

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

PRINTED: 11/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/19/2010
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 135 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 323	Continued From page 17 1:30 p.m. and 2:25 p.m., with SRNA #3 and SRNA #4 revealed the SRNAs were working on the North Unit on October 10, 2010. Both SRNAs stated there were three staff members (one nurse and two SRNAs) on the North Unit on the weekends. The interview revealed the nurse and one of the SRNAs took lunch break from 10:30-11:00 a.m., and the other SRNA took lunch from 11:00-11:30 a.m. The SRNAs stated one staff member was on the North Unit when resident #1 exited the facility through the North Unit side door. The interview revealed SRNA #4 was the staff member on the North Unit when resident #1 exited the building. SRNA #4 denied hearing the North side door alarm, or seeing resident #1 on the North Unit during that time. The SRNA stated he/she was in and out of resident rooms and was not at the nurses' station (near the exit door). An interview conducted on October 19, 2010, at 1:05 p.m., with SRNA #2 revealed the SRNA was working on the South Unit on Sunday, October 10, 2010. SRNA #2 stated he/she was walking up the North Unit hallway toward the time clock at around 10:45 a.m., and heard the North Unit exit door alarm. The SRNA revealed when he/she reached the exit door resident #3 was standing at the door with the resident's hand on the door handle. The SRNA #2 redirected resident #3 away from the door, reset the alarm panel, and clocked out for lunch. SRNA #2 stated he/she did not perform a visual inspection of the exterior area because the SRNA thought resident #3 had activated the North Unit exit door. According to SRNA #2, he/she was unaware resident #3 had been pushing resident #1 in the wheelchair earlier that morning.	F 323	basis to ensure all devices are functioning properly. (Attachment #8) A summary of inspections shall be included as an <i>ongoing</i> part of the Environmental Services Director's monthly Quality Assurance review. (Attachment #9) COMPLETION DATE FOR F323: October 21, 2010	

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F 323	<p>Continued From page 18</p> <p>An interview conducted on October 13, 2010, at 1:35 p.m., with LPN #2 revealed the LPN wrote a physician's order, and placed the wanderguard bracelet on resident #1, on Sunday, September 26, 2010, because the resident was wandering around the front door.</p> <p>Interviews conducted on October 12, 2010, at 3:10 p.m., and on October 13, 2010, at 3:40 p.m., with the DON revealed when a side exit door alarm sounded, staff was required to check the alarm reset panel to determine which door was opened, and observe the interior and exterior area surrounding the door to ensure there were no residents outside the facility prior to resetting the alarm. The DON stated the facility thought resident #3 let resident #1 out the North Unit side door because resident #3 was pushing resident #1 in a wheelchair throughout the facility earlier that day. The DON revealed staff reviewed the facility's exterior video surveillance for October 10, 2010, and verified resident #1 exited the facility out the North Unit side door. According to the DON, the facility video indicated that no staff opened the door to perform a visual inspection of the exterior after resident #1 exited the facility. The DON stated when a wanderguard bracelet was applied to a resident no other interventions were implemented to monitor the wandering resident. The interview revealed the facility did not perform additional monitoring of residents with wanderguard bracelets.</p> <p>An interview conducted on October 13, 2010, at 4:17 p.m., with the Administrator revealed the review of the exterior video surveillance indicated resident #1 exited the facility on Sunday October 10, 2010, at 10:45 a.m., and was found by SRNA #1 at 11:20 a.m. The interview revealed the</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>facility's front door was the only door equipped with the wandeguard alarm system, which sounded when the door was opened and a resident with a wandeguard bracelet was in the area. The Administrator stated the three side exit doors were equipped with an alarm system that sounded when the doors were opened. According to the Administrator, the wandeguard alarm was louder and more intense than the side exit door alarms.</p> <p>Interviews conducted on October 13, 2010, at 2:00 p.m., with SRNA #5, at 2:10 p.m., with LPN #3, at 2:40 p.m., with SRNA #6, and at 3:00 p.m., with LPN #4, and on October 19, 2010, at 1:05 p.m., with SRNA #2 revealed when a side exit door alarm sounded, staff was required to check the alarm reset panel to determine which door was opened, and observe the interior and exterior area surrounding the door to ensure there were no residents outside the facility prior to resetting the alarm.</p> <p>An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on October 19, 2010, which alleged removal of Immediate Jeopardy effective October 16, 2010. A partial extended survey was conducted on October 18-19, 2010, which determined the Immediate Jeopardy was removed on October 16, 2010.</p> <p>Interviews with the Administrator and the Director of Nursing (DON), observations, and review of facility records on October 18-19, 2010, revealed on October 10, 2010, an immediate head count was performed for all facility residents following the discovery of the elopement of resident #1. Two additional head counts were performed on</p>	F 323		
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F 323	Continued From page 20 the same date to ensure all residents were accounted for. On October 11, 2010, the facility initiated head counts performed every four hours around the clock and documented on the 24-hour communication sheets and the resident census sheet. The head counts were performed by the nursing staff utilizing the resident census sheet to do a visual accountability. The head counts practice continued until October 12, 2010, at which time a monitor (Charge Nurse) was placed at each nurses' station at all times. If the Charge Nurse left the nurses' station to perform other duties the Charge Nurse was responsible to ensure a replacement staff member visually monitored the exit doors in his/her absence. The Charge Nurse was required to sign a monitoring form which indicated the Charge Nurse or designee was on duty monitoring the doors. In the event of an emergency situation, the South Unit Charge Nurse shall assign a person to remain in the front hallway where a visual and auditory monitoring can be performed of all three side exit doors. The nursing supervisor in-serviced staff on this new practice from October 12, 2010, through October 15, 2010. Observations were conducted on October 18-19, 2010, that verified each nurses' station had at least one staff member monitoring the side exit doors at all times. The monitoring forms were also reviewed and the forms indicated staff was monitoring the exit doors as planned. Interviews with the Administrator, observations, and review of facility records on October 12-19, 2010, revealed on October 11, 2010, deterrent strips (mesh strips that display a large, red Stop sign) which covered the width of the doorway were placed over each side exit doorway. The deterrent strips were observed over the exit	F 323			

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F 323	Continued From page 21 doorways on October 19, 2010. Interviews with Charge Nurses and review of the facility records on October 18-19, 2010, revealed the Charge Nurses were to visually inspect the alarm panel four times during each shift (a total of eight times in 24 hours) and document the alarm panel status on the communication sheet. This practice continued until October 12, 2010. Interviews with the Administrator and the DON, observations, and review of the facility records on October 12-19, 2010, revealed the Department Head supervisors verbally reviewed the Door Alarm Protocol with their respective staff as each employee reported for their work duties. The Protocol was documented as a Memo and posted at each nurses' station and at the time clock. Observations on October 12, 2010, verified the Memos were posted at the nurses' stations and at the time clock. Interview with the Administrator, observations, and review of the facility records on October 18-19, 2010, revealed a new Protocol was initiated regarding an "Identification Record" to be compiled of each resident assessed to be at risk of elopement. The "Identification Record" contained a picture image of the resident with identifying information for use in the event of an elopement. A copy of the completed "Identification Record" binder will be kept in the Medical Records office, at each nurses' station, and in the Business office, and a poster of the residents will be placed in the employee break room for ongoing reference. Observations on October 19, 2010, verified the "Identification Record" binders and poster were in the designated areas.	F 323			

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F 323	Continued From page 22 Interview with the Administrator and the Maintenance Supervisor, observation, and review of the facility records on October 18-19, 2010, revealed on October 13, 2010, a new "back-up" door alarm was placed on the side exit doors. The "back-up" door alarm sounded, in addition to the original door alarm, and must be manually disarmed by a key. The Charge Nurse was responsible for disarming the second alarm and carried the disarming key. Observations on October 18-19, 2010 verified the "back-up" alarms were in place on the side exit doors. The temporary alarms will be replaced with permanently mounted alarm units which were ordered on October 13, 2010. Interview with the Administrator and the DON and review of the facility records on October 18-19, 2010, revealed on October 13, 2010, the facility revised the Door Alarm protocol/policy to include the "back-up" door alarms applied to the side exit doors. The protocol/policy also included the staff instruction for response to a triggered door alarm. All employees were verbally in-serviced on the protocol/policy on October 13, 2010. Interviews with staff on October 18-19, 2010, confirmed staff attended the in-service training and was knowledgeable of the information regarding the revised door alarm protocols. Interview with the Administrator and review of the facility records on October 18-19, 2010, revealed the following additions have been added to the Orientation practice. Nursing staff shall orient all employees upon hire and at least annually on the Elopement Policy and the Door Alarm Policy and provide each a copy of the policies.	F 323		

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F 323	<p>Continued From page 23</p> <p>Interview with the Administrator and review of the facility records on October 18-19, 2010, revealed the following additions have been added to the Quality Assurance practice. The DON or ADON shall review shift reports on a daily basis to ensure the signature of the assigned charge nurse was documented for the monitoring of the doors and the door alarm panel. Once the Immediate Jeopardy has been removed the DON will summarize the daily reviews on a monthly basis as part of the QI review.</p> <p>Interview with the Administrator and review of the facility records on October 18-19, 2010, revealed staff was in-serviced on October 11-15, 2010, that in the event of a triggered door alarm nursing staff was to inspect the exterior and interior area for any residents and initiate an Immediate head count of all facility residents. Interviews with staff on October 19, 2010, confirmed staff attended the In-service training and was knowledgeable of the information regarding the door alarm protocols.</p> <p>Based on the above findings, it was determined on October 19, 2010, the Immediate Jeopardy was removed effective October 16, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the implementation of systemic changes and quality of assurance activities.</p>	F 323		
F 490 SS=J	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>	F 490	<p>F490 EFFECTIVE ADMINISTRATION/ RESIDENT WELL-BEING</p> <p><i>The facility has ensured the following corrective actions:</i></p> <p>The individual care plan for Residents #1, identified as being</p>	

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F 490	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the Administration of the facility failed to ensure the facility's resources were utilized effectively and efficiently to provide the required care and services to the residents. The facility Administration failed to ensure resident #1 had interventions in place to prevent elopement, and failed to ensure staff implemented the door alarm policy. (Refer to F280 and F323.) Resident #1, who was assessed by the facility to be at risk for wandering/elopement, exited the facility without staff knowledge on October 10, 2010. The resident was located in the employee parking lot, at the side of the facility 35 minutes later. The facility Administration's failure to ensure adequate supervision was provided placed residents in the facility at risk for serious injury, harm, impairment, or death. The findings include: Review of nurse's notes dated September 26, 2010, revealed resident #1 attempted to exit the facility, and had a wanderguard bracelet placed at that time. Observation on October 12, 2010, revealed only the facility's front door was equipped with the wanderguard system. Further observation revealed the three additional side doors were equipped with only an alarm that sounded when the door was opened. Review of the facility Door Alarm policy dated	F 490	at risk for wandering / elopement behavior, was revised on 10/13/10. The care plan revision includes wandering / elopement risk as a problem area, and outlined interventions for staff use. Examples of interventions include, but are not limited to: notification of physician; the placement of a wander guard device if ordered by physician; offering of alternate activities, such as toileting, snacks, group activity; and 1:1 supervision as needed. A designated staff member was assigned to monitor the three exit fire doors, around-the-clock, until the permanent secondary alarms were placed on each door. Each nurse station charge nurse coordinated, assigned and documented that the monitor was in place on the daily shift report sheets provided to the Director of Nursing. Staff were in-service on the revised Door Alarm Policy and additional alarms on 10/13/10.	

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F 490	<p>Continued From page 25</p> <p>January 24, 2004, revealed when a door alarm sounded staff should observe both the interior of the facility and the exterior of the facility.</p> <p>Review of the facility's investigation into resident #1's elopement dated October 10, 2010, revealed the facility's exterior video surveillance showed resident #1 exited the North Unit side door on October 10, 2010, at 10:45 a.m. The investigation stated SRNA #1 found resident #1 in the employee parking lot at 11:30 a.m. The investigation revealed SRNA #2 heard the North Unit side door alarm, observed resident #3 with the resident's hand on the door handle, redirected the resident away from the door, reset the door alarm, and clocked out for lunch. According to the investigation the exterior video revealed no staff member observed the exterior of the facility prior to resetting the alarm. The investigation concluded that SRNA #2 did not perform an exterior inspection of the facility, as per door alarm protocol, assuming resident #3 pushed on the door handle, sounding the side door alarm. (Refer to F323.)</p> <p>An interview conducted on October 19, 2010, at 8:50 a.m. and 10:40 a.m., with the Director of Nursing (DON) revealed the wanderguard bracelets were an intervention added to a resident's care plan when the bracelet was applied to the resident. In addition, the DON stated a resident's wandering behavior was not identified as a care plan problem; therefore, no other interventions were implemented other than the wanderguard bracelet. (Refer to F280.)</p> <p>An interview conducted on October 13, 2010, at 4:17 p.m. and on October 19, 2010, at 1:25 p.m., with the Administrator revealed the facility's front</p>	F 490	<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 facility entrance door has in place a wander guard system that alerts staff by alarm to the potential elopement of a resident who are wearing a wander guard device. All other exit doors, designated as fire exits, have been equipped with a permanent secondary alarm that sounds at 105 decibels until manually disengaged by a key. All staff were in-serviced on the Door Alarm Policy revisions on 10/13/10, with the specification of the Charge nurse personnel as the designated staff permitted to re-set any door alarm and the mandate for the initiation of a complete head count of residents any time a door alarm is activated. <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 placement of secondary alarms at each exit fire door shall provide the staff with two separate and independent alarming systems, each requiring separate 	

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F 490	Continued From page 26 door was the only door equipped with the wanderguard alarm system, which only sounded when the door was opened and a resident with a wanderguard bracelet was in the area. The Administrator stated the three side exit doors were equipped with an alarm system that sounded when the doors were opened. According to the Administrator, the wanderguard alarm was louder and more intense than the side exit door alarms. The interview revealed the Administrator was unaware there was only one intervention (wanderguard) implemented for residents identified to exhibit wandering behavioral symptoms, even though the wanderguard system was present only on the front door. **An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on October 19, 2010, which alleged removal of Immediate Jeopardy effective October 16, 2010. A partial extended survey was conducted on October 18-19, 2010, which determined the Immediate Jeopardy was removed on October 16, 2010. Interviews with the Administrator and the Director of Nursing (DON) and review of the facility records on October 18-19, 2010, revealed the facility reassessed all residents in the facility on October 12, 2010, utilizing a Elopement Risk Assessment. Other than the 12 residents previously assessed to be at risk for elopement who wore wanderguard bracelets, no other residents were identified as an elopement risk. The facility implemented new Elopement care plans for each of the 12 residents assessed to be at risk for elopement with multiple interventions to be implemented to include visual checks every	F 490	action to disengage / re-set The facility will sustain performance through the following monitoring practice: <ul style="list-style-type: none"> All activated door alarms shall be recorded by the charge nurse on the Elopement Attempt Report sheet and submitted to the Director of Nursing as they occur. For all activated door alarms, the Charge Nurse shall initiate an immediate resident head count to determine if an elopement has occurred. If an elopement occurred, the Charge Nurse shall proceed with the facility investigative reporting proceedings per facility policy. (Attachment #4) All Elopement Attempt Reports will be reviewed, per occurrence, by the facility Administrator, Director of Nursing, and other designees as appointed by the Administrator. Nursing Staff were in-serviced on the Elopement Attempt Report on 10/20/10. (Attachment #10) As part of the ongoing monthly Quality Assurance review indicators for the nursing department, the Director of Nursing shall review and report a summary of the # of activated alarms, elopement attempts, and 	

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F 490	<p>Continued From page 27</p> <p>two hours. Observations revealed the residents' care plans were followed and all interventions related to wandering/elopement for residents were implemented.</p> <p>Review of the facility's in-service records and interviews with the Administrator and DON on October 18-19, 2010, revealed staff was re-educated on the facility's new Elopement Risk Assessment, the new 3.0 MDS assessment forms, and the new Elopement care plan to include visual checks every two hours. Interviews with staff on October 19, 2010, confirmed staff attended the in-service training and was knowledgeable of the information regarding the new Elopement resident assessment and care plan information.</p> <p>Interviews with the Administrator and the Director of Nursing (DON), observations, and review of facility records on October 18-19, 2010, revealed on October 10, 2010, an immediate head count was performed for all facility residents following the discovery of the elopement of resident #1. Two additional head counts were performed on the same date to ensure all residents were accounted for. On October 11, 2010, the facility initiated head counts performed every four hours around the clock and documented on the 24-hour communication sheets and the resident census sheet. The head counts were performed by the nursing staff utilizing the resident census sheet to do a visual accountability. The head counts practice continued until October 12, 2010, at which time a monitor (Charge Nurse) was placed at each nurses' station at all times. If the Charge Nurse left the nurses' station to perform other duties, the Charge Nurse was responsible to ensure a replacement staff member visually</p>	F 490	<p>to the Administrator (Attachment #5)</p> <p>The facility Medical Director shall review all monthly quality indicator reports, including those of the nursing and maintenance departments, during the quarterly Quality Assurance Meeting.</p> <p>COMPLETION DATE FOR F490: October 21, 2010</p>	

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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 C 10/19/2010
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 490	<p>Continued From page 28</p> <p>monitored the exit doors in his/her absence. The Charge Nurse was required to sign a monitoring form which indicated the Charge Nurse or designee was on duty monitoring the doors. In the event of an emergency situation, the South Unit Charge Nurse shall assign a person to remain in the front hallway where a visual and auditory monitoring can be performed of all three side exit doors. The nursing supervisor in-serviced staff on this new practice from October 12, 2010, through October 15, 2010. Observations were conducted on October 18-19, 2010, that verified each nurses' station had at least one staff member monitoring the side exit doors at all times. The monitoring forms were also reviewed and the forms indicated staff was monitoring the exit doors as planned.</p> <p>Interviews with the Administrator, observations, and review of facility records on October 12-19, 2010, revealed on October 11, 2010, deterrent strips (mesh strips that display a large, red Stop sign) which covered the width of the doorway were placed over each side exit doorway. The deterrent strips were observed over the exit doorways on October 19, 2010.</p> <p>Interviews with Charge Nurses and review of the facility records on October 18-19, 2010, revealed the Charge Nurses were to visually inspect the alarm panel four times during each shift (a total of eight times in 24 hours) and document the alarm panel status on the communication sheet. This practice continued until October 12, 2010.</p> <p>Interviews with the Administrator and the DON, observations, and review of the facility records on October 12-19, 2010, revealed the Department Head supervisors verbally reviewed the Door</p>	F 490			

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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 490	<p>Continued From page 29</p> <p>Alarm Protocol to their respective staff as each employee reported for their work duties. The Protocol was documented as a Memo and posted at each nurses' station and at the time clock. Observations on October 12, 2010, verified the Memos were posted at the nurses' stations and at the time clock.</p> <p>Interview with the Administrator, observations, and review of the facility records on October 18-19, 2010, revealed a new Protocol was initiated regarding an "Identification Record" to be compiled of each resident assessed to be at risk of elopement. The "Identification Record" contained a picture image of the resident with identifying information for use in the event of an elopement. A copy of the completed "Identification Record" binder will be kept in the Medical Records office, at each nurses' station, and in the Business office, and a poster of the residents will be placed in the employee break room for ongoing reference. Observations on October 19, 2010, verified the "Identification Record" binders and poster were in the designated areas.</p> <p>Interview with the Administrator and the Maintenance Supervisor, observation, and review of the facility records on October 18-19, 2010, revealed on October 13, 2010, a new "back-up" door alarm was placed on the side exit doors. The "back-up" door alarm sounded in addition to the original door alarm, and must manually be disarmed by a key. The Charge Nurse was responsible for disarming the second alarm and carried the disarming key. Observations on October 18-19, 2010, verified the "back-up" alarms were in place on the side exit doors. The temporary alarms will be replaced with</p>	F 490			

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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 490	Continued From page 30 permanently mounted alarm units which were ordered on October 13, 2010. Interview with the Administrator and the DON and review of the facility records on October 18-19, 2010, revealed on October 13, 2010, the facility revised the Door Alarm protocol/policy to include the "back-up" door alarms applied to the side exit doors. The protocol/policy also included the staff instruction for response to a triggered door alarm. All employees were verbally in-serviced on the protocol/policy on October 13, 2010. Interviews with staff on October 18-19, 2010, confirmed staff attended the in-service training and was knowledgeable of the information regarding the revised door alarm protocols. Interview with the Administrator and review of the facility records on October 18-19, 2010, revealed the following additions have been added to the Orientation practice. Nursing staff shall orient all employees upon hire and at least annually on the Elopement Policy and the Door Alarm Policy and provide each a copy of the policies. Interview with the Administrator and review of the facility records on October 18-19, 2010, revealed the following additions have been added to the Quality Assurance practice. The DON or ADON shall review shift reports on a daily basis to ensure the signature of the assigned Charge Nurse was documented for the monitoring of the doors and the door alarm panel. Once the Immediate Jeopardy has been removed the DON will summarize the daily reviews on a monthly basis as part of the QI review. The Administrator oversees the QI meetings. Interview with the Administrator and review of the	F 490			

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 795 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 490	<p>Continued From page 31</p> <p>facility records on October 18-19, 2010, revealed staff was in-serviced on October 11-15, 2010, that in the event of a triggered door alarm nursing staff was to inspect the exterior and interior area for any residents and initiate an immediate head count of all facility residents. Interviews with staff on October 19, 2010, confirmed staff attended the in-service training and was knowledgeable of the information regarding the door alarm protocols.</p> <p>Based on the above findings, it was determined on October 19, 2010, the Immediate Jeopardy was removed effective on October 16, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the implementation of systematic changes and quality of assurance activities.</p>	F 490		