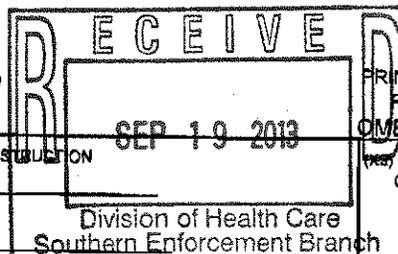


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SOD



PRINTED: 09/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETED 07/31/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS An abbreviated standard survey (KY20470) was initiated on 07/30/13 and concluded on 07/31/13. The complaint was substantiated with deficient practice identified at 'D' level.	F 000	F 157 Failure to Notify of Changes The facility has ensured the following corrective action: <ul style="list-style-type: none"> On 7/31/13, the Charge Nurse notified the Resident's POA that the abraded area to buttocks was designated as a Stage II pressure area by the Nurse Practitioner. The facility has taken the following action to prevent this practice from affecting others: <ul style="list-style-type: none"> On 7/31/13, DON and ADON made a review of the facility medical records of residents with pressure areas to ensure that the physician and responsible party were informed as to pressure area designation. (Attachment #1a) Further review was made of all facility resident medical records to ensure physician and family notification was accomplished for all other occurrences. (Attachment #1b) On 7/31/13, the Director of Nursing issued the Physician Order and Progress Note Review Protocol, directing all Charge Nurses to review progress notes made by physicians, or other staff under their direction, and make a comparison to the written order, if one was given. The protocol outlines steps to take for any noted discrepancy. (Attachment #2) Facility nurses were in-serviced on the protocol on 8/2/13. (Attachment #3) 	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anne Hills</i>	TITLE <i>Administrator</i>	(X6) DATE 9/19/13
--	-----------------------------------	--------------------------

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 Sep. 19. 2013 3:10PM No. 0319

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X4) COMPLETION DATE	
F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to notify the resident's family member of a change in the resident's condition for one of three sampled residents (Resident #1). Resident #1 was assessed by the facility on 07/19/13 and 07/24/13 to have abrasions to the left and right buttocks. The resident's family was notified of the abrasions. On 07/25/13, Resident #1 was assessed by the Advanced Registered Nurse Practitioner (ARNP) to have two small Stage II pressure areas to the left buttock and one small Stage II pressure area to the right buttock. The facility failed to notify Resident's #1's family that the open areas on the resident's buttocks had been assessed on 07/25/13 as pressure areas. The findings include: A review of Resident #1's medical record revealed the resident was admitted to the facility on 09/08/10 with diagnoses including Dementia, Hypertension, and Diabetes Mellitus Type 2. A review of the nurse's notes dated 07/19/13, revealed Resident #1 was observed to have two abrasions to the left buttock with documented evidence that the resident's family member was notified of the abrasion. Further review of the nurse's notes, dated 07/24/13, revealed a small abrasion was observed on the resident's right buttock with documented evidence that the resident's family member was notified of the abrasion. Review of the ARNP's note, dated 07/25/13, revealed the resident was observed to have two small open areas to the left buttock and	F 157	The facility initiated the following systemic changes to prevent this practice from recurring: <ul style="list-style-type: none"> On 8/30/13 and 8/31/13, all facility nursing staff received in-service training review on the facility's Family Notification Policy and Federal Regulations, including physician and family notification. (Attachments #4a-c) As stated in the Physician Order and Progress Note Review Protocol, the Charge Nurse will indicate review of physician's progress note and order by recording the date and his/her initials. The Charge Nurse will place a copy of the physician's progress note in the Assistant Director of Nursing's mailbox. The ADON shall review / compare the note and order on the next business day, taking immediate corrective action for any noted discrepancy regarding the orders, or failure to notify the responsible party of pressure area classification. The facility will sustain performance through the following monitoring practice: <ul style="list-style-type: none"> Charge Nurse Staff shall continue to document any resident change of condition and physician/resident/family notification on the Condition Change Form. (Attachment #5) The duplicate forms shall be distributed as follows: White - Chart copy / Nurses notes section; Yellow - DON (or designee / ADON); Pink - MDS Coordinator; Gold 		

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

PRINTED: 09/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 one small open area to the right buttock. Further review of the ARNP's note revealed the areas had been identified as Stage II pressure areas with recommendations for an Allevyn bandage (a protective dressing), and turning and repositioning every two hours from side to side. A review of the nurse's notes, dated 07/25/13, revealed Resident #1's family member was notified of the ARNP's treatment recommendations; however, there was no documented evidence the family member had been notified the areas had been staged as pressure areas. Interview on 07/30/13 at 4:45 PM with Licensed Practical Nurse (LPN) #1 revealed the LPN had notified Resident #1's family member of the abrasions, treatment ordered for the abrasions, and the ARNP's recommendations for the areas. Further interview revealed the LPN did not notify the family member the areas had been identified as Stage II pressure areas because the LPN had not read the ARNP's notes and was not aware the areas had been identified by the ARNP as pressure areas. The interview revealed the family member should have been notified of the change. Interview on 07/30/13 at 5:15 PM with the Assistant Director of Nursing (ADON) revealed the family had not been notified of the areas on Resident #1's bottom being identified as Stage II pressure areas because the facility staff had not read the ARNP's notes and were not aware the ARNP had identified the area as a pressure area.	F 157	- Pharmacy. The DON, or designee / ADON, shall review the Condition Change Forms on the next business day for accuracy, taking immediate corrective action for any noted discrepancy regarding orders, physician/family notification, etc. • The ADON's monthly report to the Director of Nursing has been amended to include a summary of the Condition Change review findings / corrective action. (Attachment #6) • Per facility policy, the DON reviews and includes this report in the monthly Nursing Department Quality Assurance Report, which is reviewed monthly by the Administrator. • The Director of Nursing shall present a summary of the monthly reports each quarter to the Medical Director as part of the Nursing Department Quality Assurance review. (Attachment #7) Completion Date F 157: 8/30/13	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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

PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 3</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility policy, and review of the Resident Assessment Instrument User Manual 3.0 (MDS manual) the facility failed to ensure an effective pressure ulcer prevention and treatment program was in place to identify the presence of pressure ulcers for one of three sampled residents (Resident #1). Resident #1 was assessed by the facility on 07/19/13 and 07/24/13 to have abrasions to the left and right buttocks. The Advanced Registered Nurse Practitioner's (ARNP's) notes, dated 07/25/13, revealed two small open areas to the left buttock and one small open area to the right buttock which were identified as Stage II pressure areas.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Definition, Prevention, Identification and Treatment of Pressure Ulcers," revised date 06/26/07, revealed a complete assessment is essential to an effective pressure ulcer prevention and treatment program. A comprehensive, individual evaluation helps the facility to identify the presence of pressure ulcers.</p>	F 314	<p>F314 - Treatment / Services to Prevent / Heal Pressure Sores</p> <p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> On 7/31/13, the facility changed the classification of the abraded area to a Stage II pressure ulcer per the APRN's designation. Allevyn dressing, ordered as a preventative measure, was initiated per the APRN's request. <p>The facility has taken the following action to prevent this practice from affecting others</p> <ul style="list-style-type: none"> The Director of Nursing consulted the Medical Director regarding standardized protocol for facility physicians, or designee staff, to use for unity of wound staging. The Wound Assessment and Classification Protocol was developed based on MDS 3.0 guidelines and was provided to facility physicians. (Attachment #1) 	

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

PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 4 A review of the Resident Assessment User Manual 3.0 (MDS manual) revealed a Stage II pressure ulcer is a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed. Stage II pressure ulcers are often related to friction and/or shearing force. A review of Resident #1's medical record revealed the resident was admitted to the facility on 09/08/10 with diagnoses including Dementia, Hypertension, and Diabetes Mellitus Type 2. A review of the nurse's notes dated 07/19/13, revealed Resident #1 was observed to have two abrasions to the left buttock with documented evidence that the resident's physician was notified of the areas, with a new order received to clean the abrasions with wound cleaner and apply Silvadene ointment and a dry dressing two times per day until healed. Further review of the nurse's notes, dated 07/24/13, revealed a small abrasion was observed on the resident's right buttock with documented evidence that the resident's physician was notified of the area, with a new order received to clean the abrasion with wound cleaner, apply Silvadene, and apply a Telfa pad two times per day until healed. Review of the ARNP's note, dated 07/25/13, revealed the resident was observed to have two small open areas to the left buttock and one small open area to the right buttock. Further review of the ARNP's note revealed the areas had been identified as Stage II pressure areas with recommendations for an Allevyn bandage (a protective dressing), and turning and repositioning every two hours from side to side. Interview on 07/30/13 at 4:37 PM with Licensed Practical Nurse (LPN) #2 revealed the LPN had	F 314	<ul style="list-style-type: none"> Facility staff nurses were provided an in-service training on the protocol on 8/2/13. (Attachment #2) A chart audit was performed on 7/31/13 by the DON and ADON to ensure that all facility residents with a pressure area designation were accurately classified per the MDS 3.0 guidelines. (Attachment #3) On 8/30/13 and 8/31/13, in-service training review was conducted with all nursing staff on the facility Pressure Ulcer Policy, which includes directives for prevention (Hydration, Nutritional needs, Functional abilities, Transfer and repositioning needs, Moisture management, Need for pressure reduction devices, Observation of behaviors that indicate skin discomfort); treatment (Notifying physician, Daily assessment of pressure area, Wound Care Team evaluation, Consult with physician for an unfavorable response to treatment, Consult with other specialties as necessary, Evaluate and update Plan of Care as needed); and follow-up assessment and reporting to physicians of pressure areas. (Attachment #4a-b) <p>The facility initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The Charge Nurse and ADON (or DON in his/ her absence) shall 	

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

PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 196 BERRYMAN ROAD FRENCHBURG, KY 40322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 5</p> <p>observed the areas on Resident #1's bottom the day the areas were found. The interview further revealed the three areas appeared to be abrasions caused by shearing and looked like blisters that the top layer of skin had been peeled off of with no depth. The LPN denied being aware the ARNP had assessed the areas to be pressure areas.</p> <p>Interview on 07/30/13 at 4:45 PM with LPN #1 revealed the LPN found the areas on Resident #1's bottom which appeared to be tiny open abrasions. The interview revealed the doctor was notified of the abrasions and treatment was started to the areas immediately. The LPN denied being aware the areas had been identified by the ARNP as pressure areas but was aware of the recommendations the ARNP had made for treatment of the areas.</p> <p>Interview on 07/30/13 at 5:21 PM with the ARNP revealed the ARNP was asked by staff to look at the resident's bottom because of redness and the areas. The interview revealed Resident #1's bottom was red and there were three small open areas which were staged because the areas were open in an area that does have pressure. The interview further revealed the ARNP made a recommendation for a protective dressing and for the resident to be turned and repositioned from side to side to prevent further breakdown.</p> <p>Interview on 07/30/13 at 5:15 PM with the Assistant Director of Nursing (ADON) revealed the three areas on the resident's bottom were assessed during the weekly wound rounds and identified as abrasions that had been caused by shearing. The interview further revealed the facility uses the MDS definitions to identify and</p>	F 314	<p>review and compare all physician progress notes and orders. (Attachment #5a-b) Any noted discrepancy from the Wound Assessment and Classification Protocol will be immediately clarified per physician order (written or telephone clarification).</p> <ul style="list-style-type: none"> Charge Nurse Staff will continue to perform weekly skin assessments per facility policy, and present any new / unusual findings from the assessment to the ADON, who shall inform the physician. <p>The facility Wound Care Team, per facility practice, shall observe, measure and review, all new resident pressure areas on the next business day after designation. The Wound Care Team shall, per facility standing practice, observe, measure, and review all pressure areas on a minimum of a weekly basis. The team shall document this review on the Wound Care Team Assessment Review Form. (Attachment #6) A copy of the Wound Care Team Assessment Review Form shall be faxed by the ADON (or the DON in her absence) on the date of review to the physician for his/her review and desired follow-up. The ADON shall request physician medical record documentation for any pressure area designated as unavoidable due to medical condition. A copy shall be presented to and reviewed weekly by the Administrator.</p>		

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

PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6 stage pressure areas and the ADON did not feel like the areas were pressure areas. The ADON denied being aware the ARNP had identified the areas as pressure areas because the ADON had not read the ARNP's notes from the last visit. The interview further revealed there were no changes to the treatment of the areas once identified as pressure areas, only recommendations for a protective dressing.	F 314	The facility will sustain performance through the following monitoring practice: <ul style="list-style-type: none">The ADON's monthly report to the Director of Nursing has been amended to include: 1) a summary of review of pressure area classifications, 2) any noted discrepancy per the Wound Assessment and Classification Protocol and MDS 3.0 guidelines, and, 3) corrective action taken. (Attachment #7)A copy of each Wound Care Team Assessment Review Form shall be included with the ADON report.Per facility practice, the Director of Nursing reviews and includes this report as part of the monthly Nursing Department Quality Assurance Report, which is reviewed monthly by the Administrator.The Director of Nursing shall present a summary of the monthly reports each quarter to the Medical Director, as part of the Nursing Department Quality Assurance review. (Attachment #8)	
			Completion Date F 314: 8/31/13	