

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

AMENDED

A Standard Survey for Recertification was initiated on 05/22/13 and concluded on 05/24/13. Deficiencies were cited with the highest Scope and Severity of a "E".

F 253 483.15(h)(2) HOUSEKEEPING & SS-E MAINTENANCE SERVICES

F 000

F 253

See Attached 6/4/13

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policies and cleaning forms, it was determined the facility failed to ensure housekeeping and maintenance services maintained a sanitary, orderly and comfortable interior. Observations revealed resident room 113 bed (B) had paint peeling on the wall above the bed; room 110, 111, 313, and 216 had non-skid strips peeling off the floor; the general bath 112 had discolored grout; the air intake vent by room 113 was covered with an accumulation of dust; room 313 bathroom had discoloration around the base of the toilet and baseboards; the east dining room had an area on the ceiling which was patched and discolored with evidence of water damage on the ceiling and along the wall; the east dining room had a cob web in the corner near the exit door; the door by rehab had two (2) large cobwebs; rust stains were present on the floor of the east dining room; a light fixture over a

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JUL 15 2013
BY: _____

OPTIONAL DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deborah Zech</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/10/13</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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table in the east dining room contained debris and cobwebs; and resident room 217 had cobwebs over bed (A).

The findings include:

Review of the facility's policy titled, "Maintenance", undated, revealed maintenance services would be provided to all areas of the building, grounds and environment. Under the procedures section, the maintenance personnel were to maintain the building in good repair and free from hazards.

Review of the facility's policy titled, "Cleaning Schedules", undated, revealed the facility would develop cleaning schedules and implement cleaning schedules to ensure the facility is maintained in a clean and comfortable manner.

Review of the facility form, "Daily Steps to Clean Resident's Rooms", dated 02/97, revealed the form did not instruct housekeepers to high dust resident rooms.

Review of the "Bathroom/Restrooms" cleaning form, undated, revealed floors were to be swept and mopped. The form did not address grout cleaning.

Review of the "Corridors/Hallways" cleaning form, undated, revealed no instructions to clean vents or perform high dusting.

Review of the "Dining Rooms" cleaning form, undated, revealed no instructions to perform high dusting or cleaning of the light fixtures.

F 253 *See Attached* 6/4/13

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Review of the "Edgemont QI Rounds" form, revised 08/24/12, revealed Quality Improvement (QI) staff members were to complete the form twice daily after AM care. Items checked on this list included: bathroom cleanliness including commode bases; environmental issues; and cleanliness of rooms.

1. Observation of room 113 during initial tour, on 05/22/13 at 9:30 AM, revealed paint was peeling off the wall in several areas over bed B.

Interview with the Environmental Services Director, on 05/23/13 at 2:33 PM, revealed it appeared the paint was peeling due to removal of tape. The Environmental Services Director reported he was unsure how long the paint had been peeling, but he was currently trying to paint two (2) resident rooms per month. The Environmental Services Director stated the condition of the paint had not been reported to him.

Interview with the Administrator and the Corporate Executive Director, on 05/24/13 at 2:15 PM, revealed the facility was currently in the process of painting two (2) resident rooms a month to address the appearance of the rooms.

2. Observation of rooms 111, 110, 313, and 216 during the environmental tour, on 05/23/13 at 2:39 PM, revealed non-skid strips were peeling off the floor.

Interview with the Environmental Services Director, on 05/23/13 at 2:50 PM, revealed the peeling non-skid strips had not been reported and/or a work order had not been placed. The

F 253 *See attached* *6/14/13*

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Environmental Services Director stated the strips were hard to remove, and required a work order to put down. So, the Environmental Services Director stated he would talk with the nurses and see which residents need the non-skid strips and replace/repair/remove accordingly.

Interview with the Administrator and the Corporate Executive Director, on 05/24/13 at 2:15 PM, revealed non-skid strips were to be replaced if presented as a safety hazard. They reported staff conducting QI rounds should have reported these concerns.

3. Observation of the general bath 112 during the environmental tour, on 05/23/13 at 2:46 PM, revealed the grout was discolored throughout the bathroom.

Interview with Housekeeper #1, on 05/24/13 at 1:50 PM, revealed bathroom floors were cleaned daily with a mop. Housekeeper #1 stated she had not noticed the discolored grout in general bath 112.

Interview with the Environmental Services Director, on 05/23/13 at 2:46 PM, revealed he agreed the grout was discolored. The Environmental Services Director stated the discolored grout had not been reported to him. He stated the housekeepers mopped the bathrooms daily, but grout cleaning was not part of their cleaning schedule. Instead, the Environmental Services Director reported the grout was cleaned on an as needed basis.

Interview with the Administrator and the Corporate Executive Director, on 05/24/13 at 2:15

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See attached

6/4/13

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PM, revealed the facility had purchased grout cleaner and was working to address the discolored grout in the general bath. They stated it was important for the facility to be clean and homelike because it was the residents' home.

4. Observation of the hallway air intake vent by room 113, on 05/23/13 at 2:49 PM, revealed the vent was covered with an accumulation of dust.

Interview with Housekeeper #1, on 05/24/13 at 1:50 PM, revealed air intake vents were cleaned as needed.

Interview with the Environmental Services Director, on 05/23/13 at 2:49 PM, revealed the vent was a cold air return. The Environmental Services Director stated cleaning of these vents were not on a cleaning schedule, but was cleaned on an as needed basis by himself or the housekeepers. The Environmental Services Director stated the accumulation of dust on the vent had not been reported to him.

5. Observation of the bathroom attached to room 313, on 05/23/13 at 2:50 PM, revealed the base of the toilet was discolored with a white appearance. In addition, the floor was discolored (dark brown) along the edges of the baseboard.

Interview with the Environmental Services Director, on 05/23/13 at 2:50 PM, revealed the white discoloration around the base of the toilet was most likely due to bleach cleaners used by the housekeepers. The Environmental Services Director stated the discoloration along the baseboards was an accumulation of wax that needed to be stripped. The Environmental

F 253: *See attached* 6/14/13

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Services Director stated these concerns had not been reported to him.

F 253

See Attached

6/14/13

6. Observation of the east dining room, on 05/23/13 at 2:52 PM, revealed evidence of water damage on the ceiling and along the wall by the window. The ceiling had a concave area with patchwork in place. The patched area on the ceiling had not been painted and was orange along edges. The wall by the window (under the patched area) had dark areas of discoloration. A large bucket was on the floor under the patched ceiling area. The floor by this area of the dining room was rust colored and had a metal weight with rust build-up sitting on the floor.

Interview with Housekeeper #1, on 05/24/13 at 1:50 PM, revealed the east dining room ceiling leak had been present for a long time. Housekeeper #1 reported the roof had been patched, but the ceiling continued to leak when it rained hard. Housekeeper #1 stated the rust stains on the floor of the east dining room were from a metal weight stored by the scales. Housekeeper #1 stated she did not believe the stains would come up, but stated she had not tried to remove them.

Interview with the Rehab Manager, on 05/24/13 at 9:30 AM, revealed the leak in the east dining room ceiling had been present for several months.

Interview with the Environmental Services Director, on 05/23/13 at 2:52 PM, revealed the patched area in the east dining room leaked occasionally when it rained hard. He reported the leak had been present for several months. The

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Environmental Services Director reported the roof was replaced 2-3 years ago. He stated there was a fire wall on the side of the wall which he had applied waterproofing over the concrete, but he reported those efforts were unsuccessful. The Environmental Services Director stated he was currently trying to keep the ceiling patched and clean. The Environmental Services Director stated he needed to get on the roof and check the fire wall to make sure there were no caps missing. The Environmental Services Director reported the rust stains on the floor were caused by water coming in from the ceiling and making contact with the metal weight used to calibrate the scales. The Environmental Services Director agreed the floor needed to be cleaned to remove the rust stains.

Interview with the Administrator and the Corporate Executive Director, on 05/24/13 at 2:15 PM, revealed they were aware the area in the east dining room ceiling need to be addressed. They reported the roof had been replaced a couple of years ago, but the ceiling continued to have problems. They also reported contractors had visited the facility in the past trying to determine the cause of the leak, but no conclusion was reached. They stated the rust stains on the floor of the east dining room had been noted on the QI rounds before. The Administrator and the Corporate Executive Director reported the metal weight needed to be moved off the floor to prevent the floor from rusting.

Continued interview with the Corporate Executive Director, on 05/24/13 at 3:45 PM, revealed the issues with the roof/ceiling in the east dining room.

F 253 *See Attached* *6/14/13*

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F 253	<p>Continued From page 7</p> <p>were longstanding and the last contractor visited in 09/10. The Corporate Executive Director reported additional repairs had been completed since the contractor visited; which included replacing the sheet rock and sealing the wall, but both were unsuccessful.</p> <p>7. Observatton of the east dtning room, on 05/23/13 at 2:58 PM, revealed a large cobweb in the ceiling corner of the room by the exit door. Additionally, the black doors off of the east dining room by rehab had two (2) large cobwebs from the door frame across front/top of the doors. Lastly, a light fixture in the east dining room contained debris inside the glass, and cobwebs hanging downward.</p> <p>Observation, on 05/23/13 at 3:03 PM, revealed the light fixture at the end of the east hallway had cobwebs hanging from the sides.</p> <p>Interview with Housekeeper #1, on 05/24/13 at 1:50 PM, revealed high dusting was to be conducted daily, but "a lot of times this was not done." Housekeeper #1 reported she tried to ensure high dusting was done 2 (two)-3 (three) times per week. Housekeeper #1 reported light fixtures were cleaned approximately twice yearly. Housekeeper #1 stated she had not noticed any cobwebs or dust in the corners of the rooms or light fixtures.</p> <p>Interview with the Environmental Services Director, on 05/23/13 at 3:03 PM, revealed the dining rooms were cleaned after every meal, but high dusting the room was not included as part of the cleaning list for the dining rooms. He also reported the halls were cleaned daily, but high</p>	<p>F 253 <i>See Attached</i></p>	<p><i>6/4/13</i></p>

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F 253 Continued From page 8
dusting was conducted on as needed basis. Furthermore, the Environmental Services Director reported cleaning of the light fixtures and high dusting was performed when he noticed it needed to be done.

F 253

See Attached

6/14/13

8. Observation, on 05/23/13 at 3:09 PM, revealed cobwebs were along the ceiling edges over bed A in room 217.

Interview with Housekeeper #1, on 05/24/13 at 1:50 PM, revealed resident rooms were cleaned daily, but were not deep cleaned unless the resident was discharged. Housekeeper #1 stated deep cleaning was also done if the resident had lived in a room for a long period of time, and staff noted that deep cleaning need to be performed.

Interview with the Environmental Services Director, on 05/23/13 at 3:09 PM, revealed resident rooms were cleaned daily. The Environmental Services Director reported high dusting in resident rooms was not conducted daily, but on an as needed basis. He also reported these housekeeping concerns had not been previously reported to him during QI rounds. The Environmental Services Director reported he would perform audits by going behind staff from time to time and checking the cleanliness of the rooms.

Interview with the Administrator and the Corporate Executive Director, on 05/24/13 at 2:15 PM, revealed the housekeepers were responsible for high dusting and light fixture cleaning. They stated department heads conducting QI rounds should have reported these concerns because cleanliness is covered on the QI Rounds form.

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F 253	Continued From page 9 The Administrator and the Corporate Executive Director reported QI rounds were conducted twice daily during weekdays and by mangers on duty during weekends.	F 253	<i>See Attached</i>	6/4/13	
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	F 441	<i>See Attached</i>	6/4/13	

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F 441	<p>Continued From page 10</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to 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 for four (4) Unsampled Residents (Unsampled Resident A, B, C, and D).</p> <p>Observation during medication pass revealed a Kentucky Medication Aide (KMA) failed to wash or sanitize her hands prior to or after administration of medication for Unsampled Resident A, B, C, and D.</p> <p>The findings include:</p> <p>Review of the facility "Handwashing Policy", dated 05/23/08, revealed all personnel was to follow the established handwashing procedure to prevent the spread of infections and disease to other personnel, residents, and visitors. Further review revealed personnel was to wash hands for approximately ten (10) to fifteen (15) seconds before preparing or handling medications.</p> <p>Observation of medication pass, on 05/23/13 at 4:15 PM, revealed Kentucky Medication Aide (KMA) #1 administered medications to Unsampled Resident A and exited the room</p>	F 441	<i>See Attached</i>	<i>6/4/13</i>

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F 441 Continued From page 11
without washing or sanitizing her hands. Further observation revealed KMA #1 set up and administered medications to Unsampled Resident B and washed her hands before exiting the room. Continued observation revealed KMA #1 administered medications to Unsampled Resident C by spoon feeding the pills whole in applesauce. KMA #1 then exited the room without washing or sanitizing her hands and pushed the medication cart up the hall and entered Unsampled Resident D's room.

F 441 *See Attached* 6/4/13

Interview, on 05/23/13 at 4:30 PM, with KMA #1 revealed she was to wash her hands every third resident while passing medications and was to sanitize her hands after administration of medications in between. She stated she realized she did not wash or sanitize her hands after administration of medications for each resident; however, she did not have the hand sanitizer on the cart during this medication pass.

Interview with the Director of Nursing (DON), on 05/23/13 at 4:45 PM, revealed she expected staff to wash their hands before and after administration of medications and between each resident.

F 465 483.70(h)
SS-E SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

F 465 *See Attached* 6/4/13

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

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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 05/24/2013
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
F 465	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies, it was determined the facility failed to provide a sanitary and comfortable environment for residents, staff and the public. Observations revealed the outside garbage receptacles were overflowing and uncovered with litter present around the base.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Grounds", undated, revealed the grounds of the facility would be maintained in a safe and attractive manner. Under procedures, the policy stated Environmental Services would be responsible for keeping the grounds free of litter.</p> <p>Review of the facility's policy titled, "Pest Control", undated, revealed garbage and trash were not permitted to accumulate in order to maintain an effective pest control program.</p> <p>Observation upon arrival to the facility for initial tour, on 05/22/13 at 9:02 AM, revealed a large trash dumpster was uncovered and overflowing with trash. One bag of trash was on the ground by the dumpster. Litter was present around the dumpster and parking lot area.</p> <p>An additional observation, on 05/23/13 at 2:30 PM, revealed a bedpan, soiled gloves, food wrappers and cigarette butts were scattered on the ground around the base of the dumpsters and parking lot/handicap accessible ramp adjacent to the dumpster.</p>	F 465	<i>See Attached</i>	<i>6/14/13</i>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	<p>Continued From page 13</p> <p>Interview with Housekeeper #1, on 05/24/13 at 1:50 PM, revealed the lids to the dumpsters were to remain closed. The Housekeeper reported staff would pile trash on one side of the receptacle which would cause the container to run over. The Housekeeper reported she had noticed litter around the dumpsters. However, she stated cleaning of the grounds was not on a cleaning schedule, and it was done as needed.</p> <p>Interview with the Environmental Services Director, on 05/23/13 at 2:33 PM, revealed housekeepers were responsible to come outside during lunch and pick up debris. The Environmental Services Director stated cleaning of the grounds around the dumpsters was not on a schedule and had not been done in a couple of weeks. The Environmental Services Director reported dumpsters were to be closed at all times. The Environmental Services Director stated staff members sometimes stacked the trash on one side of the dumpster which would prevent the lid from closing. The Environmental Services Director stated the dumpsters were emptied three (3) times per week, and the facility was looking into adding another dumpster to help with the overflowing problem. The Environmental Services Director stated the uncovered trash receptacles and litter could be a concern related to rodent/pest control.</p> <p>Interview with the Corporate Executive Director and the Administrator, on 05/24/13 at 2:15 PM, revealed the facility was currently trying to obtain a second dumpster to help prevent overflowing. The Administrator and the Corporate Executive Director reported their expectation was for staff to</p>	F 465	<i>See Attached</i>	<i>6/14/13</i>

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 465	Continued From page 14 use all compartments of the dumpster and to keep lids closed due to infection control. In addition, they reported it was the responsibility of the housekeeping staff to keep the grounds around the dumpsters maintained and free of litter.	F 465	<i>Attached</i>	6/4/13	
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure clinical records were maintained on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Resident #6 sustained a fall on 03/03/13; however, there was no documented evidence the fall occurred and no documented evidence the resident was assessed for injuries after the fall in	F 514	<i>See Attached</i>	6/4/13	

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
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F 514	<p>Continued From page 15 the Nurse's Notes.</p> <p>The findings include:</p> <p>Review of the facility "Nurse's Notes" Policy, undated, revealed Nurse's Notes were maintained for each resident and were used to record observations, assessments, and appropriate Interventions that may be of importance to the attending physician or to nursing personnel. Such notes were to be made in writing and recorded. They were to be signed and dated by the person entering such data and include the person's job title.</p> <p>Review of Resident #6's medical record revealed diagnoses which included Cerebral Vascular Disease (CVA) with Left Hemiparesis, and Cognitive Disease.</p> <p>Review of the Incident/Accident Report revealed on 03/03/13 at 5:45 PM Resident #6 had to be lowered to the floor and the resident stated her/his legs gave out. Further review revealed Range of Motion (ROM) was within normal limits and the resident did not complaint of pain.</p> <p>Review of the Twenty-Four Hour Report revealed on 03/03/13 on the day shift the resident was lowered to the floor by two (2) State Registered Nursing Assistants (SRNA's). Further review revealed ROM was within normal limits and the Power of Attorney (POA) and the Physician were notified.</p> <p>Review of the Vital Signs Flow Sheet for 03/03/13 at 5:45 PM revealed the resident's vital signs were obtained; Temperature-98.4, Pulse- 87,</p>	F 514	<i>See Attached</i>	<i>6/14/13</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185380	[X2] MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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(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)	(X6) COMPLETION DATE
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F 514 Continued From page 16
Respirations-22, and Blood Pressure-134/77.

However, review of the Nurse's Notes for 03/03/13 revealed there was no documented evidence of the fall which occurred at 5:45 PM as per the Incident/Accident Report and no documented evidence the resident was assessed for injuries or that the Physician and the Responsible Party was notified.

Interview on 05/24/13 at 10:00 AM with the Director of Nursing (DON), revealed the nurses should definitely document in the Nurse's Notes after a fall and the documentation should include vital signs, assessment, and monitoring for each shift for seventy-two (72) hours.

Interview on 05/25/13 at 9:40 AM with Licensed Practical Nurse (LPN) #1, revealed she was assigned to Resident #6 on on 03/03/13 and was walking by her/his room when she noted two (2) SRNA's were lowering the resident to the floor. She stated she obtained vital signs, checked for ROM, assessed the resident for pain and visible signs of Injury, and notified the Physician and POA. Continued interview revealed she completed the Fall Investigation Report and completed the Twenty-Hour Report, and the Nurses Report Form and ensured the vital signs were on the Flow Sheet. However, she failed to document the incident and the assessment in the Nurse's Notes. She stated it must have slipped her mind because it was supper time and she needed to help on the floor.

F 514: *See Attached* *6/14/13*

Plan of Correction/Allegation of Compliance for F253 Housekeeping and Maintenance Services

#1- All areas in the 2567 have been corrected as of 5/25/13 for:

113B peeling paint above bed on wall removed/repainted, rooms 111,110,210,313 skid strips removed/replaced, room 112 discolored grout cleaned, air intake vent by room 113 dust cleaned, 313 bathroom discoloration on floor/base of toilet, and around baseboards removed, east hall dining room water damage repaired, east hall dining room cobwebs removed from back doors as well as the debris and cobwebs inside and hanging from the light fixture, cobwebs along the ceiling edges over bed A in room 217, rust stains around scale and under weight cleaned/removed.

Administrator inserviced/reinserviced Maintenance/Housekeeping Supervisor on 5/24/13 to ensure the facility provides a safe, sanitary, and comfortable environment for residents, staff, and the community.

Maintenance/Housekeeping Supervisor inserviced/reinserviced Housekeeping staff on 5/24/13 regarding maintaining a safe, sanitary, and comfortable environment for residents, staff, and the community, including high dusting, bathroom floors, peeling paint, skid strips, rust stains, and grout cleaning as well as other environmental issues. Staff voiced understanding of policy and procedures and voiced no concerns regarding these issues.

#2 All residents have the potential to be affected by said practice. QI audits have been conducted by designated department manager's assigned areas of building/rooms as of 5/25/13 by making rounds and noting on checklist for any additional areas as noted in 2567 needing repairs. Any audits that noted issues found have been identified and have been corrected as of 5/25/13 by Maintenance/Housekeeping Supervisor. No adverse affects have been noted by said practice.

#3/4 In addition to Maintenance/Housekeeping Supervisor making rounds daily of building, QI members are designated specific rooms and common areas to inspect for issues on a weekly basis and will document any concerns needing repaired. Items will be corrected/repaired based on findings ongoing accordingly to QI rounds performed (painting, cleaning, skid strips, discolored grout, any environmental concerns, etc). 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 for QA. QI rounds form has been changed as of 5/25/13 to include items not already listed for department managers to monitor on weekly basis in addition to staff being in-serviced to report and complete work order request. Admin/designee shall review work orders as well weekly times 60 days to assure being completed.

Administrator In-serviced Maintenance/Housekeeping Supervisor, Department Managers/QI members on 5/24/13 to identify issues/procurement related to maintenance/upkeep of the facility, and to ensure compliance with identified issues/procedures and timeliness of work orders being performed.

In-service given by Administrator/DON to general all staff (Nursing, Dietary, Housekeeping, etc.) on 5/29/13 regarding maintaining a safe, sanitary, environment for residents, staff, and the community, and the importance of notifying management of needed work repairs and to complete work orders.

QA meeting scheduled for 6/12/13 to discuss survey results with Medical Director as well as intervention/corrections and issues/concerns. QI members responsible for additional oversight to perform inspections/monitoring of resident environment. Audits and concerns with QI rounds shall be discussed as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 6/04/13

Responsible: Maintenance/Housekeeping Supervisor/designee

Plan of Correction/Allegation of Compliance for F441 Infection Control

#1-Unsampled residents A, B, and C continue to reside at the facility and there are no adverse effects from said practice. No other issues/concerns noted by monitoring infections/common bacteria reports from labs, etc.

KMA #1 In-serviced by DON on 5/24/13 regarding policies and procedures of infection prevention and importance of Infection prevention during medication administration. Staff voiced understanding of policy and voiced no concerns regarding these issues.

Director of Nursing inserviced/reinserviced nursing staff (CNA's, KMA's, and nurses) on policies and procedures of infection prevention including the importance of hand-washing, maintain a safe, sanitary and comfortable environment and prevent the spread of disease and infection on 5/24/13. Staff voiced understanding of policy and voiced no concerns regarding these issues.

#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 Administrator/Director of Nursing to general all staff (Nursing, Dietary, Housekeeping, etc.) on 5/29/13 regarding infection control/prevention policy and procedures including hand washing, maintaining a safe sanitary, and comfortable environment which prevents the spread of disease and infection. Staff voiced understanding of the policy and voiced no concerns regarding this issue.

Adminstrator inserviced/reinserviced Department Managers/QI on policy and procedures of infection prevention, including hand washing to ensure compliance with identified issues.

DON/designee are also randomly monitoring infection control/prevention, medication administration, and proper hand washing as of 5/25/13 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 monitoring at that time and along with next QA meeting.

QA meeting scheduled for 6/12/13 to discuss survey results with Medical Director as well as intervention/corrections and issues/concerns. QI members responsible for additional oversight to perform inspections/monitoring of resident environment including proper hand washing on at least a weekly basis and document on audit report form/checklist and note concerns for Administrator/Director of Nursing 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 as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of compliance 6/04/13

Responsible: Director of Nursing/designee

Plan of Correction/Allegation of Compliance for F465 Safe/Functional/Sanitary/Comfortable environment

#1-The garbage was removed from around the dumpster on 5/23/13. The bedpan, soiled gloves, food wrappers and cigarette butts were removed from around the dumpster and parking lot/handicap accessible ramp on 5/23/13.

Maintenance/Housekeeping Supervisor inserviced/reinserviced general all staff (Nursing, Housekeeping, Dietary etc.) on 5/23/13 regarding a safe, functional, sanitary and comfortable environment for residents, staff, and the public, including storage of trash/dumpster use. Staff voiced understanding of policy and voiced no concerns regarding these issues.

Administrator inserviced/reinserviced Maintenance/Housekeeping Supervisor on 5/24/13 to ensure the facility provides a safe, sanitary, and comfortable environment for residents, staff, and the community, including the facility grounds and around the dumpster.

#2- All residents have the potential to be affected by said practice. QI audits have been conducted by Maintenance/Housekeeping Supervisor as of 5/23/13 by making rounds and noting on checklist for any additional areas as noted in 2567. Any audits that noted issues found have been identified and have been corrected as of 5/23/13 by Maintenance/Housekeeping Supervisor. No adverse effects have been noted by said practice.

#3/4- Inservice/reinservice given by Administrator/Director of Nursing to general all staff (Nursing, Dietary, Housekeeping, etc.) on 5/29/13 regarding a safe, functional, sanitary, and comfortable environment for residents, staff, and the public including storage of trash/dumpster use. Staff voiced understanding of policies and procedures and voiced no concerns regarding these issues.

In addition to Maintenance/Housekeeping Supervisor making rounds daily of grounds/dumpster, Corporate Executive Director/designee designated to inspect/monitor for issues on a weekly basis times 60 days and ongoing. Issues/concerns documented on audit report form/checklist. Concerns/issues will be corrected based on findings ongoing accordingly to QI rounds performed (garbage around dumpster and parking lot handicap ramp etc.). QI rounds audit forms/checklist shall be reviewed by Administrator/designee at least two times weekly times 60 days to assure compliance/corrections are done for QA.

QA meeting scheduled for 6/12/13 to discuss survey results with Medical Director as well as corrections and issues/concerns. QI members responsible for additional oversight to perform inspection/monitoring of resident environment. Audits and concerns with QI rounds shall be discussed as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 6/04/13

Responsible: Maintenance/Housekeeping Supervisor/designee

Plan of Correction/Allegation of Compliance for F514 Administration/Clinical Records

#1-Resident #6 continues to reside at the facility and there have been no adverse effects for said practice. No other issues/concerns noted by monitoring nursing documentation/nurses notes/assessments as of compliance date.

LPN #1 in-serviced/reinserviced by the Director of Nursing on 5/24/13 regarding proper documentation/assessment, including nursing notes, in accordance with accepted professional standards of practice and that they should be complete, accurately documented, readily accessible, and systematically organized.

Director of Nursing inserviced/reinserviced nurses on 5/24/13 regarding proper documentation/assessment, including nursing notes, in accordance with accepted professional standards of practice and that they should be complete, accurately documented, readily accessible, and systematically organized. Staff voiced understanding of policy and voiced no concerns regarding these issues.

#2-Resident #6 continues to reside at the facility and there are no adverse effects from said practice no other issues or concerns noted by monitoring clinical records/documentation/assessment as of compliance date.

#3/4-Administrator/DON inserviced/reinserviced nursing staff (CNA's, KMA's, nurses) on 5/29/13 regarding documentation/assessment including nurse notes, in accordance with accepted professional standards of practice and that they should be complete, accurately documented, readily accessible, and systematically organized. Staff voiced understanding of policy and procedures and voiced no concerns regarding these issues.

Administrator inserviced/reinserviced Department Managers/QI members on 5/24/13 regarding proper documentation/assessment, including nursing notes/assessment to ensure compliance with identified issues.

DON/designee randomly monitoring clinical records/documentation/assessments to ensure compliance with identified issues as of 5/25/13 on at least weekly basis times 60 days and ongoing. Any issues shall be documented on audit report form for additional monitoring/in-service at that time and at next QA meeting.

QA meeting scheduled for June 12, 2013 to address issues with Medical Director as well as corrections/concerns. QI members/Nurse Managers responsible for additional oversight by monitoring clinical record/documentation/assessment noting concerns for Administrator/DON on at least a weekly basis times 60 days for quality assurance.

Administrator/designee review clinical records/documentation/assessment as well as QI audits at least 2 times weekly times 60 days to ensure/compliance/corrections/reinservices are done to maintain compliance.

Audits and concerns with QI monitoring shall be discussed at next scheduled QI meeting to review outcomes as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 6/04/13

Responsible: Director of Nursing/designee

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 05/23/2013
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: Unknown</p> <p>Survey under: 2000 Existing</p> <p>Facility Type: SNF/NF</p> <p>Type of structure: One story Type V(111) with basement</p> <p>Smoke Compartments: 3</p> <p>Fire Alarm: Full fire alarm system</p> <p>Sprinkler System: Automatic (dry) sprinkler system</p> <p>Generator: Type II Diesel Generator</p> <p>A life safety code survey was initiated and concluded on 05/23/13. Edgemont Healthcare was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) with no deficiencies cited. The facility is licensed for sixty-eight (68) beds and the census was fifty-eight (58) on the day of the survey.</p>	K 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.