STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue Cynthiana, KY 41031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue Cynthiana, KY 41031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide 2 (Resident (R) 54 and R10) of 21 sampled residents the right to reside and receive services with reasonable accommodation of the resident's needs and preferences except when to do so would endanger the health or safety of the resident or others. The facility moved or removed personal items, furnishings, and/or equipment without consideration of resident preferences and accommodation of each resident's individual needs. This failure caused R54 emotional distress over a sustained period of time and the resident was tearful as she related that the facility moved and mounted her television on the wall in a place where she had difficulty seeing it due to her physical limitations, as well as removed shelving that housed her personal collectibles. The findings include: Review of the facility's Homelike Environment Policy, revised 07/08/2023, revealed that it was the policy of the facility to provide a homelike environment for the residents. Further review of the policy revealed that it was the procedure of the facility to encourage residents to decorate their space using their personal belongings to reflect their identity and preferences.Review of the facility's policy titled, Resident Rights, revised 04/12/2024, revealed that it was the policy of the facility to promote the rights of the residents residing in the facility. Review of this policy stated that it was the procedure of the facility to provide the resident with a dignified existence, self-determination, and communication with and access to persons and services both in and outside of the facility. Further review of the policy revealed that the facility would make every effort possible to assist the resident in exercising his/her rights and to assure that he/she was always treated with respect, kindness, and dignity. The facility would ensure that the resident could exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility.Review of the facility's policy titled, Notice of Resident Rights and Responsibilities, revised 03/27/2024, revealed that it was the policy of the facility to promote and protect the rights of all residents residing in the facility. Further review of the policy revealed that residents have the right to keep and use their own personal belongings and property if it did not interfere with the rights, safety, or health of others.1. Review of Resident (R)54's Face Sheet revealed that she was admitted to the facility on [DATE], with diagnoses of [NAME] Disease (a rare, chronic, progressive cerebrovascular disorder), multiple sclerosis, muscle contractures (where joints become permanently fixed in a bent or shortened position, limiting movement), stiffness of unspecified joint, and cerebrovascular disease. Review of R54's current Physician Orders revealed an order dated 09/08/2021 that stated, May have convoluted foam mattress [also known as an egg crate mattress] on bed.Review of R54's quarterly Minimum Data Set (MDS), dated [DATE], revealed that she was assessed as participating in assessments and goal setting. Review of R54's Assessments tab revealed a Brief Interview for Mental Status Evaluation (BIMS) score of 15/15, dated 07/02/2025, indicating that the resident was cognitively intact. Review of R54's Comprehensive Care Plan, with the initiation date of 10/28/2024 and a target date of 10/08/2025, revealed that R54 was care planned for being at risk for little or no participation at times in activities per her wishes. The goal for this focus was that R54 would be encouraged to attend or participate in activities of her choice and would socialize with staff and others to improve the quality of her life. One intervention for this focus was that during leisure times in her room, she liked to watch television (TV). Observation on 07/22/2025 at 2:50 PM of R54's room revealed R54 was sitting to the left of the TV, partially in the doorway so that she could view the TV by rolling her eyes to the left to view the TV out of the corner of her eyes. Further observation revealed that the resident had two shelves hanging over her bed. Both of these shelves were greater than 18 inches from the height of any sprinkler heads in the room. The shelves contained stuffed animals and a few Coca-Cola items, messily and tightly stuffed on them. R54's TV was mounted on the wall beside the door. R54's bed was unmade at the time of the observation and there was no foam mattress/mattress topper upon the bed.In an interview with R54 on 07/22/2025 at 2:50 PM, she said that the TV once sat on her bedside table, which was observed to be approximately 2 - 3 feet below where the TV was currently mounted on the wall. R54 tearfully stated that the Administrator told her that her television had to be mounted on the wall and that it was to be placed where the Administrator chose. R54 stated that she was not allowed to have the television placed where she (R54) could see it easily, explaining that due to her neck contracture, she had to sit beside the television and look out of the corner of her eyes to watch the TV. R54 also noted that the facility also took down one of her shelves and was planning on removing her other shelves. R54 stated she had no other place to display her Coca-Cola memorabilia and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue Cynthiana, KY 41031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of National Weather Service records, the facility failed to ensure each resident had a right to a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents. The facility failed to promptly respond to problems with its cooling system and ensure that the facility was maintained at a safe, comfortable temperature, with temperatures in resident areas noted as high as 90 degrees Fahrenheit (F). The failure to provide safe, comfortable temperatures had the potential to affect all residents of the facility and constituted Substandard Quality of Care (SQC). In addition, multiple resident rooms (Rooms 209, 302, 317, and 320), a common resident gathering area, and the main dining hall needed repair and/or or cleaning. The findings include: In an interview with Ombudsman1 on 07/23/2025 at 9:32 AM, she stated she was first made aware that the facility's air conditioning (AC) was broken on 06/19/2025, which was also when the first family complaint about the AC being broken was called in to her office. She stated that she went to the facility at 8:30 PM at night and it was “like a sauna” in the facility. Ombudsman1 stated she was told by the Administrator that the AC repair person would be coming the next day. Continued interview revealed she called Ombudsman2 who came to the facility that evening and offered four large industrial fans for use in the interim. However, the Administrator declined this offer. Per interview, the following morning Ombudsman1 went back to the facility, and using her personal thermometer, found that the temperature was 83 degrees F (Fahrenheit) at 9:00 AM. By 5:30 PM when she went again it was even higher: 86-87 degrees F in the common area where the residents were eating. She stated the cook came out of the kitchen which was even hotter and almost passed out. She stated Ombudsman2 came to the facility again and the residents began saying that it was very hot. When they visited on Saturday at 2:00 PM, the facility had a large industrial fan in the hallway and had residents sitting in the hallway because the rooms had no air flow. She stated the vents were closed in many of the rooms, and one resident's room was extremely hot, at 88-89 degrees F. As part of the investigation of this concern, the survey team requested all documentation related to any issues with the cooling system. Although the Ombudsman stated she began receiving phone calls on 06/19/2025 and went to the facility that day to personally verify the complaints, the first “Work Order” from the Heating, Ventilation, and Air Conditioning (HVAC) repair company was not until 06/26/2025, one week later. Review of the National Weather Service Records revealed that, during the time from when the AC problem was first identified on 06/19/2025 until 06/26/2025, temperatures ranged as high as 91 degrees F on 06/23/2025, with a heat index of 104 degrees F. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue Cynthiana, KY 41031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the HVAC Work Order revealed that upon arrival on 06/26/2025, the repair person found the air temperature was 90 degrees F on the hallway where the HVAC unit the company was there to repair was located. In addition, there were two other units that were not cooling that the company was to also assess. Further review revealed that the HVAC systems were running properly but that the return drops on both systems in the attic were disconnected. It was found that the plenum (a piece of ductwork attached to the air handler) had major air leaks and the ductwork needed repair. Review of a “Work Order” from the HVAC repair company, dated 06/27/2025, revealed the facility had five units that the repair person was not able to look at and the work order stated they needed to get them cooling as best they could until they could return to finish the repair. Further review revealed that the repair company cleaned the condenser coils and added refrigerant, but they could not test fully until the systems were thoroughly cleaned. Per the work order, they scheduled a return appointment for performance of all units, indicating the need for spring maintenance. Review of a “Work Order” from the HVAC repair company, dated 06/30/2025, revealed the HVAC unit for the kitchen was not cooling and it was 91 degrees F. Inspection found the condensing coils for the unit that supplied the air conditioning (AC) to the kitchen was 80% blocked. The repair company cleaned the coil and placed more refrigerant and stated they would be back to do maintenance on the other units. Review of a “Work Order” from the HVAC repair company, dated 07/07/2025, revealed the kitchen HVAC unit was still having issues with temperatures reaching 110 degrees F in the kitchen. Review of a “Work Order” from the HVAC repair company, dated 07/10/2025, revealed system maintenance and cleaning was performed, and the system was now functioning as required, 21 days after the HVAC issues were first identified . Review of Resident (R) 27’s “Face Sheet” revealed a quarterly “Minimum Data Set (MDS),” with an assessment reference date (ARD) of 05/30/2025, which documented the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. In an interview with R27 on 07/23/2025 at 1:12 PM, she said that it had been hot during the time that the AC system was not working properly. She stated staff did not bring extra water and ice for residents that she remembered during this time. She stated that in the previous year during “hot spells” fans were purchased for residents by the facility and now she did not know where the facility put her fan. In an interview with State Registered Nurse Aide (SRNA) 2 on 07/23/2025 at 8:33 AM, she stated the facility’s AC broke down back at the end of June when there was a heat wave. She stated that the facility did not have fans on until the last two days that the AC was broken. She thought the AC was out for two weeks and noted that there was hot air coming out of the vents. SRNA2 stated the resident were complaining about the heat, and when staff mentioned how hot it was in the facility, the Administrator told staff they were complaining. In an interview with Registered Nurse (RN) 3 on 07/23/2025 at 9:05 AM, she stated that the AC was out about a month ago and the heat was “bad.” RN3 stated that only one large fan was brought in the facility, and it was placed in the East hallway. Residents were educated to leave their room door open and to sit in their doorways or in the hallway if possible. She stated that temporary AC units were never brought in to help cool the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue Cynthiana, KY 41031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with Contract Services (CS) 1 on 07/23/2025 at 10:49 AM revealed that during the time the HVAC was not functioning correctly, it would work on and off. She said that during this time, there was only one facility fan, which was blowing on the Back Hallway. She indicated that because of the heat, she educated residents to keep their doors open and sit in the hallway. She added that during morning meeting, staff were instructed to provide extra fluids and popsicles; however, she was unsure of this was effective due to the large number of agency staff who did not know the residents. In an interview with the Director of Maintenance on 07/23/2025 at 3:16 PM, he stated that the AC system never went completely out; however, six units had lower output than they should have and were not cooling the facility as well as needed during the time daily temperatures were in the high 80’s and 90’s. The facility called the repair man because the AC was not working well and because they needed it serviced and cleaned since the routine cleaning/maintenance which should have been completed in the Spring of 2025 had not occurred. Although interviews with the Ombudsman and review of work orders revealed problems with the HVAC system lasted 21 days, the Director of Maintenance stated he thought they were only having problems with the AC for a week. Further interview with the Director of Maintenance revealed he had no written evidence of verify his claim that the system was only down for a week. The Director of Maintenance added that although no portable AC units were provided during this time, large fans were brought in to cool down the facility. However, the Maintenance Director also had no evidence of verify this claim or the number of fans actually provided. He stated that he checked the temperature of the facility daily, but did not keep written logs of the temperatures, and as a result, had no evidence of how hot it became during the time that the HVAC system was not fully functioning. In an interview with the Director of Nursing (DON) on 07/24/2025 at 7:58 AM, she stated that the AC never stopped working completely and that the repair people were there several times throughout the week working on the AC. She stated there were fans and that staff gave out extra water and popsicles, and residents were able to get extra fluids anytime they requested them. In an interview with the Administrator on 07/24/2025 at 9:24 AM, she stated that the AC repair people were at the facility multiple times over the week the AC was not working, starting on 06/20/2025. However, review of all HVAC work records provided by the facility no work orders until 06/26/2025, one week after the AC issues were first noted. She stated that due to electrical plug issues, there could only be one large industrial sized fan, and this was why she did not accept the fans offered by Ombudsman2. Further interview with the Administrator revealed that the Director of Maintenance was supposed to be taking temperatures and recording them. The Administrator stated that it was never over 76 degrees in the facility during the time period in question. However, the Administrator could provide no evidence that this was, in fact, accurate. The Administrator confirmed that the Director of Maintenance failed to document and maintain a log of any temperatures during the period in which the AC system was not fully functioning and temperatures as high as 90 degrees in a residential area and 110 degrees in the kitchen were documented by the facility’s own contractor. Additional interview with the Administrator revealed that the facility had no policies/procedures related to mechanical failure of the HVAC system or temperature monitoring in the event of such a failure. This interview revealed that the lack of policies related to these areas was present at the time of the HVAC problems starting 06/19/2025, and continued as of the time of the survey, with no policies developed in response to this recent incident to ensure that in the future, appropriate temperatures were maintained, temperatures were monitored and recorded, and all necessary actions were taken to ensure both the comfort and health of residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue Cynthiana, KY 41031

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 07/24/2025 at 1:00PM of resident rooms and common areas revealed the following: a. room [ROOM NUMBER] had large water stains and peeling paint on the ceiling above the bed area. Additionally, the baseboards were heavily scuffed and covered in visible dust and debris. b. room [ROOM NUMBER] had numerous cracks in the ceiling with brownish-yellow decolorization. c. room [ROOM NUMBER] had a wall behind the headboard of the bed with a large area (½ wall panel) of brownish-yellow discoloration, indentions, and holes. d. The hallway near room [ROOM NUMBER] had a cracked ceiling with remnants of water damage and decaying infrastructure, with multiple cracks and dust collection. e. In the common area where residents gather, the wall behind the television set had no baseboard, and exposed drywall and screws. Additionally, there were pieces of drywall present along the wall base and floor. Observation on 07/25/2025 at 11:00 AM in the main dining hall revealed the areas along the baseboard and corner panels had dust build up, peeling/cracks in the ceiling, chipped paneling, and old discoloration stains consistent with previous water damage. During an interview with R1 on 07/24/2025 at 2:30 PM, she stated the walls had looked like that for a while and it did not feel clean. During an interview with R37 on 07/24/2025 at 3:00 PM, he stated the facility's disrepair made him feel like nobody cares. During an interview with the Director of Maintenance on 07/24/2025 at 1:30 PM, he acknowledged that some of the damaged areas had been present for several months. He stated they tried to get to the repairs when they could, but there was a backlog of repairs, and they were short-staffed. He further stated he had no autonomy to make the repairs, and a day-to-day work list was given by the Administrator. During a concurrent interview with RN1 and SRNA1 on 07/25/2025 at 1:30PM, they revealed the damages were known to the administration, as residents and family had made multiple complaints due to the conditions of the facility. However, they continued, nothing was ever done to repair them. During an interview with the DON on 07/25/2025 at 2:00PM, she confirmed repairs were needed for multiple resident rooms. She stated a plan was in place, but it was not progressing as fast as the facility had hoped. The DON stated continued deterioration could lead to safety and health hazards for all residents, staff, and visitors. During an interview with the Administrator on 07/25/2025 at 2:30PM, she stated that a lot of work was needed to be done on the older building. The Administrator confirmed that the facility was aware of the conditions in the building and indicated a plan was in place to refurbish areas. However, no specific timeline was provided to indicate when needed repairs/cleaning would occur. Further interview with the Administrator revealed that all residents had the right to a safe and clean environment that was homelike.