

R E C E I V E D  
 SEP 13 2012

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 FORM APPROVED  
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/23/2012
NAME OF PROVIDER OR SUPPLIER  EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Southern Baptist Hospital Branch 321 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
F 000	INITIAL COMMENTS	F 000	<i>See attachment</i>	
F 164 SS-B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced by:	F 164	<i>See attached</i>	

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

*Deborah Zech*

TITLE  
*Administrator* (X6) DATE  
*9/13/12*

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 notes, 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 164	<p>Continued From page 1</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure resident health information was maintained in a private and confidential manner during medication administration. Observation of medication pass on 08/22/12, for six sampled residents and seventeen unsampled residents, revealed the Medication Administration Record (MAR) that contained resident health information was left open on top of the medication cart in the hallway and, as a result, the personal information for three of the unsampled residents (Residents C, D, and E) was exposed to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's Confidentiality of Resident Information policy (not dated) revealed facility staff was responsible to maintain the confidentiality of the residents' personal and clinical records.</p> <p>Observation during medication pass on 08/22/12, at 10:35 AM, revealed Kentucky Medication Aide (KMA) #1 entered Resident C's room to administer one medication to the resident. Further observation revealed the MAR located on top of the medication cart in the hallway had been left open and the resident's personal and confidential information was exposed to anyone in the area of the hallway where the cart was located. The page exposed was titled Resident Specific Medication Administration Guidelines, and contained the resident's name, room number, how the resident could take the medications (crushed, with pudding/applesauce, or via gastrostomy tube), if the resident was</p>	F 164	<i>See attached</i>		

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F 164	<p>Continued From page 2</p> <p>diabetic, and also contained a picture of the resident.</p> <p>At 1:10 PM, KMA #1 was observed to enter resident room 302 and administered two medications to Resident D. The MAR was left open on top of the medication cart in the hallway and exposed the Resident Specific Medication Administration Guidelines sheet to anyone that passed by the medication cart. Several staff members and visitors were observed to walk past the medication cart while the MAR was left exposed. KMA #1 failed to ensure confidentiality of residents' health information located in the MAR while he administered medications to residents.</p> <p>Further observation revealed KMA #1 continued the medication pass and entered resident room 308 at 1:25 PM, to administer an Inhaler to Resident E. The MAR was observed to be open on the medication cart in the hallway with Resident E's medication sheet exposed. The medication sheet listed individual medications and times the medications were to be administered to Resident E, the resident's admission date and birth date, the physician's name, diet order, code status, and allergies. The KMA failed to maintain the confidentiality of the resident's personal and clinical records as mandated by facility policy.</p> <p>Interview conducted on 08/22/12, at 2:20 PM, revealed KMA #1 had been trained to maintain confidentiality of residents' medical information. The KMA stated he always covered the MAR during medication administration but was not sure if the information on the page that contained the</p>	F 164	<i>See Attached</i>		

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F 164	Continued From page 3 residents' picture was a concern. The KMA stated the facility policy stated residents' personal information should be kept private and concluded the Resident Specific Medication Administration Guidelines sheet should not be visible to the public. The KMA acknowledged he had left the residents' health information exposed.  Interview with the Director of Nursing (DON) on 08/23/12, at 2:45 PM, revealed staff should protect residents' private information during medication pass and was required to keep all information on the MAR covered during medication administration.	F 164	<i>See attached</i>	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, a review of resident meal tray cards and facility policy, it was determined the facility failed to accommodate individual preferences for one of four unsampled residents (Resident A) and fifteen sampled residents. Resident A had made the facility aware of food dislikes; however, the facility served food to the resident which the resident had indicated he/she disliked.	F 242	<i>See Attached</i>	

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F 242	<p>Continued From page 4</p> <p>The findings include:</p> <p>A review of the facility policy titled Resident Nutritional Care (undated) revealed Food Service would complete a diet pattern card (tray card) for each resident and the tray card would be the basis for serving the tray to each resident. Further review of the policy revealed the cards would include personal food dislikes of residents.</p> <p>Observation of the noon meal on 08/21/12, at 12:13 PM, revealed Resident A was served beef tips for lunch. Resident A stated, "I don't like beef of any kind."</p> <p>A review of the tray card for Resident A revealed facility staff had identified/listed that the resident disliked beef on the tray card.</p> <p>An interview conducted on 08/21/12, at 12:38 PM, with State Registered Nurse Aide (SRNA) #1 who delivered and set up the tray for Resident A revealed the SRNA had checked the resident's tray card but did not notice the resident disliked all beef.</p> <p>An interview conducted with the Cook on 08/21/12, at 12:40 PM, revealed the Cook had checked the resident's tray card before preparing the tray for resident A but thought the resident disliked beef stew and not beef tips. According to the Cook, she had not noticed the resident disliked all beef.</p> <p>An interview conducted on 08/21/12, at 12:47 PM, with the Dietary Aide who conducted a check of the tray prepared for Resident A prior to placing the tray on a delivery cart revealed the Dietary</p>	F 242	<i>See Attached</i>		

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F 242	Continued From page 5 Aids had not noticed the resident was being served beef which was listed as a dislike for the resident.  An interview conducted with the Dietary Manager (DM) on 08/23/12, at 12:45 PM, revealed the facility procedure was for the Cook to read the tray card and prepare the tray, and then the tray was to be checked by the Dietary Aide before placing the tray on the cart for delivery. According to the DM, staff serving the tray was supposed to compare the items on the tray with the resident's tray card prior to serving the tray to the resident. Further interview revealed the DM monitored the tray service at lunch and supper in the kitchen and had not identified any problems. Further interview revealed the DM did not monitor tray delivery on the floor.	F 242	<i>See Attached</i>	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure foods served to residents were palatable and at the proper temperature during the evening meal on 08/21/12. Observation revealed two resident dinner trays remained on a cart for forty minutes before staff attempted to deliver the trays to residents.	F 364	<i>See Attached</i>	

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F 364	Continued From page 6  The findings include:  A review of the facility Tray and Food Distribution at Meal Time policy and Food Temperatures policy (not dated) revealed foods would be served at appropriate temperatures. The policy directed staff to have temperatures of food taken or return trays to the Dietary Department if a food tray had been stored in the holding container for an extended period of time or past normal delivery times. The policy listed acceptable serving line temperatures but did not reflect temperature guidelines for point of service for the residents and failed to detail what normal delivery times were.  Observation of the evening meal on 08/21/12, revealed a closed meal cart was transferred from the kitchen to the South Wing at 5:05 PM. Staff was observed to deliver meal trays to residents in their rooms and then positioned the cart at the entrance of the South Wing dining area. A second tray cart was delivered to the South Wing dining area at 5:25 PM. Staff removed meal trays from the two carts and delivered the trays to residents seated in the dining room. Several residents seated in the dining room required assistance from staff throughout the meal. CNAs were observed to deliver trays to resident rooms and remained in the room to assist/feed the resident the evening meal. Further observation revealed two meal trays remained on the first tray cart for 40 minutes. A CNA approached the meal cart at 5:45 PM (40 minutes after it arrived at the unit), to remove one of the two meal trays for a resident but the tray, along with the tray that remained on the cart, was intercepted by the	F 364	<i>See attached</i>		

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F 364	<p>Continued From page 7 surveyor.</p> <p>A palatability test of the two trays conducted with the Dietary Manager (DM) on 08/21/12, at 5:48 PM, revealed the pureed meatballs tasted barely warm, the mashed potatoes tasted lukewarm, and the zucchini/tomato mixture tasted cold. The second tray, which was mechanical soft consistency, revealed the fish tasted cold, potatoes tasted lukewarm, and the zucchini/tomato mixture tasted cold. The temperature of the milk was 64 degrees Fahrenheit. The DM confirmed the palatability and temperature of the food items.</p> <p>Interview with the Dietary Manager (DM) on 08/21/12, at 5:55 PM, revealed she had accepted the position as Dietary Manager approximately one week prior. The DM stated the milk was too warm and could easily spoil and could harm a resident. Review of a Quality Control audit sheet dated 08/21/12, 07/10/12, and 06/27/12, revealed the Registered Dietitian had conducted test trays but the monthly checks were conducted of the noon meal.</p> <p>Interview conducted with the Director of Nursing (DON) on 08/23/12, at 2:45 PM, revealed 40 minutes would be too long for trays to remain on the meal cart. The DON stated the facility had several residents that required total assistance from staff for meals. The DON revealed a system to stagger trays was used and staff was to go to the Dietary Department to obtain "call for" trays. Several resident trays were classified as "call for" trays, meaning the food remained on the steam table and would be plated when staff notified dietary staff that they were available to</p>	F 364	<i>See Attached</i>		

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F 354	Continued From page 8 feed the resident. The DON concluded that more residents probably needed to be placed on the "call for" list.	F 354	<i>See Attached</i>	
F 441 SS=D	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 direct contact will transmit the disease. (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.  (c) Linens Personnel must handle, store, process and	F 441	<i>See Attached</i>	

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F 441	<p>Continued From page 8</p> <p>transport liners so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one of fifteen sampled residents (Resident #7). Observation on 08/22/12, revealed Certified Nursing Assistant (CNA) #4 failed to properly dispose of an incontinence brief. CNA #4 completed incontinence care for Resident #7, and placed the soiled incontinence brief on the floor beside the resident's bed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Prevention of Cross Contamination, dated 07/14/09, directed staff that items should not be placed on the floor.</p> <p>Observation on 08/22/12, at 10:15 AM, revealed CNA #4 had completed Incontinence care for Resident #4. Upon entering the resident's room, CNA #4 had placed the soiled incontinence brief on the floor next to Resident #4's bed.</p> <p>Interview conducted on 08/22/12, at 3:00 PM, with CNA #4 revealed she was knowledgeable of the requirement to place soiled briefs in a trash bag. CNA #4 stated she usually used the trashcan for discarding the soiled items during</p>	F 441	See Attached		

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F 441	Continued From page 10 incontinence care and then removed the trash bag and placed a clean trash bag in the trashcan when she had completed the task. CNA #4 revealed she failed to place the trashcan near the work area so she laid the brief on the floor. CNA #4 confirmed that placing the soiled brief on the floor could transmit germs on the floor and be an infection control issue.  Interview with the Director of Nurses (DON) on 08/23/12, at 2:45 PM, revealed staff was trained to never place soiled items on the floor to prevent transmission of germs.	F 441	<i>See attached</i>	

## **Plan of Correction/Allegation of Compliance for F164 Personal Privacy/Confidentiality of Records**

#1- Residents C, D, and E still continue to reside at the facility and there have been no adverse effects from said practice. No other issues/concerns noted by monitoring and they have voiced no adverse effects related to said practice as of compliance date.

KMA #1 was in-serviced by the Director of Nursing on 8/24/12 to ensure confidentiality of resident's personal health information, particularly residents C, D, and E as well as all other residents. KMA #1 voiced understanding of policy and procedure regarding privacy and confidentiality of personal health information. Director of Nursing also in-serviced nursing staff (KMA's, and Nurses) regarding privacy and confidentiality of resident's personal health information on 8/24/12.

#2- All residents have the potential to be affected by said practice but no residents have been adversely affected as of compliance date. In addition to QI members DON shall randomly monitor nursing staff (KMA's and nurses) during resident's medication pass to ensure resident's confidentiality is met.

#3/4- In-service given by DON/Administrator to address privacy/confidentiality per policy to general all staff (Nursing, Dietary, Housekeeping, etc.) 8/29/12. Staff voiced understanding of the policy and expressed no concerns regarding these issues. Director of Nursing to perform random audits on resident rights, privacy and confidentiality/MARS and medication sheets at least on a weekly basis for 30 days and ongoing.

Social Services Director met with Resident Council on 9/11/2012 to educate/re-educate resident's rights. Residents were reminded of facility policy on resident rights and encouraged to report/identify any concerns/issues ongoing. No residents had concerns regarding these issues.

Department Managers serve as QI members and meet quarterly to address issues and concerns ongoing.

Administrator in-serviced Department Managers on 8/23/12 regarding policy/privacy and confidentiality of personal health records. QA meeting scheduled for 9/12/12 to discuss survey results with QI members and Medical Director, interventions/corrections, and issues/concerns. QI members responsible for additional oversight to perform inspections/monitoring of resident confidentiality/MAR's /medication pass/medication sheets on at least weekly basis and document on audit report form/checklist and note concerns for Administrator/Director of Nursing to address times 60 days for quality assurance. QI members shall turn in QI rounds audit forms for Admin/designee review at least 2 times weekly times 60 days to assure compliance/corrections are done. Audits and concerns with QI rounds shall be discussed at next scheduled QI meeting to review outcomes and listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 8/26/12

Responsible: Director of Nursing

## **Plan of Correction/Allegation of Compliance for F242 Self Determination and Participation Right to Make Choices**

#1-Resident A continues to reside at the facility. She was offered a food substitute and declined. She has voiced no adverse effects related to said practice and no other issues/concerns noted by monitoring of her food/beverage preferences/tray card as of compliance date.

SRNA #1 In-serviced by DON regarding the importance of honoring resident right to make choices including food/beverage preferences when passing trays and to check tray card to verify that resident does not receive any food/beverage items listed under dislikes on the card.

Administrator met with Dietary Manager and Dietician as of survey exit on 8/23/12 to ensure that resident likes and dislikes are honored. Administrator also met with Department Managers/ QI members on 8/23/12 to discuss/ensure compliance with tray cards/resident likes and dislikes, resident right to make choices in all aspects of care that is important to them.

Dietary Manager in-serviced dietary staff on 8/24/12 regarding resident right to make choices particularly choices related to food likes and dislikes. Staff to check tray card when serving residents to ensure that food/beverages listed as dislikes are not served to the resident and substitutions are honored.

Tray cards/ resident likes and dislikes were monitored by Dietary Manager on 8/24/12 and ongoing to ensure that tray cards and meals served accurately reflect resident likes and dislikes. Director of Nursing in-serviced nursing staff (CNA's, KMA's, and nurses) on 8/24/12 and ongoing regarding resident right to make choices including resident likes and dislikes of food/beverage. When passing trays, check tray card to verify that resident does not receive any food/beverage items listed under dislikes on the card.

#2- All residents have potential to be affected by said practice. No residents have been adversely affected by said practice as of compliance date by randomly monitoring tray cards/food preferences/food served.

Social Services Director held Resident Council meeting on 9/11/12 to discuss resident rights to make their own choices including food/beverage likes and dislikes. Residents educated on right to make their own choices and encouraged to report concerns/ issues regarding their rights especially the right to make their own food/beverage choices.

#3/4- In-service given by DON/Administrator to general all staff (Nursing, Dietary, Housekeeping etc.) regarding resident rights, self determination/right to make choices on 8/29/12 to ensure that resident's tray cards and meals served accurately reflect resident likes and dislikes and to ensure that residents right to make choices are honored.

Administrator in-serviced Dietician regarding issues related to tray distribution/food preferences and temperatures on 8/23/12 to ensure that resident likes and dislikes are honored and the food/beverage is palatable, attractive and served at the proper temperature.

DON/designee are also randomly monitoring food/beverage service to ensure that residents rights are honored and that likes and dislikes are honored as of 8/24/12 on a weekly basis times 60 days and ongoing. Any issues shall be documented on QA audit report form to be discussed for additional in-services needed or additional monitoring at that time and along with next QA meeting.

Dietary Manager/designee to ensure resident tray cards are monitored and that residents do not receive any food/beverage items listed under dislikes on the card at least on a weekly basis for 60 days and ongoing. Issues/concerns will be documented on audit report form and reported to Administrator/designee for follow up.

QA meeting scheduled for 9/12/12 to discuss survey result with Medical Director, interventions/corrections, and issues/concerns. QI members responsible for additional oversight to perform inspections/monitoring of resident care, resident tray cards and food/beverage served to ensure that residents have the right to make their own choices and that their likes and dislikes are honored on at least weekly basis and document on audit/report form checklist and note concerns for Administrator times 60 days for quality assurance purposes. Issues/concerns will also be discussed/reviewed for additional follow up and to ensure compliance with next scheduled QA meeting.

Date of Compliance: 8/26/12

Responsible: Dietary Manager, Director of Nursing

## **Plan of Correction/Allegation of Compliance for F364 Food**

#1-Resident trays found to be below acceptable time frame/temperature were replaced at time of discovery with new trays and those residents were changed to call for trays.

Administrator met with Dietary Manager and Dietician as of survey exit on 8/23/12 to ensure that food served is palatable, attractive, and at the proper temperature.

In-service was conducted by Dietary Manager on 8/24/12 with dietary staff to ensure that tray/food/beverage is served to residents within acceptable time frame to avoid food/beverage to be out of expected temperatures at time of delivery. Food is to be palatable, attractive and at the proper temperature.

Director of Nursing in-serviced nursing staff (CNA's, KMA's, and Nurses) on 8/21/12 and 8/24/12 to ensure timely service of food and to ensure that food is palatable, attractive, and at the proper temperature.

#2-All residents have potential to be affected by said practice but no residents were affected by said practice as resident trays that were found to be below acceptable time frame/temperatures were replaced with new trays.

Social Services Director held Resident Council meeting on 9/11/12 to discuss resident rights including their right to have food/beverages that are palatable, attractive, and served at the proper temperature. Hot foods are to be served hot and cold foods are to be served cold. Residents were encouraged to report concerns/ issues regarding their food/beverages especially hot foods that are too cool and cold foods that are served too warm. Issues/concerns to be reported in resident council minutes and reported to Administrator/QA committee for follow up. There were no new issues expressed at that time.

#3/4- Administrator met with Department Managers/QI members on 8/23/12 at survey exit to ensure monitoring of resident trays/ food/beverage is served in a timely manner and that it is palatable, attractive and at the proper temperature.

In-service given by Director of Nursing/Administrator to general all staff (Nursing, Dietary, Housekeeping etc.) on 8/29/12 regarding food/beverage policy. To ensure food is served palatable, attractive, and at the proper temperature. Hot foods are to be served hot and cold foods are to be served cold. If tray is found to be out of proper timeframe/temperature it is to be replaced with a new tray. Staff voice understanding of policy.

In-service given by Dietician to dietary staff on 9/11/12 regarding resident food preferences, serving food at appropriate temperatures at serving line and point of service, hot foods must be served hot and cold foods must be served cold, and serving food in acceptable timeframes. Food must be served that is palatable, attractive and at appropriate temperatures. Dietician monitored/inspected lunch meal on 9/11/12 to ensure food/beverage met appropriate guidelines for point of service, attractiveness, and palatability. Dietician to monitor/inspect meal trays bi-weekly rotating meal times, times 60 days and monthly ongoing. Issues/concerns will be reported to the Dietary Manager/Administrator for follow up and issues/concerns will be discussed/reviewed to ensure compliance with next scheduled QA meeting.

QI members responsible for additional oversight to perform inspections/monitoring of residents food/beverage to ensure that food/beverage is attractive, palatable, and at the proper serving

temperature on at least weekly basis and document on audit/report form checklist and note concerns for Administrator times 60 days for quality assurance purposes. QA meeting scheduled for 9/12/12 to discuss survey results with QI members and Medical Director, interventions/corrections, and Issues and concerns. Issues/concerns will also be discussed/reviewed for additional follow up and to ensure compliance with next scheduled QA meeting.

Date of Compliance: 8/26/12

Responsible: Dietary Manager, Director of Nursing

#### **Plan of Correction/Allegation of Compliance for F441 Infection Control**

#1- Resident #7 continues to reside at the facility and there have been no adverse effects from said practice. No other issues/concerns noted by monitoring resident care and routine skin assessments as of compliance date.

CNA#4 in-serviced by DON regarding policies and procedures of infection prevention and importance of infection prevention during ADL care. Staff voiced understanding of policy and voiced no concerns regarding these issues.

Director of Nursing in-serviced nursing staff (CNA's, KMA's, and Nurses) on 8/24/12 regarding infection control/prevention policy and procedures, including proper disposal of briefs, hand washing, maintain a safe, sanitary and comfortable environment and prevent the spread of infection.

#2- All residents have the potential to be affected by said practice but no residents have been affected as of compliance date by monitoring infections/common bacteria reports from labs, etc.

#3/4-In-service given by Director of Nursing/Administrator to general all staff (Nursing, Dietary, Housekeeping, etc.) on 8/24/12 regarding infection control/prevention policy and procedures including proper disposal of briefs, hand washing, proper handling of linens, and maintaining a safe sanitary, and comfortable environment which prevents the spread of infection. Staff voiced understanding of the policy and voiced no concerns regarding this issue.

DON/designee are also randomly monitoring infection control/prevention, incontinence care, and proper brief disposal as of 8/24/12 on at least a weekly basis times 60 days and ongoing. Any issues shall be documented on QA audit report form to be discussed for additional in-services needed or additional monitoring at that time and along with next QA meeting.

Date of Compliance: 8/26/12

Responsible: Director of Nursing

F364

**Edgemont  
Healthcare****Food Temperatures - Stream Table****Policy:**

Food shall be serviced at appropriate temperature (hot food are served hot and cold foods are served cold)

**Procedure:**

The following guidelines will be used for acceptable serving line.

Meat/Entrée	135
Potato/Starch	135
Vegetable	135
Ground or Pureed Food	135
Milk	40
Cold Entrée or Vegetable	40

F364

## EDGEMONT HEALTHCARE

## POLICY/PROCEDURE

## TRAY AND FOOD DISTRIBUTION AT MEAL TIME

**POLICY:** To deliver tray/food to residents within acceptable time frame to avoid food/beverages from being served out of acceptable time limits that could cause items to be out of expected temperatures at time of delivery. (Refer to Temperature guidelines for food/beverage ranges as needed for temperature expectations at holding carts)

**PROCEDURE:**

- Determine normal dining area where resident eats on most days so dietary assures placed on appropriate carts for faster delivery to unit/dining room, etc.
- If staff members know ahead of time that resident will not be in building for meal, change of normal location/unit/room for eating that meal, they need to notify dietary if able prior to meal service to change, withhold, and/or place on appropriate cart for delivery.
- Staff shall start passing trays to residents after carts arrive to residents in dining rooms. Staff assigned to feeders or in rooms shall keep covered until able to assist with feeding as possible.
- Staff should notify different unit/appropriate staff if tray was put on cart that is not their normal dining experience to be served during/after distribution to residents in that area.
- If food tray has been stored in holding container for extended period of time past normal delivery times for that resident (due to illness, change in location, etc then staff should assess if temperatures of foods/dairy products appear to be out of acceptable ranges). If unsure or appears to look or feel out of range even if given within normal time range (ie milk carton warm, ice cream melted, etc), staff shall have temps taken or return tray/dairy products back to dietary for replacements as needed.

(If unsure how long tray was in holding cart due to change in location or resident unable to eat soon after delivery due to other unavoidable situations, etc. staff shall follow above instructions to assure temps esp for food/dairy items that can turn temperatures quickly.)

**Edgemont Dietary QI Rounds to be completed by QI members. Please complete at least 2 times daily.**

*F364*

Date: \_\_\_\_\_

Dietary/Basement Area	Initials							
Dishes/Pan are put away free of particles.								
Dishes Dry/Pans Dry?								
Only Resident Items in Refrigerator								
Dented Cans Properly Stored.								
Scoops are properly stored.								
Proper Hand washing								
Proper Glove Use								
Hair Nets On Properly								
Food refrigerated promptly								
Raw meats stored on shelves below fruits vegetables or other ready to eat foods, so meat juice does not drip on these foods.								
Towels/Cloths stored properly								
Thawing food in proper container and area.								
Tray line free of cross contamination								
Log Book's Checked?								
<b>Stove/Grease Trap cleaned</b>								
Mixer/Blender/Toaster/ Food Proc./Slicer checked/stored properly.								
Refrigerator checked for proper labeling/dates								
Shelves/bottom of refrig. Checked								
Food stored on shelves not on floor.								
Thermometer in Place.								
Walls/floor checked								
Range and Oven checked								
Foods Properly rapped in freezer and refrigerator								
All Items stored in a manner to prevent cross contamination.								
Dish Machine/Sink washing/sanitizing correctly?								
Received Time: Sep. 13, 2012 5:58PM No. 0998								

\*Any Comments, put on QA Form and inform Administrator or Executive Director.



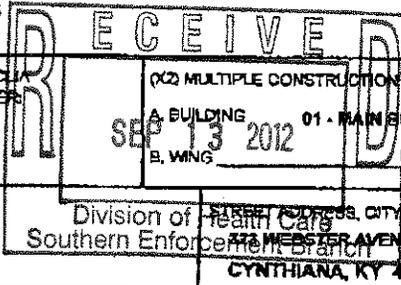
Edgemont LH Rooms to be completed by all members. Please complete at least 4 units every other 15.00 by member for this unit.  
 Date: \_\_\_\_\_ Times \_\_\_\_\_ Name \_\_\_\_\_ Title \_\_\_\_\_ List RM#s/Area \_\_\_\_\_

Resident/Rooms List	OK	Room # and Action Needed	Area/Misc East/North(circle)	OK	Area and Action Needed-Additional Comments in General
Hygiene needs met-shaven, hair combed, nails clean, appropriate/clean care, no odors, eyes not matted, had good oral care, Nutritional needs met, Food preferences honored. Rights honored			Hall/Unit, Floors clean (not sticky. Nothing on Floors and free of clutter		
Special need equipment in place (see care plan for specifics) bed/body alarms in place, mat on floor, respiratory equip. in place/clean, splints, special therapy positioning devices, etc. Side Rails per order (properly positioned at all times)			All equipment cleaned according to schedule shower chairs, w/c geri-chairs, pumps, hooyer lifts, ice coolers etc./No ext. Cords.		
Rooms clean and bed made - free of spots/food crumbs (no frayed linens)			All items on one side of hallway-safe pass.		
Waste Free-nothing on floor-trash cans in room does not contain diapers/ect. Room looks tidy overall.			Trash can/sharps containers not more than 3/4 full		
Water pitcher/ice and water - unless NPO			Dining Rms clean		
Suction machine covered and emptied - O2 tubing dated and bagged when not in use			Nsg stations clean and HIPPA maintained		
Call-light within reach-working			Hskeeping carts locked		
Tables/Misc. clean including under bed and furniture.			No equip. in hallway free of hazards-carts/lifts		
Food in appropriate containers-no food left if needing refrigerated, Beverages/Food is served palatable, attractive at proper temp			Maintaining of hand-washing/knocking on doors		
Bathroom-clean and odor free.			Call lights being answered quickly		
Commode-base/bowl clean			STAFFING: name badges/gait bells on		
Privacy curtain clean and neat-privacy provided in/out of rooms			Appropriate attire/clean jewelry not appr.		
Other environmental issues, please list			Professional to others		
Maintenance request form filled out for: (please complete)			Not C/O staffing etc.		
Torn or marred equipment/furniture (ie. wheelchairs, cushions, mats, etc.)			Staying busy, talking with resident, not each other.		
Handrails tight.					

F164 F364  
 F242 F441

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

PRINTED: 09/06/2012  
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  08/22/2012
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NAME OF PROVIDER OR SUPPLIER  EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 475 WEBSTER AVENUE CYNTHIANA, KY 41031
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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 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 story Type V(111) with basement  Smoke Compartments: 3  Fire Alarm: Full fire alarm system  Sprinkler System: Automatic (dry) sprinkler system  Generator: Type II Diesel Generator  A Life Safety Code survey was conducted on 08/22/12. Edgemont Healthcare was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 64. The facility is licensed for 68 beds.  The following findings demonstrate noncompliance with the highest scope/severity at "D" level.	K 000	<i>see attached</i>	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	<i>see attached</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Debrah Zeel* TITLE: *Administrator* (X3) DATE: *9/13/12*

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.

Received Time Sep. 13. 2012 5:15PM No. 0996

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

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 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186309	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  08/22/2012
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	
K 062	<p>Continued From page 1</p> <p>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 the facility failed to ensure sprinkler heads were maintained as required. The facility is licensed for 68 beds and the census on the day of the survey was 64.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour on 08/22/12, between 10:00 AM and 1:00 PM, with the Maintenance Director, revealed corrosion and paint on four sprinkler heads under canopy outside of the employee smoking area and outside apartments #4 and #5. Not maintaining sprinkler heads can decrease their ability to react as intended.</p> <p>Interview with the Maintenance Director on 08/22/12, at 10:25 AM, revealed he was not aware of paint loaded heads or corroded heads being deficient and stated he thought the sprinkler company would have replaced the heads if needed.</p> <p>Reference: NFPA 25 (1998 Edition).</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).</p>	K 062	<i>See attached</i>		

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

PRINTED: 09/06/2012  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 E. WING _____		(X3) DATE SURVEY COMPLETED  08/22/2012
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)	COMPLETION DATE	
K 062	Continued From page 2 Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	<i>See Attached</i>		

**Life Safety Plan of Correction (K tag)**

Plan of Correction for K062  
NFPA 101 Life Safety Code Standard

#1- Bids have been taken to replace the four paint-coated sprinkler heads located in the outside canopy by the employee break room. Administrator met with Maintenance Supervisor on 8/23/12 to ensure compliance with safety/sprinkler issues. Vendor who has ability to replace quickly and best bid will be contracted by facility to install sprinklers.

#2- No residents were affected by said practice as sprinkler heads are located outside resident area. An audit was completed on all sprinklers on 8/27/12. No issues or concerns were noted.

#3/4- When the paint-coated sprinkler heads are replaced they will be checked at least monthly times 60 days in addition to checking sprinklers on monthly report ongoing. Issues/concerns will be documented on audit report form and reported to Administrator and Executive director for follow up. Issues/concerns will also be discussed/reviewed at next quarterly meeting for additional follow up and to ensure compliance.

Date of Compliance: 8/28/12

Responsible: Maintenance Supervisor/designee