



PRINTED: 03/06/2014
FORM APPROVED
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: 165423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/20/2014
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 (KY21180) was conducted on 02/20/14. The complaint was substantiated with deficient practice identified at "E" level.	F 000	F 202 Documentation for Transfer / Discharge of Res The facility has ensured the following corrective action:	
F 202 SS=E	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the resident's physician documented in the medical record when a discharge and/or transfer was appropriate, because the resident's health had improved sufficiently and the resident no longer needed the services provided by the facility or when the needs of the resident could no longer be met at the facility, for three of three sampled residents (Residents #1, #2, and #3). Interviews revealed the facility transferred Residents #1 and #3 to a lesser (licensed) level of care and Resident #2 to a higher (certified) level of care in order to appropriately meet the needs of the residents; however, the physician failed to document why the transfers were necessary.	F 202	The facility has taken the following action to prevent this practice from affecting other residents: <ul style="list-style-type: none"> A 'Transfer and Discharge Policy' was developed 2/20/2014 (Policy Attached). The policy outlines the requirements for physician documentation regarding discharge / transfer plans (Attachment #1) and written notification to the resident and/or responsible family member (Attachment #2). The staff charge nurse shall be responsible for informing a physician of a pending transfer / discharge and ensure the completion of the 'Edgwood Estates Discharge Plans' form. The Social Services Director shall be responsible for providing written notification to resident / responsible family member and obtain appropriate signature on the 'Discharge Notice' form. Nursing / Social Services staff received in-service training on the policy / attachments on 2/20/2014 - 2/21/14 (Attachment #5). 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Anne Niles

TITLE

Administrator

(X8) DATE

3/13/14

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.

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2014
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 202	Continued From page 1 The findings include: Interview with the Social Worker on 02/20/14 at 12:40 PM revealed the facility did not have a discharge/transfer policy. A review of the facility's Resident Rights policy, dated 10/24/02, revealed it was the facility's policy to honor all residents' rights. A review of the resident rights policy revealed the definition of transfer and discharge included movement of a resident to a bed outside of the certified facility whether that bed was in the same physical plant or not. The facility was to permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility; the transfer or discharge was appropriate because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility; the safety of individuals in the facility was endangered; the health of individuals in the facility would otherwise have been endangered; the resident failed after reasonable and appropriate notice to pay for a stay at the facility; or the facility ceased to operate. When the facility transferred or discharged a resident because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility or the resident's needs could not be met in the facility, the resident's clinical record was required to be documented. The documentation was to be made by the resident's physician when the transfer or discharge was necessary because the resident's health improved or the needs could not be met by the facility.	F 202	The facility has initiated the following systemic changes to prevent this practice from recurring: <ul style="list-style-type: none"> The staff charge nurse shall complete the 'Transfer/Discharge Checklist' (Attachment #3) and forward to the Social Services Director for review. The Social Services Director shall review and sign the 'Transfer/Discharge Checklist' for accurate completion, or document any needed corrective action / follow-up. <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> The Social Services Director shall present a summary of Transfer / Discharge reviews each quarter as part of the facility's ongoing Quality Assurance monitors (Attachment #4). <p>F 202 Completion Date: 3/13/14</p>		

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

PRINTED: 03/08/2014
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 02/20/2014
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 202	<p>Continued From page 2</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 08/16/11. Further review revealed on 01/21/13 the facility transferred Resident #1 from a higher (certified) level of care facility to a lesser (licensed) level of care facility. However, the facility failed to obtain a physician's order and/or documentation from the resident's physician to indicate why the resident's transfer to a lesser (licensed) level of care was appropriate and/or necessary.</p> <p>2. A review of the medical record for Resident #2 revealed the facility admitted the resident on 03/01/12 to the facility's lesser (licensed) level of care. Further review revealed the facility transferred the resident on 11/08/13 to the facility's higher (certified) level of care. However, the facility failed to obtain a physician's order and/or documentation from the resident's physician to indicate why the resident's transfer was appropriate and/or necessary.</p> <p>3. A review of the medical record for Resident #3 revealed the facility admitted the resident on 09/13/13. Further review revealed on 11/08/13 the facility transferred Resident #3 from the higher (certified) level of care to a lesser (licensed) level of care. However, the facility failed to obtain a physician's order and/or documentation from the resident's physician to indicate that the transfer to a lesser level of care was appropriate and/or necessary.</p> <p>Interview with the Social Worker on 02/20/14 at 3:15 PM revealed the facility did not obtain a written transfer/discharge order for Resident #1 and Resident #3 when they were moved from a</p>	F 202		

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

PRINTED: 03/08/2014
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 02/20/2014
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 202	Continued From page 3 higher level of care to a lesser level of care; or when Resident #2 was moved from a lesser level of care to a higher level of care. The Social Worker acknowledged the resident's physician had not documented in the medical record the reason for the transfer/discharge of the residents. Interview further revealed the Social Worker was not aware the physician was required to document a transfer/discharge order when a resident's level of care changed from a higher to lesser level or from a lesser level of care to a higher level of care. Interview with the Director of Nursing (DON) on 02/20/14 at 1:50 PM revealed she was not aware the resident's physician was required to document the reason a resident was transferred/discharged from one level of care to another level of care. The DON acknowledged the facility had failed to obtain the appropriate documentation from the physician to indicate why the transfer/discharge of Resident #1, Resident #2, or Resident #3 was necessary.	F 202		
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or	F 203	F 203 Notice Requirements Before Transfer/Discharge The facility has ensured the following corrective action: • A 'Transfer and Discharge Policy' was developed 2/20/14 (Policy Attached). The policy outlines the requirements for physician documentation regarding discharge / transfer plans (Attachment #1) and written notification to the resident and/or responsible family member (Attachment #2).	

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

PRINTED: 03/06/2014
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 02/20/2014
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 185 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 203	<p>Continued From page 4</p> <p>discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 203	<p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> A record review was completed 2/20/14 with no other current resident noted to be affected by this practice. The Social Services Director shall be responsible for providing written notification to resident / responsible family member and obtain appropriate signature on the 'Discharge Notice' form. Nursing / Social Services staff received in-service training on the policy / attachments on 2/20/14 - 2/21/14 (Attachment #5). <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The staff charge nurse shall complete the 'Transfer/Discharge Checklist' (Attachment #3) and forward to the Social Services Director for review. The Social Services Director shall review and sign the 'Transfer/Discharge Checklist' for accurate completion, or document any needed corrective action / follow-up. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/06/2014
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 02/20/2014
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 198 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 203	<p>Continued From page 5</p> <p>Based on interview and record review the facility failed to ensure three of three sampled residents (Residents #1, #2, and #3) and their family members were notified, in writing, within thirty days or as soon as practicable of the resident's transfer and/or discharge. Interviews revealed the facility transferred/discharged Resident #1 and Resident #3 from a higher (certified) level of care to a lesser (licensed) level of care due to improvement in the resident's conditions. Further, according to interview, the facility transferred/discharged Resident #2 from a lesser (licensed) level of care to a higher (certified) level of care due to a decline in the resident's condition. However, the facility failed to provide a written statement to the residents and family regarding the transfer/discharge.</p> <p>The findings include:</p> <p>Interview with the Social Worker on 02/20/14 at 12:40 PM revealed the facility did not have a policy on transfer/discharge.</p> <p>A review of the facility's Resident Rights policy dated 10/24/02 revealed it was the facility's policy to honor all residents' rights. A review of the resident rights policy revealed the definition of transfer and discharge included movement of a resident to a bed outside of the certified facility whether that bed was in the same physical plant or not. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility; the transfer or discharge was appropriate because the resident's health had improved sufficiently so the resident no longer</p>	F 203	<p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> The Social Services Director shall present a summary of Transfer / Discharge reviews each quarter as part of the facility's ongoing Quality Assurance monitors (Attachment #4). <p>F 203 Completion Date: 3/13/14</p>		

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2014
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 203	<p>Continued From page 6</p> <p>needed the services provided by the facility; the safety of individuals in the facility was endangered; the health of individuals in the facility would otherwise have been endangered; the resident failed after reasonable and appropriate notice to pay for a stay at the facility; or the facility ceased to operate. Before the facility transferred or discharged a resident the facility must notify the resident and, if known, a family member or legal representative of the resident and the reasons for the move in writing, and in a language and manner understood. The notice must have been made by the facility at least 30 days before the resident was transferred or discharged. Notice could be made as soon as practicable before discharge or transfer when the resident's health improves sufficiently to allow a more immediate transfer or discharge.</p> <p>1. A review of Resident #1's medical record revealed the facility admitted the resident on 08/16/11. On 01/21/13, the facility transferred/discharged the resident to a lesser (licensed) level of care. According to an interview on 02/20/14 at 12:20 PM with the Social Worker, the transfer was due to an improvement in the resident's health. However, even though the facility verbally informed the resident and his/her family member of the transfer/discharge, the facility failed to provide the resident and his/her family member a written transfer/discharge notice.</p> <p>2. A review of Resident #2's medical record revealed the facility admitted the resident on 03/01/12 to the facility's lesser (licensed) level of care. Further review revealed the facility transferred the resident on 11/08/13 to the facility's higher (certified) level of care. Interview</p>	F 203			

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

PRINTED: 03/06/2014
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 02/20/2014
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 203	<p>Continued From page 7</p> <p>with the Director of Nursing on 02/20/14 at 1:50 PM revealed the resident's transfer was due to a decline in the resident's health. However, even though the facility verbally informed the resident and family of the transfer/discharge, the facility did not provide a written transfer/discharge notice to the resident and family member.</p> <p>3. A review of Resident #3's medical record revealed the facility admitted the resident on 09/13/13. On 11/08/13 the facility transferred/discharged the resident to a lesser (licensed) level of care bed. However, even though the facility verbally informed the resident and his/her family member of the transfer/discharge, the facility failed to provide the resident and his/her family member a written transfer/discharge notice.</p> <p>Interview on 02/20/14 with the Social Worker at 12:20 PM and the and the Director of Nursing (DON) at 1:50 PM revealed they were not aware the facility was required to provide a written transfer/discharge notice to residents and families when the resident was transferred/discharged from a higher (certified) level of care to a lesser (licensed) level of care; or from a lesser (licensed) level of care to a higher (certified) level of care. The Social Worker and the DON acknowledged the facility had not provided a written notice to Resident #1, Resident #2, or Resident #3 and/or their family members of their transfer/discharge.</p>	F 203			