (Gas)

Policy:

Ranges will be kept clean and free of spills and grease.

Procedure:

1. Range tops should be cleaned daily or on each shift as assigned by the food service director.
2. Wipe up spills as they occur to make general cleaning easier.
3. Avoid over-filling pans to avoid excessive spills.
4. Remove each section of the cooking surface and wash in hot detergent water. Use a stiff bristle brush to remove hard to remove spills.
5. Remove drip pans and wash in hot detergent water. Use a stiff bristle brush to remove hard to remove spills.
6. Wipe all exterior parts of the range with a cloth and warm detergent water. Clean sides, back, front, shelf, and burner knobs.
7. Rinse cooking surfaces and drip pans in fresh hot water and return to the range after drying.
8. Clogged burners should be opened with a narrow brush or wire.
9. Hot top cooking surfaces should be cleaned in hot detergent water in a pot sink.

F371
~~000~~DIETARY SERVICES SYSTEM ASSESSMENT
FOOD SERVICE SANITATION

	YES	COMMENT
REA	✓	
storeroom	✓	
shelves, walls, and floor clean		
Food Stored on shelves (no boxes on floor) and in a manner protecting it from contamination	✓	
No damaged cans, packages stored on shelves	✓	
Food, paper supplies only stored in storeroom	✓	
Toxic items (such as insecticides, detergent, polishes) not stored with food.	✓	
Toxic items properly labeled	✓	

	YES	COMMENT
WAREWASHING AREA	✓	
Dishes, flatware, scraped and pre-rinsed	✓	
Dishes, flatware, etc. racked properly		
*Dishmachine temperatures correct:	✓	
Temperature Disinfect 150° Wash 180° Rinse		
Chemical Disinfect 120° Wash 120° Rinse		
*Manual sanitation adequate (immersion for at least 1 minute in a solution containing not less than 50ppm and not more than 200 ppm of available chlorine.		
Racks stored off floor at end of duty	✓	

	YES	COMMENT
REFRIGERATORS	✓	
*Thermometer in place, temperature 45°F or below	✓	
Shelves, walls and bottom of refig. Clean		
Leftovers, juices, etc. in covered containers and labeled and dated	✓	
Raw foods not stored over cooked foods	✓	
Outside refrigerator clean	✓	

	YES	COMMENT
FREEZERS	✓	
*Thermometer in place; temperature 0°F or below	✓	
Shelves, walls and bottom of freezer clean	✓	
Foods properly wrapped and labeled		

	YES	COMMENT
FOOD PREPARATION AREA	✓	
Range and grill clean, no old spills	✓	
Drip pans clean	✓	
Ovens clean and free from old spills	✓	
Hood and filters clean	✓	
Work tables and drawers clean	✓	
Slicer blade, base and handle clean	✓	

F37

AREA	YES	COMMENT
Cupboards clean inside and outside	✓	
Pots and pans stored inverted or on rack	✓	
Three compartment sink for pot and pan washing	✓	
Pots and pans air dried	✓	
Mixer and base clean and free from old spills	✓	
Blender/Food Processor clean and free from old spills	✓	
Toaster, outside clean, crumb tray clean	✓	
Can opener, clean, blade sharp	✓	
Ingredient bins clean and marked with name	✓	
Scoops stored outside ingredient bins	✓	
Hot/Steam Table clean; temperature controls working properly	✓	

FOOD HANDLING	YES	COMMENT
Potentially hazardous foods refrigerated until serving time	✓	
Tongs or gloves used to handle foods such as bread rolls, etc.	✓	
Dishes, flatware, glasses handled to prevent contamination	✓	
*Frozen foods thawed in refrigerator, under cold running water (if in well-sealed covering) or in microwave	✓	
*Hot Foods kept at 140°F or above and cold food kept at 45°F or below during display and service	✓	
*Food is transported to dining room and resident rooms in a way that protects from contamination (covered containers, wrapped or packaged)	✓	
Potentially hazardous refrigerated leftovers are discarded after 24 hours	✓	

GENERAL	YES	COMMENT
*Lavatory available for handwashing	✓	
*Soap, paper towels and waste basket available	✓	
Floor and walls clean	✓	
Unauthorized traffic prohibited in kitchen	✓	
Smoking and eating prohibited in kitchen	✓	
Employees wearing clean uniforms/clothing	✓	
Employees wearing hair nets or specified covering for hair	✓	
Cleaning schedule posted	✓	

8011

AREA	YES	COMMENT
*Foods obtained from services approved or considered satisfactory by Federal, State or Local authorities	✓	
*Potable and no potable water systems are connected in accordance with State or Local laws	✓	
*All sewage, including liquid waste, properly disposed by a public sewage system or by sewage disposal system constructed and operated in accordance with State or Local laws	✓	
*Garbage and refuse containers are in good condition (no leaks) and was is properly contained in dumpsters or compactors	✓	
*There is no sign of rodent or insect infestation	✓	
*The water source is safe; sufficient hot and cold water under pressure	✓	

RECOMMENDATIONS:

Kitchen looks good - keep up the good work. Gross trap was inspected & looks fine.

CORRECTIVE ACTION (Include dates problem areas were corrected)

Gross trap has been added to cleaning schedule & inspections.

J. Watermiller, RD, W
Conducted By

8-3-11
Date

*Indicates these are monitors from Dietary Task 9 Food Service Sanitation.

F371

"Quick Rounds" Checklist

Complete by
8/21/11

Surveys Due: 12/31/11

AD

8/15/11

Area Requiring Action or Area Requiring to be Cleaned	Assigned Employee	Date Completed
---	-------------------	----------------

Both sets of Basement Steps	Beth	8/19/11 AR 8-19
-----------------------------	------	-----------------

Sweep/Map Basement	Matt	8/19/11 MS
--------------------	------	------------

Floor Under Dishmachine	Chelsea	8/21
-------------------------	---------	------

Walls Around Dishmachine	Ruth Ruth	8/20/11 MS
--------------------------	-----------	------------

Fans	Lacey L Blacey	8/20/11 AR 8-20
------	----------------	-----------------

Inside/outside of All Basement	Veronica	8/19/11 MS
--------------------------------	----------	------------

Fridge/freezers	Michaela	8/19/11 MS
-----------------	----------	------------

* Wall Behind drink Table	Donna	8/21
---------------------------	-------	------

* De-lime Dishmachine	Ashley	8/21
-----------------------	--------	------

* Grease Traps		
----------------	--	--

* When Complete have someone check that complete *

F371

"Quick Rounds" Checklist

complete by
8/14/11

(10)

Signature Date

When Completed

8/8/11

Area Requiring Attention Area Needing to be Inspected	Assigned Employee	Date Completed
Both Sets of Basement Steps	Amber	NLWL
Sweep/mop Basement	Chelsea	Chelsea 8-13-11 (10)
Floor Under Dishmachine	Ruth	Ruth 8-13-11 (10)
Walls Around Dishmachine	Lacey	Lacey 8-12-11 (10)
Fans	Veronica	Veronica 8-12-11 (10)
Inside/outside All Basement Fridge/Freezers	Michaela	(10)
Wall Behind drink table	Donna	DK 8/14/11 (10)
Delime Dishmachine	Ashley	AR 8/14/11 (10)
Grease traps	Beth Laura Beth	8-14 AR 8-14

* When complete have some check and

Received Time Aug, 23, 2011 3:59PM No. 160 that complete *

Quick Rounds Checklist

Complete by
8/7/11

8/1/11

Sign & Date
when
Completed



Area Requiring Cleaning or Area Needing to be Cleaned	Assigned Employee	Date Completed
--	-------------------	----------------

Both Sets of Basement Steps Chelsea

Sweep/mop Basement Ruth RB 8/1/11 ABC

Floor Under Dishmachine Lacey LB 8-3-11 ABC

Walls Around Dishmachine Veronica U.K.P. ABC

Fans Michaela MJ 8-5-11 ABC

Inside/outside All Basement Donna 8/4/11 ABC
Fridge/Freezers

Wall Behind drink Table Ashley AL 8-4-11 U.K.P.

* Delime Dishmachine Beth ABC 8/3/11 ABC

* Grease Trap Amber 8-3-11 U.K.P.

* when complete have someone check
and Initial off that complete.

F37,

Edge: QI Rounds to be completed by QI members. Please complete at least 2 times daily.

Date: 8-5-11

Dietary/Basement Area	Initials							
Dishes/Pan are put away free of particles.	Q	B.H						
Dishes Dry/Pans Dry?	✓	✓						
Only Resident Items in Refrigerator	✓	✓						
Dented Cans Properly Stored.	✓	✓						
Scoops are properly stored.	✓	✓						
Proper Hand washing	✓	✓						
Proper Glove Use	✓	✓						
Hair Nets On Properly	✓	✓						
Food refrigerated promptly	✓	✓						
Raw meats stored on shelves below fruits vegetables or other ready to eat foods, so meat juice does not drip on these foods.	✓	✓						
Towels/Cloths stored properly	✓	✓						
Thawing food in proper container and area.	✓	✓						
Tray line free of cross contamination	✓	✓						
Log Book's Checked?	✓	✓						
Mixer/Blender/Toaster/ Food Proc./Slicer checked/stored properly.	✓	✓						
Refrigerator checked for proper labeling/dates	✓	✓						
Shelves/bottom of refrig. Checked	✓	✓						
Food stored on shelves not on floor.	✓	✓						
Thermometer in Place.	✓	✓						
Walls/floor checked	✓	✓						
Range and Oven checked	✓	✓						
Foods Properly rapped in freezer and refrigerator	✓	✓						
All Items stored in a manner to prevent cross contamination.	✓	✓						
Dish Machine/Sink washing/sanitizing correctly?	✓	✓						
	✓	✓						

Pr Received Time: Aug. 23, 2011 3:59PM No. 1607

*Any Comments, put on QA Form and inform Administrator or Executive Director.

F-311

Edge: QI Rounds to be completed by QI members. Please complete at least 2 times daily.

Date: 8/3/11

Dietary/Basement Area	Initials								
Dishes/Pan are put away free of particles.	OK	OK							
Dishes Dry/Pans Dry?									
Only Resident Items in Refrigerator									
Dented Cans Properly Stored.									
Scoops are properly stored.									
Proper Hand washing									
Proper Glove Use									
Hair Nets On Properly									
Food refrigerated promptly									
Raw meats stored on shelves below fruits vegetables or other ready to eat foods, so meat juice does not drip on these foods.									
Towels/Cloths stored properly									
Thawing food in proper container and area.									
Tray line free of cross contamination									
Log Book's Checked?									
Mixer/Blender/Toaster/ Food Proc./Slicer checked/stored properly.									
Refrigerator checked for proper labeling/dates									
Shelves/bottom of refrig. Checked									
Food stored on shelves not on floor.									
Thermometer In Place.									
Walls/floor checked									
Range and Oven checked									
Foods Properly rapped in freezer and refrigerator									
All Items stored in a manner to prevent cross contamination.									
Dish Machine/Sink washing/sanitizing correctly?	OK	OK							

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Edgemont Dietary QI Rounds to be completed by QI members. Please complete at least 2 times daily.

Date: _____

Dietary/Basement Area	Initials							
Dishes/Pan are put away free of particles.								
Dishes Dry/Pans Dry?								
Only Resident Items in Refrigerator								
Dented Cans Properly Stored.								
Scoops are properly stored.								
Proper Hand washing								
Proper Glove Use								
Hair Nets On Properly								
Food refrigerated promptly								
Raw meats stored on shelves below fruits vegetables or other ready to eat foods, so meat juice does not drip on these foods.								
Towels/Cloths stored properly								
Thawing food in proper container and area.								
Tray line free of cross contamination								
Log Book's Checked?								
<input checked="" type="checkbox"/> Stove/Grease Trap cleaned								
Mixer/Blender/Toaster/ Food Proc./Slicer checked/stored properly.								
Refrigerator checked for proper labeling/dates								
Shelves/bottom of refrig. Checked								
Food stored on shelves not on floor.								
Thermometer in Place.								
Walls/floor checked								
Range and Oven checked								
Foods Properly rapped in freezer and refrigerator								
All Items stored in a manner to prevent cross contamination.								
Dish Machine/Sink washing/sanitizing correctly?								

Received Time: Aug. 23, 2011, 3:59PM No. 1607

*Any Comments, put on QA Form and inform Administrator or Executive Director.

FHZ

MEDICATION ORDERING AND RECEIVING FROM PHARMACY

IC5a: EMERGENCY PHARMACY SERVICE AND EMERGENCY KITS

Policy

Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, controlled substances and products for infusion is supplied by the provider pharmacy in limited quantities, in compliance with applicable state regulations. If the infusion pharmacy and provider pharmacy are not the same, then the infusion pharmacy will provide the products for infusion emergency supply and infusion emergency medications.

Procedures

- A. Telephone/fax numbers for emergency pharmacy service are posted at the facility.
- B. When an emergency or "stat" order is received, the charge nurse:
 - 1) Follows the procedure for order documentation in accordance with the policy on Prescriber Medication Orders (see IB1: PRESCRIBER MEDICATION ORDERS).
 - 2) Determines that the order is a true emergency, i.e., order cannot be delayed until the scheduled pharmacy delivery.
 - 3) Ascertains whether the ordered medication is contained in the emergency kit by referring to the list of contents posted (on the emergency kit/box).
 - 4) If the medication is not available, calls the pharmacy. If it is after pharmacy hours, the nurse uses the after-hours emergency number(s).
- C. The dispensing pharmacy supplies emergency or "stat" medications according to the (dispensing pharmacy provider, noncontract or infusion therapy products) agreement.
- D. ~~If medications are used from the emergency box, the nurse completes the emergency ebox usage form, faxes it to the pharmacy and places the completed sheet inside the e-box. If the medication is not in the e-box the nurse contacts the pharmacy if the medication is needed before the next scheduled delivery.~~
- E. The dispensing pharmacy is called if an emergency arises requiring immediate pharmacist consultation about appropriateness of therapy, drug information, etc. If the required information is unavailable from the dispensing pharmacy, the pharmacy will determine the appropriate method for obtaining it.
- F. The emergency supply is maintained at a designated area, along with a list of supply contents posted on the emergency box.
 - 1) Emergency controlled substances are kept under double lock (key/code) in a designated medication cart.

FHZE

MEDICATION ORDERING AND RECEIVING FROM PHARMACY

- 2) Refrigerated emergency drugs are kept in a medication refrigerator under double lock (key or code).
- G. When an emergency or starter dose of a medication is needed, the nurse removes the required medication from the emergency stock.
- H. As soon as possible, the nurse records the medication use on the medication order form and faxes it to the pharmacy. The nurse places the completed form in the emergency box after it is faxed. This fax serves as notification to the pharmacy that the emergency stock needs replacement.
- I. Use of the medication is noted on the resident's medication administration record (MAR) as are all medications.
- J. Before reporting off duty, the charge nurse indicates the "opened" status of the emergency kit at the shift change report, and transfers the new medication orders to oncoming staff.
- K. If exchanging kits, when the replacement kit arrives, the receiving nurse gives the used kit to the pharmacy personnel for return to the pharmacy. If replacing used doses of medication, the nurse replaces the medication in the appropriate area.
- L. If exchanging kits, used kits are replaced with sealed kits within (72 hours) of opening. If replacing used medications, the replacement doses are added to the kit within (72 hours) of opening.
- M. The kits are inventoried by the consultant pharmacist or the provider pharmacy at least every thirty (30) days for completeness and expiration dating of the contents.
- N. For controlled substances in the emergency supply:
 - 1) Controlled substances from the emergency supply are reordered by faxing over a copy of the controlled drug sign out sheet indicating who used the controlled drug so that replacement occurs within (seventy-two (72) hours).
 - 2) The consultant pharmacist checks the controlled substances in the emergency supply monthly and reports any irregularities to the Director of Nursing.
 - 3) The controlled substances in the emergency supply are stored under double lock (key/code) in a designated medication cart (refrigerated controlled substances i.e. Ativan or Lorazepam are double locked in a designated refrigerator for medications). These controls are counted like all controls when keys are exchanged at shift change.

MED CARE PHARMACY

"Large enough to SERVE. Small enough to CARE"

350 Aristocrat Drive Suite B, Florence, KY 41042

Phone: (859) 689-7130 (800) 231-9070

Fax: (859) 689-6212 (800) 260-3393

Revised 12/21/10

F-425

MEDICATION EXPIRATION DATING****THE FOLLOWING MEDICATIONS MUST BE DATED ONCE THEY ARE OPENED! ******The following items MUST be refrigerated at ALL times!**

<u>MEDICATION</u>	<u>EXPIRATION DATE</u>	<u>COMMENTS</u>
Azasite Ophthalmic Soln.	14 days after opened	Keep Refrigerated! It has 14 days expiration once opened. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.
Flu Vaccines	30 days after opened	Keep Refrigerated! It has 30 days expiration once opened. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.
Lorazepam Intensol	90 days after opened	Keep Refrigerated! It has 90 days expiration once opened. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator, or 30 days expiration is stored at room temperature.
TB skin test/PPD/Tubersol	30 days after opened	Keep Refrigerated! It has 30 days expiration once opened. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.
Pneumovax 23/MDV	30 days after opened	Keep Refrigerated! It has 30 days expiration once opened. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.

The following items MUST be kept refrigerated until opened!

<u>MEDICATION</u>	<u>EXPIRATION DATE</u>	<u>COMMENTS</u>
Insulin Vials	28 days after opened	Keep Refrigerated until opened! It has a 28-day expiration once opened or at room temperature. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.
Calcitonin Salmon (generic for Miacalcin)	35 days after opened (Date when opened)	Keep Refrigerated! It has a 35-day expiration once opened. Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.
Levemir	42 days after opened	Keep Refrigerated until opened! This has a 42 day expiration date once opened.
Mucomyst/ Acetylcysteine Vials	96 hours after opened	Keep Refrigerated after opened! If not opened, product has an expiration on the original bottle.
Xalatan Eye Drops	6 weeks at room temp. (Date when opened)	Keep Refrigerated until opened! This has a 6-week expiration date once opened.
Byetta	30 days at room temp (Date when opened)	Keep Refrigerated after opened! Prior to opening, it has an expiration date on the original bottle if kept in the refrigerator.

<u>MEDICATION</u>	<u>EXPIRATION DATE</u>	<u>COMMENTS</u>
Ear Drops/Eye Drops/ Nose Sprays	180 days after opened	If not opened, product has an expiration on the original bottle; if stored at room temperature.
Oxycodone oral conc. 20mg/ml	90 days after opened	If not opened, product has an expiration on the original bottle; if stored at room temperature.
Sodium Chloride Irrigation Soln.	24 hours after opened	If not opened, product has an expiration on the original bottle; if stored at room temperature.
Sterile Water Irrigation Soln.	24 hours after opened	If not opened, product has an expiration on the original bottle; if stored at room temperature.
Heparin Lock Flush (MDV)	28 days after opened	If not opened, product has an expiration on the original bottle; if stored at room temperature.
Bacteriostatic Sodium Chloride Flush (MDV)	28 days after opened	If not opened, product has an expiration on the original bottle; if stored at room temperature.

F425

MEDICATION STORAGE IN THE FACILITY

IDI: STORAGE OF MEDICATIONS

Policy

Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

Procedures

- A. The provider pharmacy dispenses medications in containers that meet legal requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Transfer of medications from one container to another is done only by the pharmacy.
- B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.
- C. Orally administered medications are kept separate from externally used medications, such as suppositories, external liquids, and lotions.
- D. Intravenously administered medications are kept separate from orally administered medications.
- E. Eye medications are kept separate from ear medications.
- F. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area.
- G. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in a locked area separately from medications.
- H. Schedule II, III, IV, and V controlled medications are stored separately from other medications in a double locked (key or code) drawer or compartment designated for that purpose.
- I. Medications requiring storage at "room temperature" are kept at temperatures in accordance with the manufacturer's specifications.
- J. Medications requiring "refrigeration" or "temperatures between 2°C (36°F) and 8°C (46°F)" are kept in a refrigerator with a thermometer to allow temperature monitoring.
- K. Refrigerated medications are kept in a refrigerator designated for medications and liquids/foods used in administering medications in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. (Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator.)

F42E

MEDICATION STORAGE IN THE FACILITY

- L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (see Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reordered from the pharmacy (see IC3: ORDERING AND RECEIVING MEDICATIONS FROM THE DISPENSING PHARMACY), if a current order exists.
- M. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures.
- N. Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified.

F425



Edgemont inservice

Friday, July 29, 2011 7:52 PM

From:

To: "

<

Cc: "

Will you please call Edgemont DON to schedule an inservice on:

1. The use of an emergency box
2. Checking medication expiration dates before administering the medication to the resident
3. Review the medication list and how its broken down into each category
4. Check with Gwen to see if she wants to add additional information

Joe Mashni, Pharm.D.
Med Care Pharmacy
350 Aristocrat Drive Suite B
Florence, KY 41042
P (859) 689-7130
Fax (859) 689-6212
JMashni@gomedcare.com

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F425

Edgemont Healthcare
323 Webster Ave.
Cynthiana, KY 41031

August 1, 2011

Med Care Pharmacy
350 Aristocrat Drive Suite B
Florence, KY 41042

Delivery Method: Via email

Dear

We completed our annual state survey on July 28, 2011. During this survey, we were given a citation in Pharmacy Services. One of the examples listed under this citation was multiple expired medications available for use in the po emergency box, some expiring in April 2011. We have an in service scheduled with Gretchen Ramsey, on 8/2/2011 to educate staff on the use of the emergency box, checking medication expiration dates and administering medications to the residents, and reviewing the medication list and how it is broken down into each category. I have also made arrangements with Ms. Ramsey and a staff member from this facility to monitor the emergency box medications and expiration dates once monthly for 3 months. I would like to know what you have done prior to the emergency box arriving at the facility to assure that no expired medications are available for resident use.

Sincerely yours,

RN DON

1420

EDGEMONT MANOR

EMERGENCY BOX STOCK LIST

05/01/11

Box A

TY	MEDICATION	BRAND NAME
8	Acetaminophen 500mg tab	Tylenol
12	Amoxicillin 250mg cap	Amoxil
8	Amoxicillin 875mg tab	Amoxil
12	Ampicillin 250mg cap	Principen
8	Amoxicillin/Clav 250/125mg tab	Augmentin 250mg
8	Amoxicillin/Clav 875/125mg tab	Augmentin 875mg
8	Atenolol 12.5mg=1/2 of 25mg tab	Tenormin
8	Azithromycin 250mg tab	Zithromax
4	Cefdinir 300mg cap	Omnicef
8	Celebrex 100mg cap	
12	Cephalexin 250mg cap	Keflex
12	Cephalexin 500mg cap	Keflex
12	Ciprofloxacin 250mg tab	Cipro
8	Diphenhydramine 25mg cap	Benadryl
4	Fluconazole 100mg tab	Diflucan
1	Fluconazole 150mg tab	Diflucan
8	Furosemide 20mg tab	Lasix
8	Isosorbide Mono ER 30mg tab	Imdur
8	Levofloxacin 250mg tab	Levaquin
8	Levofloxacin 500mg tab	Levaquin
8	Loperamide 2mg cap	Imodium
4	Loratadine 10mg tab	Claritin
1	Nitroglycerin 0.4mg SL (25 tabs)	NitroSTAT
8	Promethazine 12.5mg tab	Phenergan
12	Sulfameth/Trim 400/80mg tab	Bactrim SS

BOX B

8	Avelox 400mg tab	
4	Benzotropine 0.5mg tab	Cogentin
8	Captopril 12.5mg tab	Capoten
8	Carvedilol 3.125mg tab	Coreg
8	Cefprozil 250mg tab	Cefzil
8	Cefuroxime 250mg tab	Ceftin
12	Clarithromycin 250mg tab	Blaxin
12	Clindamycin 150mg cap	Cleocin
8	Clonidine 0.1mg tab	Catapres
1	Clonidine Patch TTS-1	Catapres
1	Clonidine Patch TTS-2	Catapres
8	Dicyclomine 10mg cap	Bentyl
8	Digoxin 0.125mg tab	Lanoxin
8	Diltiazem CD 120mg cap	Cardizem CD
8	Diltiazem 30mg tab	Cardizem
8	Doxycycline 100mg tab	Vibratabs
12	Erythromycin 250mg tab	
8	Haloperidol 0.5mg tab	Haldol
8	Hydrochlorothiazide 12.5mg cap	
8	Hydroxyzine Pam 25mg	Vistaril
8	Hyoscyamine 0.125mg tab	Symax-SL
8	Ibuprofen 200mg tab	Motrin
8	Klor-Con M10 meg tab	
8	Lisinopril 2.5mg tab	Prinivil
8	Meclizine 12.5mg tab	Antivert
4	Mephyton 5mg tab	
8	Metoclopramide 5mg tab	Reglan
8	Metronidazole 250mg tab	Flagyl

BOX C

QTY	MEDICATION	BRAND NAME
8	Acyclovir 400mg tab	Zovirax
8	Indomethacin 25mg cap	Indocin
4	Metolazone 2.5mg	Zaroxolyn
8	Metoprolol 25mg tab	Lopressor
1	Methylprednisolone 4mg DosePak	Medrol
12	Nitrofurantoin 50mg cap	Macrochantin
8	Nitrofurantoin Monohydrate 100mg cap	Macrobid
8	Omeprazole 20mg capsule	Prilosec
8	Penicillin VK 250mg tab	
8	Perphenazine 2mg tab	Triafon
8	Phenazopyridine 100mg tab	Pyridium
8	Phenytoin 100mg cap	Dilantin
8	Prednisone 1mg tab	
8	Prednisone 5mg tab	
8	Prednisone 10mg tab	
8	Pseudoephedrine 30mg tab	Sudafed
8	Ranitidine 150mg tab	Zantac
8	Rifampin 300mg cap	Rimactane
4	Risperidone 0.25mg tab	Risperdal
8	Risperidone 0.25mg tab	
8	Theophylline SA 200mg tab	TheoDur
4	Tetracycline 250mg cap	Sumycin
8	Warfarin 1mg tab	Coumadin
8	Warfarin 2.5mg tab	Coumadin
8	Warfarin 5mg tab	Coumadin
4	Zyprexa 2.5mg tab	

BOX D (Injectables)

2	Atropine inj 0.4mg vial	
2	Dexamethasone 4mg/ml 1ml vial	
2	Diphenhydramine 50mg/ml inj	Benadryl
2	Enoxaparin 30mg syringe	Lovenox
2	Enoxaparin 40mg syringe	Lovenox
2	Epinephrine 1:1000 inj	Adrenalin
4	Furosemide 10mg/ml 4ml=40mg	Lasix
4	Haloperidol 5mg/ml inj	Haldol
4	Heparin inj 5000u/ml	
4	Hydroxyzine inj 25mg/ml	Vistaril
2	Methylprednisolone inj 40mg vial	DepoMedrol
2	Naloxone 0.4mg amp	Narcan
2	Promethazine 25mg/ml inj	Phenergan
4	SoluMedrol 125mg/ 2ml inj	
2	Vitamin K 10mg/ml inj	

1-425

EDGEMONT MANOR EMERGENCY BOX STOCK LIST

08/31/11

Inhalers/ Nebulizer			SUPPOSITORIES (TOP)		
5	Albuterol 2.5/3ml nebs	Proventil	6	Acetaminophen 650mg supp	Tylenol
2	Ammonia vaporoles		6	Bisacodyl 10mg supp	Dulcolax
1	Atrovent HFA inhaler 12.9gm		2	Prochlorperazine 25mg supp	Compazine
1	Combivent Inhaler 14gm				
5	Ipratropium/Albuterol neb	Duoneb			
5	Ipratropium 0.5mg/2.5ml nebs	Atrovent			
1	Ventolin HFA inhaler 18gm	Proventil			
TOPICALS (Top)			ORAL LIQUIDS (Top)		
1	Nitroglycerin 2% oint 30gm		60ml	Carbamazepine 100mg/5ml syrup	Tegretol
39ml	Permethrin 1% liquid	Nix	2	Glucose 15gm oral gel	
			120ml	Gulatuss DM	Robitussin DM
			1	Magnesium Citrate 300ml	Citrate of Mag
OPHTHALMICS (Top)			60ml	Nystatin Suspension	
1	Neomycin/Polymixin B /HC ophth susp	Cortisporin	60ml	Phenytoin susp 125/5ml susp	Dilantin susp
1	Erythromycin Ophth Oint	Ilotycin	2	Sodium Polystyrene 15gm/60ml	Kayexalate
1	Gentamicin Drops 5ml ophth	Garamycin	60ml	Valproic Acid 250mg/5ml liquid	Depakene
1	Bacitracin/Polymixin ophth Oint	Polysporin			
1	Sodium Sulfacetamide 10% ooth	Sulamvd			
REFRIGERATOR E-BOX			CONTROLLED INJECTABLES DOUBLE LOCKED		
1	Lantus Insulin 10ml		6	Hydrocodone/APAP 5/500mg tablet	Vicodin/Lortab
1	Novolin N U-100 10ml		6	Lorazepam 0.5mg tablet	Ativan
1	Novolin R U-100 10ml		4	Lorazepam 2mg/ml inj. vial (refrig)	Ativan
1	Novolin 70/30 10ml		4	Morphine 20mg/ml oral soln 4ml Morphine Rexeno vials	
1	Novolog 10ml		6	Oxycodone/APAP 5/325mg tablet	Percocet
3	Promethazine 12.5mg SUPP	Phenergan	4	Zolpidem 5mg tablet	Ambien
3	Promethazine 25mg SUPP	Phenergan			
			INJECTABLES (Top)		
			1	Dextrose 50% 50ml syringe	
			2	Glucagon 1mg inj	
IV ANTIBIOTIC MEDICATION BOX			IV FLUID/SOLUTION STOCK (IN MED ROOM)		
4	Ampicillin/Sulbactam 1.5gm vial (generic for Unasyn)		2	Dextrose 5% (D5W)	1000ml
4	Cefazolin 1gm vial (generic for Ancef/Kefzol)		3	Dextrose 5%/0.9% Sodium Chloride (D5WNS)	1000ml
4	Ceftriaxone 1gm vial (generic for Rocephin)		3	Dextrose 5%/0.45% Sodium Chloride (D5W1/2NS)	1000ml
4	Ceftazidime 1gm vial (generic for Fortaz/Tazidime)		2	Dextrose 5% Lactated Ringers (D5LR)	1000ml
4	Gentamicin 80mg/2ml vials		2	Dextrose 5%/0.45% Sodium Chloride +KCL 20mEq (D5W1/2NS + 20 KCL)	1000ml
4	Heparin flush 5ml vial		3	Sodium Chloride 0.9% (NS)	1000ml
2	Invanz 1gm vial		2	Sodium Chloride 0.45% (1/2NS)	1000ml
2	Levaquin 500mg premix bags		4	Sodium Chloride (NS)	100ml
4	Lidocaine 1% 2ml		4	Sodium Chloride (NS)	250ml
3	Piperacillin/Tazobactam 3.375gm vial (gen. for Zosyn)		2	Dextrose 5%/0.2% Sodium Chloride D51/4NS	1000ml
4	Sodium Chloride 0.9% Bact. 30ml				
4	Sterile Water 10ml				
4	Tobramycin 40mg/ml 2ml=80mg vial				
2	Vancocycin 1gm vial				

MED CARE PHARMACY
 "Large enough to SERVE. Small enough to CARE"

F431

AUDIT REPORT FORM

Date of Audit 7/28/11 - ongoing Auditor Gwen Turkey
 Item Audited temps of med room / locked room

Resident Name	Result of Audit	Followup	Followup
7/28/11	temp OK		GT
7/29/11	temp OK		GT
2/30/11	temp OK		GT
7/31/11	temp OK		GT
8/1/11	temp OK		GT
8/2/11	temp OK		GT
8/3/11	temp OK		GT
8/4/11	temp OK		GT
8/5/11	temp OK		GT
8/6/11	temp OK		GT
8/7/11	temp OK		GT
8/8/11	temp OK		GT
8/9/11	temp OK		GT
8/10/11	temp OK		GT
8/11/11	temp OK		GT
8/12/11	temp OK		GT
8/13/11	temp OK		GT
8/14/11	temp OK		GT
8/15/11	temp OK		GT
8/16/11	temp OK		GT
8/17/11	temp OK		GT
8/18/11	temp OK		GT
8/19/11	temp OK		GT
8/20/11	temp OK		GT
8/21/11	temp OK		GT
8/22/11	temp OK		GT
8/23/11	temp OK		GT

MEDICATION STORAGE IN THE FACILITY

MD1: STORAGE OF MEDICATIONS

Policy

Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

Procedures

- A. The provider pharmacy dispenses medications in containers that meet legal requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Transfer of medications from one container to another is done only by the pharmacy.
- B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.
- C. Orally administered medications are kept separate from externally used medications, such as suppositories, external liquids, and lotions.
- D. Intravenously administered medications are kept separate from orally administered medications.
- E. Eye medications are kept separate from ear medications.
- F. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area.
- G. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in a locked area separately from medications.
- H. Schedule II, III, IV, and V controlled medications are stored separately from other medications in a double locked (key or code) drawer or compartment designated for that purpose.
- I. Medications requiring storage at "room temperature" are kept at temperatures in accordance with the manufacturer's specifications.
- J. Medications requiring "refrigeration" or "temperatures between 2°C (36°F) and 8°C (46°F)" are kept in a refrigerator with a thermometer to allow temperature monitoring.
- K. Refrigerated medications are kept in a refrigerator designated for medications and liquids/foods used in administering medications in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. (Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator.)

MEDICATION STORAGE IN THE FACILITY

F-431

- L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (see Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reordered from the pharmacy (see IC3: ORDERING AND RECEIVING MEDICATIONS FROM THE DISPENSING PHARMACY), if a current order exists.
- M. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures.
- N. Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified.

F441

Infection control (continued)

Prevention of Cross contamination

Policy Statement: Preventing cross contamination-This should apply to any clean supplies, equipment, linens, etc It is the policy of this facility to maintain a clean environment and prevent contamination of materials and supplies to help reduce chance of infection.

"Clean" items should be kept separate from "dirty" items. (This is addressed under both universal precautions, wound care, and other sanitation for every department separately)

"Clean" items should not come in contact with other nonclean (considered dirty) items (ie uniforms, floors, other dirty or contaminated items)

Assure clean surface/environment is available to place clean items on. No items shall be placed on floors or against non-clean or unsanitary conditions.

For proper cleaning of specific devices, see manufacturer recommendations.

See infection control policies for other specific policies for handwashing, disposal of waste or disinfecting items after coming into contact with dirty environment, gloving, infectious wastes, wound care, proper cleaning of individual equipment/ supplies, ect.

Clean being defined as not contaminated or coming in contact with a contaminated surface or item.

Dirty being defined as contaminated or coming in contact with a contaminated surface or item.

7/14/09

F441

HANDWASHING

POLICY STATEMENT

It is the policy of Edgemont Healthcare that handwashing shall be regarded as the single most important means of preventing the spread of infections.

PROCEDURES

1. All personnel shall follow our established handwashing procedure to prevent the spread of infections and disease to other personnel, residents, and visitors.
2. Wash hands for approximately 10 – 15 seconds, performed under the following conditions:
 - a) When coming on duty;
 - b) Whenever hands are obviously soiled;
 - c) Before performing invasive procedures;
 - d) Before preparing or handling medications;
 - e) Before handling cleaned or soiled dressings, gauze pads, etc.;
 - f) After handling used dressings, contaminated equipment, etc.;
 - g) After contact with blood, body fluids, excretions, secretions, mucous membranes, or nonintact skin;
 - h) After handling items potentially contaminated with blood, body fluids, excretions, or secretions;
 - i) After personal body function (ie: use of toilet, blowing or wiping nose, smoking, combing hair, etc.);
 - j) After removing gloves;
 - k) Before and after eating;
 - l) Whenever in doubt; and
 - m) Upon completion of duty.
3. If liquid soap is used, reservoirs must be discarded when empty. If refillable, they must be emptied and cleaned, rinsed and dried, and never topped off with additional soap.
4. The use of gloves does not replace handwashing.

5/23/06

F441

Edgemont Healthcare

Policy Ice Passing

Policy and Procedure:

It is the policy of Edgemont Healthcare to follow the guidelines listed below when ice is being passed.

- Ice Cart will be cleaned daily by Dietary
- Ice will be passed to residents twice daily
- Standard precautions will be observed while passing ice, (gloves, ice scoop etc.)

Revised 8/11/11

F-468

Edgemont Healthcare
In-Service Attendance

Topic: Housekeeping and Maintenance

Date: August 2, 2011

procedures
Department managers

Deborah Zech
Lilly Hagen
Michelle Jones
Carlene Hester
William Miller
Spice Smith
Karen Brown
Arthur Leung
C. Hill

Comments:

Discussed housekeeping and maintenance
procedures with department managers
Discussed importance of monitoring repairing
bedrails to ensure the safety of
everyone at the facility. Make recommendations
on going. Please fill out work orders on
issues identified and turn them in to
maintenance promptly

F468

Edgemont Healthcare
In-Service Attendance

Topic: Housekeeping/Maintenance procedures/
procurement
Date: 8/2/11
Maintenance

Gracie M. Kay
Michelle Hagen

Supervisor
and
Executive
Director

Multiple sets of horizontal lines for recording attendance.

Comments:

Multiple horizontal lines for recording comments.

F 468

Edgemont Healthcare
In-Service Attendance

Topic: Hard Rails / Drywall / Terra-tiles Chaco
Chair
Date: 8/12/11

~~Yves Lule~~
~~Chantelle P. Peltier~~
~~Kaehle Neale~~
~~Jean Frederick~~
~~Susan Quisenberry~~
~~SPNA~~
~~H. Hagen SS~~
~~M. Wickmanen~~
~~S. K. Williams~~
~~Cassandra Toney~~
~~Carb Castano~~
~~Deborah Pratt~~
~~Philip J. Lipp~~
~~Mark W. Lipp~~
~~David Keith Simmons~~
~~Lacey Buckley~~
~~Laura S. Thomas~~
~~Dee S. Smith~~
~~Ch. J. Peltier~~
~~Alon~~

~~Adama Wierick~~
~~Debra Blum~~
~~Blackburn WPN~~
~~Barbara Hatten~~
~~Michelle Kelly~~
~~Rita Smith SRNA~~
~~George Joch~~
~~Michael Joch~~
~~Michelle E. Korman~~
~~Michelle Joch~~
~~John Joch~~
~~K. Collins~~
~~LRN~~
~~W. J. Lipp~~
~~Michelle Joch~~
~~Amanda Bureau SRNA~~
~~Donna Lipp~~
~~Michelle Joch~~
~~F. Richardson RN~~
~~Ch. J. Peltier~~

~~Shaundra Edwards~~
~~LRN~~
~~Jessica Edwards~~
~~Clara Witz~~
~~R. Fulton~~
~~K. Ballenger~~
~~Ricardo SRNA~~
~~Michelle~~
~~Amber Jones SRNA~~
~~Christy Joch~~
~~CNA~~
~~Synn Conn CNA~~
~~Patty Meyer~~
~~Beverly Joch~~
~~Ernie Lipp~~
~~John K. Lipp~~
~~Michelle Joch SRNA~~

Comments:

Standard checked randomly by
employee (Maintenance) report will
be done on report to Department Head
Maintenance Dept.

All bills will be reported to maintenance /
department head.

Part or drywall issues will be reported
to maintenance

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

PRINTED: 08/11/2011
FORM APPROVED

DME NO. 0838-0351

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	RECEIVED AUG 2 307/26/2011 DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	

Division of Health Care
Southern Enforcement Branch

(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
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K 000	INITIAL COMMENTS K3 Building: 0101 K8 Plan Approval: Unknown K7 Survey under: 2000 Existing K8 SNF Type of structure: One story Skilled Nursing Facility Type V unprotected construction. The facility was fully sprinklered (dry system) with a complete fire alarm system. Type 2 diesel generator was present. The facility had three smoke compartments and the capacity for 68 beds with a census of 67 on the day of the survey. A Life Safety Code survey was initiated and concluded on 07/26/11, for compliance with Title 42, Code of Federal Regulations, 483.70, and found the facility not to be 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	<i>See Attached</i>	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056	<i>See Attached</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Deborah Zech* TITLE *Administrator* (X6) DATE *8/23/11*

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.

Received Time: Aug. 23. 2011 4:31PM No. 1617

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2011
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 056	<p>Continued From page 1</p> <p>supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 07/26/11, at 1:35 PM, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficient practice has the potential to affect all residents, staff, and visitors. The facility has the capacity for 68 beds with a census of 67 on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 07/26/11, at 1:35 PM, with the Maintenance Supervisor revealed three overhangs with no sprinklers. The overhangs were located at the Patio Exit Canopy, Front Entrance Canopy, and Side Exit Canopy. All overhangs were over four feet in width.</p> <p>Interview on 07/26/11, at 1:35 PM, with the Maintenance Supervisor revealed he was not aware the overhangs needed to be sprinklered.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or</p>	K 056	<i>See Attachment</i>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2011
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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 056	Continued From page 2 limited combustibile construction. NFPA 101 LIFE SAFETY CODE STANDARD SS#D 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 observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected one of three smoke compartments, staff, and approximately twenty-two residents. The facility has the capacity for 68 beds with a census of 67 on the day of the survey. The findings include: During the Life Safety Code survey on 07/26/11, at 1:15 PM, with the Maintenance Supervisor corrosion was noted on the three sprinkler heads in the outside canopy of the Zone 4 porch area. Not maintaining sprinkler heads can decrease their ability to react as intended. Interview with the Maintenance Supervisor on 07/26/11, at 1:15 PM, revealed he thought the sprinkler company would replace them if it was required. Reference: NFPA 25 (1998 Edition). 2-2 1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of	K 056	<i>See attachment</i>	
K 062		K 062		<i>See attachment</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2011
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 062	Continued From page 3 corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	<i>See attachment</i>	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficient practice has the potential to affect all residents, staff, and visitors. The facility has the capacity for 68 beds and the census on the day of the survey was 67 residents. The findings include: Observation on 07/26/11, at 2:00 PM, with the Maintenance Supervisor revealed hanging decorations on resident room doors 216, 203, 102, 110, 302, and 301. Interview with the Maintenance Supervisor on 07/26/11, at 2:00 PM, revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material. Reference: NFPA 101 (2000 Edition).	K 073	<i>See attachment</i>	

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

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(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 073	Continued From page 4 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	<i>See Attachment</i>	

Life Safety Plan of Correction (K Tag)

Plan of Correction for K056
NFPA 101 Life Safety Code Standard

#1- Administrator met with Maintenance Supervisor on 7/26/11 and again after survey team exited to ensure compliance with sprinkler/safety issues. Bids for sprinklers were placed as 8/2/11 and Landmark sprinkler inc. has been contracted by facility to install sprinklers. Date of repair expected to be within next week of POC completion.

#2- No residents were affected by said practice. No other areas in facility have areas identified without sprinklers.

#3/4- When the sprinkler heads are installed they will be monitored monthly by the maintenance supervisor/designee for 60 days in addition to contracted sprinkler company performing tests/inspections of sprinklers per policy/regulations. Issues/concerns will be documented on audit report form and reported to Administrator and Executive Director for follow up. Issues/concerns will be discussed/reviewed at next quarterly meeting and ongoing for additional follow up and to ensure compliance.

Date of Compliance: 8/18/11
Responsible: Maintenance Supervisor

Plan of Correction for K052
NFPA 101 Life Safety Code Standard

#1- Bids have been taken to replace the three corroded sprinkler heads located in the outside canopy of zone 4. Administrator met with Maintenance Supervisor and Executive Director on 7/26/11 to ensure compliance with safety/sprinkler issues. Landmark sprinkler inc. has been contracted by facility to install sprinklers.

#2- No residents were affected by said practice. An audit was completed on all sprinklers on 8/1/11. No issues or concerns were noted.

#3/4- All sprinkler heads shall be inspected on a quarterly basis by maintenance supervisor documenting on monthly checklist of rooms inspected that month which will assure that they are all inspected on at least a quarterly basis thereafter. This shall be in addition to contracted sprinkler vendor who are paid to perform inspections and test of sprinkler system per regulatory guidelines. This monthly check list shall be given after completed to Administrator/designee to review for compliance times 90 days. Issues/concerns will be documented on audit report form and reported to Administrator and Executive director for follow up. Issues/concerns will also be discussed/reviewed at next quarterly meeting for additional follow up and to ensure compliance.

Date of Compliance 8/18/11
Responsible: Maintenance Supervisor

Plan of Correction for K073
NFPA 101 Life Safety Code Standard

#1- Administrator in-serviced Maintenance Supervisor as of survey exit to ensure that no combustible decorations were used in the facility. Audit system put in place to monitor flame retardant and flammable materials. Residents in rooms 216,203,102,302, and 301 have hanging decorations treated with flame retardant.

#2- No residents were affected by said practice. Any other areas identified have been treated or placed on list to be retreated and then logged after to reveal dates.

#3/4- Flame retardant was applied to decorations and other highly flammable materials as of 8/15/11 and 8/16/11. A flammable material log implemented to record dates retardant was applied to ensure ongoing compliance with safety issue. Administrator to audit flammable materials log monthly times 60 days and quarterly ongoing. Issues/concerns will be reported in quarterly QA meetings to ensure compliance.

Date of compliance: 8/17/11

Responsible: Maintenance Supervisor

K 056

Edgemont Healthcare
In-Service Attendance

K-Jagg - Deborah Zech
advis
Expenditures
Flammable
Materials

Topic: Sprinkler heads / safety monitoring

Date: 7/26/11

Mike Hagan
Travis Pflug

Comments:
Met with Maintenance
Supervisor to discuss K-Jagg
sprinkler installation / monitoring
expenditures and policy and
procedures for flammable
materials

Edgemont Healthcare
In-Service Attendance

K 062

K-Jagg - Deborah
Zeal
adm.
Expenditures
Flammable
Materials

Topic: Sprinkler heads / safety monitoring
Date: 7/26/11

~~Mike Hagan~~
~~Devitt Phleg~~

Comments:

Met with Maintenance
Supervisor to discuss K-Jagg
sprinkler installation / monitoring
expenditures and policy and
procedures for flammable
materials

