

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

PRINTED: 10/23/2014  
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  10/09/2014
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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 000 INITIAL COMMENTS

F 000 *See attached* 10/15/14

A Recertification and Abbreviated Survey investigating KY00022302 was initiated on 10/07/14 and concluded on 10/09/14. KY00022302 was unsubstantiated with no deficiencies cited. Deficiencies were cited during the Recertification Survey at the highest Scope and Severity of an "E".

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

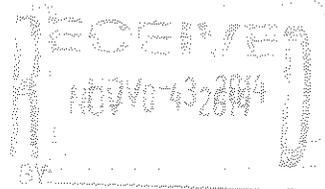
F 279 *See attached* 10/15/14

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, it was determined the facility failed to ensure a Comprehensive Care Plan was developed for one



10/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Deborah Zeck* TITLE *Administrative* (X6) DATE *10/31/14*

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.

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F 279	<p>Continued From page 1</p> <p>(1) of fourteen (14) sampled residents. Resident #7 was prescribed Zoloft 25 milligrams (mg) daily for a documented diagnosis of Depression; however, the Comprehensive Care Plan developed for the resident did not include interventions related to the resident's Depression.</p> <p>The findings include:</p> <p>No policy on Comprehensive Care Plans was provided by the facility.</p> <p>Interview, on 10/09/14 at 6:34 PM with the Director of Nursing (DON), revealed care plans were supposed to be individualized to meet resident needs. She stated the purpose of the care plan was to allow staff to know the resident's needs.</p> <p>Review of the medical record for Resident #7 revealed the resident was admitted by the facility on 09/13/12 with diagnoses which included Anemia, Heart Failure, Non-Alzheimer's Dementia, Depression and Chronic Kidney Disease. Review of the Annual Minimum Data Set (MDS) Assessment, dated 04/05/14, revealed the facility assessed Resident #7's Depression Score to be 06, which indicated mild depression. Further review of the MDS revealed the resident was assessed as being on an Antidepressant medication.</p> <p>Review of the Physician's orders revealed the resident had an order, dated 03/07/14, for Zoloft 25 milligrams once daily.</p> <p>Review of Resident #7's Comprehensive Care Plan revealed the facility failed to develop a care plan for depression. Resident #7 was care</p>	F 279	<i>See Attached 10-15-14</i>

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F 279	<p>Continued From page 2</p> <p>planned for Impaired Cognitive Function which placed him/her at risk for altered moods/behaviors, and a related intervention to monitor cyclic changes in mentation/behavior; however, the resident's Depression was not addressed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/09/14 at 4:00 PM, revealed Resident #7 had a diagnosis of Depression and was on an antidepressant medication. The LPN further stated the resident should be care planned for the Depression, with written goals and related interventions.</p> <p>Interview with MDS Coordinator #1, on 10/09/14 at 5:55 PM, revealed the care plan was utilized to coordinate care of the resident based on assessed needs and diagnoses, and was supposed to be individualized for each resident. The MDS Coordinator stated Resident #7 needed a more individualized care plan that included specific interventions related to the diagnosis of Depression. The MDS Coordinator further stated after receiving training on care plans, she was developing plans that were now more individualized.</p> <p>Continued interview with the DON, on 10/09/14 at 6:34 PM, revealed Resident #7 had a diagnosis of Depression which should have been addressed in the care plan. She stated in the past, the facility attempted to combine a lot of problem areas, which resulted in a less individualized care plan. The DON stated it was important staff knew what specific interventions related to Resident #7's Depression were needed.</p>	F 279	<i>See Attached. 10-15-14</i>	

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F 323	Continued From page 3	F 323	<i>See Attached. 10-15-14</i>		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		<i>See Attached. 10-15-14</i>	
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure residents in rooms 216, 214, 211, 205, 201 and 320, and general shower rooms 202, 112 and 319 were free of accident hazards. The doorways to each of these rooms were observed to have jagged, sharp edges, with a potential for harm to the resident upon entrance or exit from those areas.</p> <p>The findings include</p> <p>Observation of the general shower room 202 doorway, on 10/07/14 at 12:45 PM, revealed jagged, sharp areas on the outer areas of the door within the doorway entrance.</p> <p>Further observations on 10/09/14, of resident rooms 216 at 2:57 PM, room 214 at 3:02 PM, room 211 at 3:04 PM, room 205 at 3:06 PM, room 201 at 3:10 PM, general shower room 112 at 3:12 PM, room 320 at 3:17 PM, and general shower room 319 at 3:19 PM, also revealed jagged sharp areas on the outer areas of the door within the doorway.</p>				

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F 323	Continued From page 4  Interview with the Director of Nursing (DON), on 10/07/14 at 12:45 PM, revealed the condition of the doorways was the responsibility of the maintenance department. She stated a work order should be completed to request repair of the doors. She further stated the jagged sharp areas of the doors had the potential to cause a skin tear to a resident in passing through the doorway.  Interview with the Maintenance Supervisor, on 10/09/14 at 2:38 PM, revealed the facility had no system in place to monitor doors for sharp, jagged edges.  Interview with the Administrator, on 10/09/14 at 7:00 PM, revealed the facility monitors the residents' rooms for safety concerns and hazards through Quality Assurance (QA) rounds, and records the information on a rounds sheet twice a day. She stated the jagged doorway surfaces at entrances to resident rooms and general shower rooms were a safety issue and could cause an injury. She further stated it was her expectation for staff to submit work requests for identified safety hazards.	F 323	<i>See Attached. 10-15-14</i>	
F 371 SS=E	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	F 371	<i>See Attached. 10-15-14</i>	

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F 371	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store and prepare food under sanitary conditions, including four (4) dented cans in stock for use, two (2) prepared milk shakes in the kitchen refrigerator which were not labeled or dated, and no thermometers found in one (1) refrigerator, one (1) freezer, or the milk cooler located in the basement of the facility.</p> <p>The findings include:</p> <p>Observation during the initial kitchen tour, on 10/07/14 at 12:20 PM, revealed two (2) prepared milk shakes were stored in the refrigerator without a label or date. Observation of the dry food storage area in the basement revealed four (4) dented cans stocked in the for use area, not in the marked dented can area. Further observation of the basement storage area revealed one (1) refrigerator, one (1) chest freezer and the milk cooler had no thermometers to monitor the temperatures.</p> <p>Interview with the Dietary Manager (DM), on 10/09/14 at 8:25 AM, revealed all food items were to be labeled and dated before being placed in the refrigerator. She stated the dietary aide reported she was in a hurry and forgot. She further stated the process related to the thermometers was for staff to notify her anytime a thermometer was missing so it could be replaced. Continued interview revealed refrigerator, freezer and milk cooler temperatures were to be checked and recorded each shift. Subsequent interview with the DM, on 10/09/14 at 10:10 AM, revealed</p>	F 371	<i>See Attached. 10-15-14</i>	

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F 371	Continued From page 6 the facility had no policy regarding dented cans.  Interview with the Administrator, on 10/09/14 at 7:25 PM, revealed it was her expectation for staff to follow the facility's process to maintain thermometers in the refrigerators, freezers and milk cooler, and to date and label all food and drinks prior to placing them in the refrigerator. She stated staff should assure all dented cans were placed in the dented can area, and never in stock for use.	F 371	<i>See Attached. 10-15-14</i>	
F 441 SS=E	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	F 441	<i>See Attached. 10-15-14</i>	

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F 441	<p>Continued From page 7</p> <p>direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which 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 review of the facility's policy, it was determined the facility failed to ensure its Infection Control policy and procedures were followed to help prevent the spread of infection for four (4) of fourteen (14) sampled residents (Residents #3, #7, #9 and #12). Observations during perineal care and a skin assessment revealed staff did not change gloves and/or wash their hands per the facility's policy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Handwashing", dated 05/23/06, revealed handwashing was regarded as the single most important means of preventing the spread of infection. Further review revealed all personnel should follow the established handwashing procedure to prevent the spread of infections and disease to other personnel, visitors and residents. Additional review revealed staff were to wash their hands after contact with blood, body fluids, excretions, secretions, or items potentially</p>	F 441	<i>See Attached. 10-15-14</i>	

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F 441	<p>Continued From page 8</p> <p>contaminated with these fluids, and after removing gloves.</p> <p>Review of the facility's in-service record related to Infection Control, dated 08/28/14, revealed handwashing was to be performed before and after gloving any time resident care was provided.</p> <p>1. Medical record review revealed Resident #3 was re-admitted to the facility on 09/08/14, with diagnoses which included Non-Insulin Dependent Diabetes, Hypertension, End Stage Renal Disease, Dementia, and Epilepsy. Continued review of the medical record revealed Resident #3 was currently in isolation for loose stools while awaiting the results of a pending lab specimen.</p> <p>Observation during a skin assessment, on 10/08/14 at 3:20 PM, revealed Registered Nurse (RN) #1 moved from a dirty area to a clean area of the body, without changing her gloves or washing her hands.</p> <p>Interview with RN #1, on 10/08/14 at 4:20 PM, revealed handwashing should be done when you enter a resident's room, when you go from a dirty area to a clean area on the body, and after completing care for the resident. Additional interview revealed she should have changed her gloves and her washed hands after touching the resident's perineal area and before proceeding to a clean area, in order to prevent the spread of any infection.</p> <p>2. Review of the medical record revealed Resident #9 was admitted by the facility on 07/30/13 with diagnoses which included Diabetes and Schizophrenia.</p>	F 441	<i>See Attached, 10-15-14</i>

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F 441	<p>Continued From page 9</p> <p>Observation of perineal care for Resident #9, on 10/09/14 at 2:20 PM, revealed Kentucky Medication Aide (KMA) #1 changed her gloves before and after cleaning the rectal area, but failed to wash her hands. Further observation revealed KMA #1 proceeded to place a bag in the waste basket and elevate the Resident's bed.</p> <p>Interview with KMA #1, on 10/09/14 at 2:35 PM, revealed hand washing during perineal care should occur before and after the procedure, and anytime gloves were changed. Further interview revealed she should have washed her hands before and after cleaning the resident's rectal area. Additionally, she stated she should have not have touched the resident's bed without washing her hands.</p> <p>Interview with RN #2, on 10/09/14 at 3:05 PM, revealed gloves were to be changed and hands washed prior to cleaning the rectal area. Further interview revealed the KMA should not have placed a bag in the wastebasket and adjusted the resident's bed without changing gloves and washing her hands. Additional interview revealed staff were in-serviced on Infection Control, including handwashing, approximately two (2) months ago.</p> <p>3. Medical record review revealed Resident #12 was admitted by the facility on 03/25/13 with diagnoses which included Hypertension, Coronary Artery Disease, and Diabetes.</p> <p>Observation of care for Resident #12, on 10/09/14 at 3:15 PM, revealed Certified Nursing Assistant (CNA) #3 washed her hands and donned gloves, handed the resident's drinking glass and cellular phone and changed gloves, but</p>	F 441	<i>See Attached. 10-15-14</i>

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F 441	Continued From page 10 did not wash her hands. Continued observation revealed CNA #3 changed her gloves at appropriate other times while caring for Resident #12, but failed to wash her hands each time.  Interview with CNA #3, on 10/09/14 at 3:30 PM, revealed hand washing and changing of gloves should be completed before and after providing care, and any time there was a potential for contamination. Continued interview revealed she should have changed her gloves and washed her hands after touching the resident's cellular phone and drinking glass.  4. Review of Resident #7's medical record revealed the resident was admitted by the facility on 09/13/12 with diagnoses which included Anemia, Heart Failure, Non-Alzheimer's Dementia, Osteoarthritis, Depression, Anxiety, Chronic Kidney Disease and Rheumatoid Arthritis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/16/14, revealed the facility assessed Resident #7 to be moderately cognitively impaired. Further review of the MDS revealed the resident was assessed to be incontinent of bowel and bladder.  Observation of Incontinence care for Resident #7, on 10/09/14 at 9:45 AM, revealed CNA #4 washed her hands and applied gloves, touched the water faucet and the doorknob, and proceeded to provide incontinence care without washing her hands or changing her gloves. Continued observation revealed after CNA #4 completed the incontinence care she helped reposition the resident, placed a pillow behind the resident's back, and handled the bed linens prior to removing her gloves and washing her hands.	F 441	<i>See Attached. 10-15-14</i>		

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Interview with CNA #4, on 10/09/14 at 10:00 AM, revealed after she washed her hands and donned gloves, she should have used a paper towel to turn the water off, and should not have touched the doorknob. She stated it was an infection control issue because she had contaminated her gloves prior to touching the resident.  
  
Interviews with the DON, on 10/09/14 at 6:20 PM and 7:15 PM revealed staff should wash their hands each time gloves were changed. Continued interview revealed the procedure for gloving and handwashing should be followed before and after the provision of care, when moving from a dirty to clean area of the body, and after touching any object that was potentially contaminated. The DON stated proper performance of handwashing and glove-changing lowered the potential for cross-contamination and spread of infection.

F 441 *See Attached. 10-15-14*

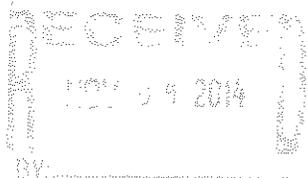
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2014  
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 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  10/09/2014
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
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Plan Approval: Unknown  Survey under: 2000 Existing  Facility Type: SNF/NF  Type of structure: One (1) story Type V(111) with basement  Smoke Compartments: Four (4)  Fire Alarm: Full fire alarm system  Sprinkler System: Automatic (dry) sprinkler system  Generator: Type II Diesel Generator  A Life Safety Code Survey was initiated and concluded on 10/09/14. The facility was not in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) with deficiencies cited. The facility is licensed for sixty-eight (68) beds and the census was fifty-five (55) on the day of the survey.  The following findings demonstrate noncompliance with the highest deficiency at "E" level.	K 000	<i>see attached 10/15/14</i>	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018	<i>see attached 10/15/14</i>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Zech TITLE: Administrator (X6) DATE: 10/31/14

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.

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K 018	<p>Continued From page 1</p> <p>hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of doors located in corridors as per National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-six (26) residents, staff and visitors. The findings include: Observation on 10/09/2014 at 1:38 PM, with the Maintenance Director, revealed the room 114 door was blocked from closing by a door wedge. Interview, with the Maintenance Director at the time of observation, revealed some staff was aware door wedges could not be used to prop corridor doors open, but the facility had not had</p>	K 018	<p><i>See Attached</i></p> <p><i>10/15/14</i></p>

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K 018	<p>Continued From page 2</p> <p>any formal training on improper use of door wedges with staff. Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and</p>	K 018	<p><i>See Attached</i></p> <p><i>10/15/14</i></p>

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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.	K 018	<i>See attached</i> 10/15/14
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, fifty-two (52) residents, staff and visitors. The findings include:  Observation on 10/09/14 at 12:48 PM, with the Maintenance Director, revealed the Maintenance	K 029	<i>See attached</i> 10/15/14

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K 029	Continued From page 4 Shop had a drop down hold open device. Interview, with the Maintenance Director, revealed he was not aware that drop down hold open devices could not be used on doors protecting hazardous areas.  Observation on 10/09/14 at 1:18 PM, with the Maintenance Director, revealed the Housekeeping Storage room ceiling was equipped with a set of pull down attic steps. Continued observation revealed when the ladder was fully retracted the ceiling had a gap of 1/2 inch around the edges of the pull down steps creating an opening in the smoke partition ceiling. Interview, with the Maintenance Director, revealed he was not aware of the gap around the pull down attic steps. Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ).	K 029	<i>See attached</i>	10/15/14

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K 029	Continued From page 5 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	<i>See attached 10/15/14</i>
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit egress was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, sixteen (16) residents, staff and visitors.  The findings include:  Observation on 10/09/14 at 12:52 PM, with the	K 038	<i>See attached 10/15/14</i>

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K 038	Continued From page 6 Maintenance Director, revealed the Utility Closet next to Nurse Station 2 projected greater than seven (7) inches into the corridor when in the fully open position. Interview, with the Maintenance Director, revealed he was not aware the door projected into the corridor greater than seven (7) inches when in the fully open position.  Observation on 10/09/1014 at 4:03 PM, with the Maintenance Director, revealed the door of the conference room being used by the State Survey team was equipped with double locks. The door had a slide bolt lock and a turn lock. Interview, with the Maintenance Director, revealed he was not aware the double locks on the conference room were not allowed since this area was only utilized by staff and was in the apartment area of the facility.  The findings were acknowledged by the Administrator during the exit conference.  Reference: NFPA 101 (2000 edition)  7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.) Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into	K 038	<i>All attached</i>	10/15/14	

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K 038	Continued From page 7 the required width of a stair or landing when the door is fully open  7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1:* Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations	K 038	<i>See attached</i>	10/15/14
K 056 SS=D	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	K 056	<i>See attached</i>	10/15/14

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K 056 Continued From page 8  
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 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

K 056

*See attached 10/15/14*

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure all areas were protected by the automatic sprinkler system, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty six (26) residents, staff and visitors.

The findings include:

Observation on 10/09/14 at 1:05 PM, with the Maintenance Director, revealed a small closet containing the electrical panels was not protected by the automatic sprinkler system. Interview, with the Maintenance Director, revealed the facility had not identified the area as needing to be protected by the automatic sprinkler system before the day of the survey.

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 101 (2000 edition)

19.1.6.2 Health care occupancies shall be limited

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K 056 Continued From page 9  
to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.)  
Exception: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:  
(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.  
(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.  
(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.

K 056 *See attached* 10/15/14

Table 19.1.6.2 Construction Type Limitations

Construction Type	Stories			
	1	2	3	4
I(443)	X	X	X	X
I(332)	X	X	X	X
II(222)	X	X	X	X
II(111)	X	X*	X*	NP
II(000)	X*	X*	NP	NP
III(211)	X*	X*	NP	NP
III(200)	X*	NP	NP	NP
IV(2HH)	X*	X*	NP	NP
V(111)	X*	X*	NP	NP
V(000)	X*	NP	NP	NP

X: Permitted type of construction.  
NP: Not permitted.

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K 056 Continued From page 10  
\*Building requires automatic sprinkler protection. (See 19.3.5.1.)  
19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.

K 056 *See attached* 10/5/14

Reference: Centers For Medicare and Medicaid Services Survey and Certification Letter 13-55-LSC

NFPA 13 (1999 Edition)  
5-13.11 Electrical Equipment. Sprinkler protection shall be required in electrical equipment rooms. Hoods or shields installed to protect important electrical equipment from sprinkler discharge shall be noncombustible. Exception: Sprinklers shall not be required where all of the following conditions are met:  
(a) The room is dedicated to electrical equipment only.  
(b) Only dry-type electrical equipment is used.  
(c) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations.  
(d) No combustible storage is permitted to be stored in the room.

K 062 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
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,

K 062 *See attached* 10/5/14

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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
K 062	<p>Continued From page 11 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler systems were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments.</p> <p>The findings include:</p> <p>Observation on 10/09/14 at 2:08 PM, with the Maintenance Director, revealed the spare sprinkler head box contained one (1) upright sprinkler and one (1) sidewall sprinkler head. Continued observations revealed the upright sprinkler head was damaged. Interview, with the Maintenance Director, revealed he was not aware of the requirement to have a minimum of two spare sprinkler head types per type of sprinkler heads located in the facility.</p> <p>Observation on 10/09/14 at 2:17 PM, with the Maintenance Director, revealed in the Laundry Room two (2) sprinkler heads which were dirty with lint. Interview, with the Maintenance Director, revealed he was unaware the sprinkler heads were dirty and he assumed the Laundry Department ensured the sprinkler heads were clean.</p> <p>The findings were confirmed with the Administrator during the exit conference.</p> <p>Reference: NFPA 25 (1998 edition) 2-4.1.4 A supply of at least six spare sprinklers</p>	K 062	<p><i>See attached</i></p> <p><i>10/15/14</i></p>

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K 062	<p>Continued From page 12</p> <p>shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100°F (38°C). Exception: Where dry sprinklers of different lengths are installed, spare dry sprinklers shall not be required, provided that a means of returning the system to service is furnished.</p> <p>2-4.1.5 The stock of spare sprinklers shall be as follows:</p> <p>(a) For protected facilities having under 300 sprinklers -no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers -no fewer than 24 sprinklers</p> <p>1-11.3 Corrective maintenance includes, but is not limited to, replacing loaded, corroded, or painted sprinklers; replacing missing or loose pipe hangers; cleaning clogged fire pump impellers; replacing valve seats and gaskets; restoring heat in areas subject to freezing temperatures where water-filled piping is installed; and replacing worn or missing fire hose or nozzies.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of 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</p>	K 062	<p><i>See attached</i></p> <p><i>10/21/14</i></p>

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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)
K 062	Continued From page 13 orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	<i>See attached</i> 10/15/14
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers were mounted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff and visitors.  The findings include:  Observation on 10/09/14 at 1:32 PM, with the Maintenance Director, revealed a fire extinguisher in the L-Hall was mounted at a height of six (6) feet and five (5) inches. Interview, with the Maintenance Director, revealed he was not aware the fire extinguisher could not be mounted at a height greater than five (5) foot.  The findings were acknowledged by the	K 064	<i>See attached</i> 10/15/14

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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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K 064	Continued From page 14 Administrator during the exit conference.  Reference: NFPA 10 (1996 edition) 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	<i>See attached</i> 10/15/14
K 147 SS=0	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical equipment was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff and visitors.  The findings include:  Observation on 10/09/14 at 1:26 PM, with the Maintenance Director, revealed two (2) electrical wiring junction boxes were missing the covers. Interview, with the Maintenance Director,	K 147	<i>See attached</i> 10/15/14

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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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K 147	Continued From page 15 revealed he was not aware the electrical wiring junction boxes did not have their covers.  Reference: NFPA 70 (1999 edition) 370-25. Covers and Canopies. In completed installations, each box shall have a cover, faceplate, or fixture canopy.	K 147	<i>See attached</i>	<i>10/15/14</i>