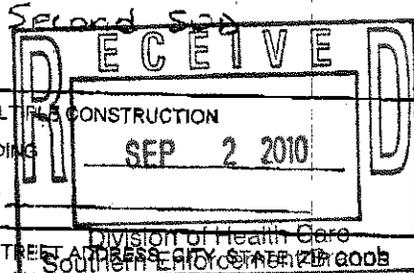


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2010
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 SEP 2 2010	(X3) DATE SURVEY COMPLETED 07/28/2010
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	Division of Health Care STREET ADDRESS, CITY, STATE, ZIP CODE 193 BERRYMAN ROAD FRENCHBURG, KY 40322
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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
F 000 F 281 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on July 26-28, 2010. Deficient practice was identified with the highest scope and severity at 'D' level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services to meet professional standards of quality for one (1) of fifteen (15) sampled residents. The facility failed to administer liquids to resident #6 as ordered by the resident's physician.</p> <p>The findings include:</p> <p>A review of the medical record for resident #6 revealed the resident was admitted to the facility on April 27, 2005, and the following diagnoses were listed: Alzheimer's, Parkinson's, Diabetes Mellitus, and Dysphagia. The medical record further revealed a physician's order dated July 1, 2010, for resident #6 to receive all liquids by spoon and no straws or cups were to be used.</p> <p>Observation of resident #6 on July 26, 2010, at 5:35 p.m., during the evening meal, revealed Licensed Practical Nurse (LPN) #1 administering liquids to the resident using a nose cup. Further observation on July 27, 2010, at 12:05 p.m., revealed Certified Nursing Assistant (CNA) #1 administering liquids to resident #6 using a nose cup.</p>	F 000 F 281	<p>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p><i>The facility has ensured the following corrective action:</i></p> <ul style="list-style-type: none"> Resident #6's tray card and diet order were reviewed. All liquids were placed in bowls for spoon feeding as ordered by physician. <p><i>The facility has taken the following action to prevent this practice from affecting other residents:</i></p> <ul style="list-style-type: none"> All facility residents who were receiving special eating equipment / special orders were reviewed for accuracy of practice on July 27, 2010. All such equipment were correct as prescribed by the resident's physician. Review and revision were accomplished to the facility's protocol for specialized eating equipment (<i>Attachment #1</i>). All diets and special utensils and/or special orders are to be administered only per written physician order. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anne Willis</i>	TITLE <i>Administrator</i>	(X6) DATE 9/2/10
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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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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 281	<p>Continued From page 1</p> <p>cup. The tray card for resident #6 revealed resident #6 was to receive liquids by spoon, and no straws or cups were to be used.</p> <p>An interview was conducted on July 27, 2010, with CNA #1 at 4:00 p.m. The CNA revealed he/she had not worked on the North Unit of the facility in at least one month, and was unaware of any resident on the unit which required liquids to be spoon fed. The CNA further revealed if a resident was required to have any special feeding requirements the information would be located on the resident's tray card and on the CNA Care Plan. The CNA stated he/she was unaware if resident #6 was required to have liquids be given only by spoon, and he/she assumed since the resident's tray had nose cups on it, the resident was to have his/her liquids fed using the nose cups.</p> <p>An interview was conducted on July 27, 2010, at 4:15 p.m., with the Dietary Manager (DM). The DM revealed dietary staff placed the nose cups on the trays for the residents who required them. The DM further revealed dietary staff receives orders from nursing staff, and this information is then placed on the resident's tray card. The DM stated dietary staff should not have put nose cups on a resident's tray which required liquids to be given by spoon.</p> <p>An interview was conducted on July 27, 2010, at 4:30 p.m., with LPN #1. The LPN revealed he/she remembered his/her mistake. The LPN stated he/she should have looked at the tray card prior to feeding resident #6. The LPN stated he/she assumed since the nose cups were on the tray the resident should have his/her liquids given with them. The LPN stated when receiving</p>	F 281	<p><i>The facility has initiated the following systemic changes to prevent this practice from recurring:</i></p> <ul style="list-style-type: none"> In-service training was provided to Dietary (7/27/10) and Nursing (7/30/10) staff regarding the facility protocol for special eating equipment / special diets / required physician orders. Nursing shall provide a copy of the written physician order for any special eating needs to the dietary staff on date received. Dietary shall provide the specified equipment ordered on the residents' meal tray. Facility Dietitian initiated the Diet Census Sheet (Attachment #2) during August 2-7, 2010. The Dietary Manager, or designee, shall modify the Diet Census Sheet and Resident Meal Tray Cards as orders are received. The Diet Census Sheet shall be posted at the serving line as reference. <p><i>The facility will sustain performance through the following monitoring practice:</i></p> <ul style="list-style-type: none"> The Dietary Manager shall review all resident Diet Census Sheets and Meal Cards on a monthly basis to ensure accuracy. A summary report for accuracy will be included monthly as an ongoing part of the Dietary department's Quality Assurance program. <p>COMPLETION DATE FOR F281: August 9, 2010</p>	

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322
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F 281	<p>Continued From page 2</p> <p>a diet order the order is placed on a diet order slip and sent to the Dietary Department. The information is then placed on the CNA Care Plan and on the Comprehensive Care Plan by the nurse.</p> <p>An interview was conducted on July 28, 2010, at 9:45 a.m., with the Director of Nursing (DON). The DON revealed when the nurse obtained a diet order from the physician the nurse was responsible for sending a diet slip to the Dietary Department. The DON further revealed the nurse then would be expected to document the diet order on the CNA Care Plan and on the Comprehensive Care Plan. The DON stated the Dietary Department was responsible for filling out the tray cards with the diet instruction and the nursing staff was responsible for looking at the tray cards to assure residents were being fed correctly.</p>	F 281		
F 456 SS=C	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain all essential equipment in safe operating condition. The facility freezer was observed on July 27, 2010, at 10:00 a.m., to have frozen condensation seeping from between the overhead ceiling plates. In addition, ice was forming on the condensation drainage pipe.</p> <p>The findings include:</p>	F 456	<p>F456 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p><i>The facility has ensured the following corrective action:</i></p> <ul style="list-style-type: none"> A certified HVAC service technician inspected the walk-in freezer on 7/29/10. Service was provided to remove a blockage to the tube drain which had resulted in the build up of condensation in the unit. <p><i>The facility has taken the following action to prevent this practice from affecting other residents:</i></p> <ul style="list-style-type: none"> The unit was repaired on 7/29/10. 	

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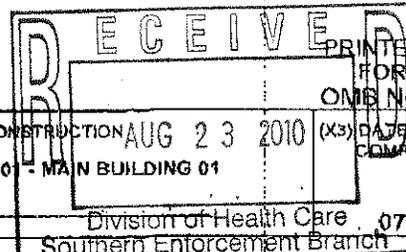
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2010
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322
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F 456	<p>Continued From page 3</p> <p>During the final sanitation audit of the facility kitchen conducted on July 27, 2010, at 10:00 a.m., frozen condensation was observed to have accumulated between the overhead metal ceiling plates in the freezer. In addition, the condensation drainage pipe had an accumulation of ice around the exterior surface of the drainage pipe. The condensation had the potential to contaminate the stored frozen foods for resident use.</p> <p>An interview was conducted with the Dietary Manager on July 28, 2010, at 3:00 p.m. The Dietary Manager stated she was unaware of the leak of condensation in the freezer. The Dietary Manager stated the leak had not been reported to the Maintenance Department.</p> <p>An interview was conducted with the Facility Administrator on July 28, 2010, at 10:30 a.m. The Facility Administrator stated he/she had not been notified of the condensation leak.</p> <p>Reference: KRS 217.127 Section 5</p>	F 456	<p><i>The facility has initiated the following systemic changes to prevent this practice from recurring:</i></p> <ul style="list-style-type: none"> The Dietary staff monitor the walk-in freezer, and other kitchen equipment, three times daily (AM, noon, PM) and record temperatures for each. All staff received in-service training to include a visual check for condensation during these periods. Any observation of condensation it to be reported immediately to the Dietary Manager and/or to maintenance personnel. <p><i>The facility will sustain performance through the following monitoring practice:</i></p> <ul style="list-style-type: none"> The Consulting Dietitian and Environmental Services Director shall inspect all refrigerators, milk cooler, and walk-in freezer weekly to ensure no further recurrences of condensation. <p>COMPLETION DATE FOR F456: July 29, 2010</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165423	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED AUG 23 2010 07/27/2010
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322
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K 000 K 062 SS=D	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on July 27, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70.</p> <p>The highest scope and severity deficiency identified was a "D" level, NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain sprinkler heads according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on July 27, 2010, at 10:21 a.m., revealed that the facility had a total of three sprinkler heads in the kitchen area that had a buildup of grease. Sprinkler heads must be kept clean in order to properly activate during a fire. The observation was confirmed with the Director of Maintenance at the time of discovery.</p> <p>Interview on July 27, 2010, at 10:21 a.m., with the Director of Maintenance, revealed that he was unaware of the three sprinkler heads in the kitchen being dirty.</p> <p>Reference: NFPA 25 (1999 Edition).</p>	K 000 K 062	<p>K062 LIFE SAFETY CODE STANDARD</p> <p><i>The facility has ensured the following corrective action:</i></p> <ul style="list-style-type: none"> Cleaning of all sprinkler head units in the kitchen area was complete on 7/27/10 by the Environmental Services and Dietary staff. <p><i>The facility has taken the following action to prevent this practice from affecting other residents:</i></p> <ul style="list-style-type: none"> The units were cleaned of grease build-up as stated above. <p><i>The facility has initiated the following systemic changes to prevent this practice from recurring:</i></p> <ul style="list-style-type: none"> The Dietary Manager shall inspect and maintain records of all sprinkler head cleaning a minimum of monthly to ensure proper maintenance/cleaning (Attachment #3). The Dietary Staff shall complete routine cleaning per facility protocol. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anne Wells</i>	TITLE <i>Administrator</i>	(X6) DATE 8/18/10
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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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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
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K 062	Continued From page 1 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 orientation.	K 062	<i>The facility will sustain performance through the following monitoring practice:</i> <ul style="list-style-type: none"> The Environmental Services Director shall inspect all sprinkler head units a minimum of monthly to ensure proper maintenance / cleaning as part of the ongoing Quality Assurance program (Attachment #3). <p>COMPLETION DATE FOR K062: July 28, 2010</p>	