

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

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/06/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based on implementation of the acceptable PoC, the facility was deemed to be in compliance, 09/06/13, as alleged.	{F 000}		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An abbreviated survey (KY #20521) was conducted on 08/13/13 through 08/14/13 to determine the facility's compliance with Federal requirements. KY #20521 was substantiated with a regulatory citation.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated.</p>	F 225	 <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F 225</p> <p>Resident #1 was transported to the hospital on 07/22/13 and is no longer a resident at this facility. On 7/31/13 the Administrator filed a report with the State agencies and Office of Inspector General for an allegation of abuse & neglect related to injury of unknown origin.</p> <p>Current resident incident & accidents were reviewed by the Director of</p>	09/6/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Gorence TITLE: Administrator (X6) DATE: 090513

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER,			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy and procedure review, it was determined the facility failed to report an injury of unknown origin to the State Survey Agency for one resident (#1), in the selected sample of three (3) residents.</p> <p>The findings include: A review of the facility policy and procedure titled, "Abuse Prohibition - State of Kentucky", dated 07/01/13, revealed an injury of unknown origin is an injury with both of the following conditions. 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the patient; and 2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Staff will identify events - such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse - and determine the direction of the investigation. Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor</p>	F 225	<p>Nursing and Assistant Director of Nursing to identify any that may be of unknown origin. No injuries of unknown origin noted.</p> <p>On 08/6/2013 the Regional Vice-President of Operations re-educated the Administrator on the center's policies and federal regulations regarding investigating/reporting injuries of unknown origin and any suspicions of abuse and neglect. On 09/04/2013 the Administrator re-educated the department managers on the center's policies and federal regulations regarding investigating/reporting injuries of unknown origin and any suspicions of abuse and neglect. On 09/05/2013 the Director of Nursing Services, Assistant Director of Nursing Services and the Staff Development Coordinator completed re-education with staff on the center's policies and federal regulations regarding investigating/reporting injuries of unknown origin and any suspicions of abuse and neglect.</p> <p>Daily for the next three months the Director of Nursing Services and Assistant Director of Nursing Services, Unit Manager or Charge Nurse will audit resident accident & incidents to ensure any injury of unknown origin is/has been reported per policy and</p>		

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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 225	<p>Continued From page 2</p> <p>immediately. The notified supervisor will report the suspected abuse immediately (not to exceed 24 hours) to the Administrator or designee and other officials in accordance with state law. Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected.</p> <p>A record review revealed Resident #1 was admitted to the facility on 01/01/06 with diagnoses to include Cerebral Palsy and Osteoporosis. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility assessed Resident #1's cognition as severely impaired.</p> <p>A review of the Change of Condition documentation dated 07/22/13 and interviews with Licensed Practical Nurse (LPN) #1 on 8/13/13 at 2:00 PM and SRNA #1 on 08/14/13 at 10:15 AM, revealed on 07/22/13, after the evening meal, the LPN and SRNA were transferring Resident #1 back to bed from the wheelchair by lifting the resident beneath the arms. When the staff pulled the resident's pants down to provide incontinent care, it was discovered the resident's left leg locked different than usual. Due to the resident's contractures, the resident's legs normally would not touch the bed but it was noted that the left leg was touching the bed. The staff immediately reported this to the charge nurse, who then notified the Advanced Practice Registered Nurse (APRN) and the family. The resident was transported to the emergency department via ambulance. A review of the hospital History and Physical (H&P), dated 07/22/13, revealed Resident #1 was admitted with a diagnosis of Mid Femoral Shaft Fracture, presumably due to longstanding osteoporosis and immobilized state.</p>	F 225	federal regulation. The Director of Nursing will report findings to the Performance improvement Committee monthly for three months for further recommendations.		

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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 225	Continued From page 3 An interview with the APRN, on 08/14/13 at 9:54 AM, revealed she received a call from the charge nurse (CN) on 07/22/13, in the evening. The CN reported to the APRN Resident #1 was noted to have a obvious deformity to the left upper leg and the staff feared it might be fractured. Orders were given to the CN to have the resident transported to the emergency department and to notify the resident's mother of the findings. The APRN revealed she had seen the resident a couple of hours earlier in the facility and the resident did not appear to be in any distress. There was no reported injury. The APRN revealed it was determined the resident had a spontaneous fracture due to the resident's history of osteoporosis and osteopenia. An interview with the Administrator, on 08/14/13 at 11:01 AM, revealed the investigation regarding Resident #1 was started on the morning of 07/23/13 by interviewing staff and getting statements from them. She stated the fracture of the leg was not reported to the State agencies because after speaking with the Nurse Practitioner, they felt the fracture was spontaneous in nature due to a similar fracture in the past and because of no known injury.	F 225			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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) COMPLETE DATE
N 000	INITIAL COMMENTS A complaint survey (KY #20521) was conducted on 08/13/13 through 08/14/13 to determine the facility's compliance with State requirements. KY #20521 was substantiated with deficiency cited.	N 000	 <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
N 110	<p>902 KAR 20:300-5(3)(d) Section 5. Resident Behavior & Fac. Practice</p> <p>(3) Staff treatment of residents. (d) The facility shall document alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, are reported immediately to the administrator of the facility or to other officials in accordance with KRS Chapters 209 and 620.</p> <p>This requirement is not met as evidenced by: Based on interview, record review and policy and procedure review, it was determined the facility failed to report an injury of unknown origin to the State Survey Agency for one resident (#1), in the selected sample of three (3) residents.</p> <p>The findings include:</p> <p>A review of the facility policy and procedure titled, "Abuse Prohibition - State of Kentucky", dated 07/01/13, revealed an injury of unknown origin is an injury with both of the following conditions. 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the patient; and 2) The injury is suspicious because of the extent of the injury or</p>	N 110		
			F 225 Resident #1 was transported to the hospital on 07/22/13 and is no longer a resident at this facility. On 7/31/13 the Administrator filed a report with the State agencies and Office of Inspector General for an allegation of abuse & neglect related to injury of unknown origin. Current resident incident & accidents were reviewed by the Director of	09/6/13

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

Carolyn J. Lawrence

TITLE

Administrative

(X6) DATE

0905/13

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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) COMPLETE DATE	
N 110	<p>Continued From page 1</p> <p>the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Staff will identify events - such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse - and determine the direction of the investigation. Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. The notified supervisor will report the suspected abuse immediately (not to exceed 24 hours) to the Administrator or designee and other officials in accordance with state law. Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected.</p> <p>A record review revealed Resident #1 was admitted to the facility on 01/01/06 with diagnoses to include Cerebral Palsy and Osteoporosis. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility assessed Resident #1's cognition as severely impaired.</p> <p>A review of the Change of Condition documentation dated 07/22/13 and interviews with Licensed Practical Nurse (LPN) #1 on 8/13/13 at 2:00 PM and SRNA #1 on 08/14/13 at 10:15 AM, revealed on 07/22/13, after the evening meal, the LPN and SRNA were transferring Resident #1 back to bed from the wheelchair by lifting the resident beneath the arms. When the staff pulled the resident's pants down to provide incontinent care, it was discovered the resident's left leg looked different than usual. Due to the resident's contractures, the</p>	N 110	<p>Nursing and Assistant Director of Nursing to identify any that may be of unknown origin. No injuries of unknown origin noted.</p> <p>On 08/6/2013 the Regional Vice-President of Operations re-educated the Administrator on the center's policies and federal regulations regarding investigating/reporting injuries of unknown origin and any suspicions of abuse and neglect. On 09/04/2013 the Administrator re-educated the department managers on the center's policies and federal regulations regarding investigating/reporting injuries of unknown origin and any suspicions of abuse and neglect. On 09/05/2013 the Director of Nursing Services, Assistant Director of Nursing Services and the Staff Development Coordinator completed re-education with staff on the center's policies and federal regulations regarding investigating/reporting injuries of unknown origin and any suspicions of abuse and neglect.</p> <p>Daily for the next three months the Director of Nursing Services and Assistant Director of Nursing Services, Unit Manager or Charge Nurse will audit resident accident & incidents to ensure any injury of unknown origin is/has been reported per policy and</p>		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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) COMPLETE DATE
N 110	<p>Continued From page 2</p> <p>resident's legs normally would not touch the bed but it was noted that the left leg was touching the bed. The staff immediately reported this to the charge nurse, who then notified the Advanced Practice Registered Nurse (APRN) and the family. The resident was transported to the emergency department via ambulance. A review of the hospital History and Physical (H&P), dated 07/22/13, revealed Resident #1 was admitted with a diagnosis of Mid Femoral Shaft Fracture, presumably due to longstanding osteoporosis and immobilized state.</p> <p>An interview with the APRN, on 08/14/13 at 9:54 AM, revealed she received a call from the charge nurse (CN) on 07/22/13, in the evening. The CN reported to the APRN Resident #1 was noted to have a obvious deformity to the left upper leg and the staff feared it might be fractured. Orders were given to the CN to have the resident transported to the emergency department and to notify the resident's mother of the findings. The APRN revealed she had seen the resident a couple of hours earlier in the facility and the resident did not appear to be in any distress. There was no reported injury. The APRN revealed it was determined the resident had a spontaneous fracture due to the resident's history of osteoporosis and osteopenia.</p> <p>An interview with the Administrator, on 08/14/13 at 11:01 AM, revealed the investigation regarding Resident #1 was started on the morning of 07/23/13 by interviewing staff and getting statements from them. She stated the fracture of the leg was not reported to the State agencies because after speaking with the Nurse Practitioner, they felt the fracture was spontaneous in nature due to a similar fracture in the past and because of no known injury.</p>	N 110	federal regulation. The Director of Nursing will report findings to the Performance improvement Committee monthly for three months for further recommendations.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/14/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(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) COMPLETE DATE