

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 66 EAST NORTH STREET MADISONVILLE, KY 42401
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>A Recertification Survey was conducted on 09/09/14 through 09/11/14 to determine the facility's compliance with Federal requirements. The facility did not meet the requirements for recertification with deficiencies cited.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to revise the Comprehensive Care Plan and Certified Nursing</p>	<p><b>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</b></p> <p><b>F 280</b></p> <p><b>Criteria 1:</b> -The care plan and C.N.A care plan for resident #7 have been reviewed/revised by the Care plan team on 9-10-14 to determine that they address the resident's current therapy positioning recommendations.</p> <p><b>Criteria 2:</b> -The care plans for current residents utilizing wheel chairs were reviewed/revised by the Care Plan Team on 9-29-14, 10-2-14, and 10-6-14 to determine that they address each resident's current wheel chair positioning recommendations.</p> <p><b>Criteria 3:</b> -The Care Plan Team have received inservice education by the Administrator on 10-1-14, on the need to address the indicated interventions for all residents on their Care plans, including but not limited to wheel chair positioning interventions. The Therapy Department has received inservice education by the Administrator on 9-18-14, on the need to address the indicated interventions for all residents on their Care Plans including but not limited to wheel chair positioning interventions.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Viki Thomason* TITLE: *Administrator* (X6) DATE: *10-3-14*

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

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 66 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 280	<p>Continued From page 1</p> <p>Care Plan for one (1) of fifteen (15) sampled residents (Resident #7) related to Resident #7 no longer needing a highback wheelchair and anti-tippers.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans, CNA", not dated, revealed the CNA care plan was to ensure that staff has accurate information needed to provide care for the resident. The policy further stated, "The CNA Care Plan will be updated by a member of the interdisciplinary team at any time there is a change in the resident's condition related to ADL's, transfers, positioning, dietary changes, and/or anything affecting the care of the resident within the CNA scope of practice. All updates made to the current CNA Care Plan will be made in Red Ink. All updates shall be dated and initialed by the team member making the update".</p> <p>Record review revealed the facility admitted Resident #7 on 05/16/14 with diagnoses to included Cranial Defect, Left Hemiparesis, Immobility Syndrome and Post-Operative Subdermal Hematoma. Review of the Quarterly Minimum Data Set (MDS), dated 05/23/14, revealed the facility assessed the resident's cognition as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident was non-interviewable and required the use of a wheelchair as a mobility device.</p> <p>Review of the Comprehensive Plan of Care, dated 05/27/14, revealed Resident #7 was to have anti-tippers on the wheelchair. The Certified Nursing Care plan, dated 05/27/14, revealed</p>	F 280	<p>The CQI indicator for the monitoring of care plan documentation for positioning interventions will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p>	10-7-14	

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 280	<p>Continued From page 2</p> <p>Resident #7 was to have a high back wheelchair with anti-tippers. Review of the Physician Order, dated 08/18/14 through 09/30/14 revealed an order for the resident to have a high back wheelchair and anti-tippers.</p> <p>Observation of Resident #7, on 09/10/14 at 8:28 AM, 9:20 AM and 9:45 AM, revealed Resident #2 was in a standard wheelchair without a highback and no anti-tippers. However, review of a Physical Therapy (PT) Note, dated 08/08/14, revealed the PT Director documented the resident was given a new wheelchair on that day to aid with his/her sitting balance and posture while he/she was up because the resident was sitting up better, holding his/her position better and no longer needed a highback wheelchair. The resident was placed in a standard wheelchair; however, still needed his/her saddle cushion and right lateral support. Further review of an Addendum in the PT Notes, dated 09/10/14, revealed no anti-tippers were needed at this time due to no safety concerns seen by Certified Occupation Therapy Aide (COTA).</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/10/14 at 11:30 AM, revealed Resident #7 did not have a high back wheelchair with anti-tippers. She stated this was the wheelchair the resident has used since she was assigned to him/her. CNA #1 stated he reviewed the CNA care plan every day and saw the resident was supposed to have a high back wheelchair with anti-tippers but Physical Therapy provided the wheelchairs needed for each resident so he used the wheelchair that therapy provided.</p> <p>Interview with CNA #4, on 09/10/14 at 11:35 AM, revealed she had never used a highback</p>	F 280			

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 280	<p>Continued From page 3</p> <p>wheelchair with anti-tippers for Resident #7 since she started working there. CNA #4 stated she reviewed the CNA care plan for Resident #7 and saw the resident was supposed to have a high back wheelchair and anti-tippers but she used the wheelchair without anti-tippers and without a high back.</p> <p>Interview with the Physical Therapy Director/Rehabilitation Director, on 09/10/14 at 11:42 AM, revealed the high back wheelchair and anti-tippers should have been removed from the care plans by Physical Therapy when their department determined there was no need for the devices. She stated the anti-tippers and high back wheelchair had been discontinued on 08/08/14 and it was Physical Therapy's responsibility to remove those devices from the Comprehensive and CNA Care Plan. Further interview, on 09/10/14 at 2:40 PM, revealed the Physical Therapy Director stated she could write a discontinue order after talking to the physician and flag it for the physician to sign and it would then be the responsibility of the Physical Therapy Director to document that they had discontinued the devices.</p> <p>Interview with the Director of Nursing (DON), on 09/10/14 at 2:25 PM, revealed Resident #7 had a physician order for anti-tippers and if there was an order for the use of a device then there should have been a physician order for the resident to be discontinued from the device. The DON stated she expected the CNA to talk to the Charge Nurse if he/she identified a device on the care plan was not being used. The DON revealed the CNA should have followed the care plan until they talked to the charge nurse for further instruction.</p>	F 280			

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 364 F 364 SS=E	Continued From page 4 483.35(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 review of the facility policy and procedures, it was determined the facility failed to ensure each resident received and the facility provided food prepared by methods that conserved nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature for fifteen (15) residents. The facility served riblet patties to fifteen (15) residents during a lunch meal. A test tray sample revealed the riblet patty to be eighty (80) degrees Fahrenheit (F).  The findings include:  Review of the facility's policy and procedure titled "Food Temperatures", not dated, revealed "All hot foods must be cooked to appropriate internal temperatures, held and served at a temperature of at least one-hundred twenty (120) degrees Fahrenheit (F) or palatable per resident". "Hot foods may not fall below one-hundred twenty (120) degrees F after cooking, unless it is an item which is to be rapidly cooled to below forty-one (41) degrees F and reheated to at least one-hundred sixty-five (165) degrees F prior to serving".	F 364 F 364	<b>F 364</b> <b>Criteria 1 and 2:</b> Residents are served meals in accordance with the regulatory requirements for food temperatures as determined by Test Tray monitoring done three times per day for 3 weeks, then two times per day for two weeks, then 2 times per week thereafter by the Dietary Manager and Dietitian.  <b>Criteria 3:</b> Dietary Supervisor inserviced Dietary Staff to batch cook (hot food) and pre-cook/pre-prep (cold food) menu items to maintain palatable and attractive food served at the proper temperature in accordance with the regulatory guidelines on 9-30-14.  Nursing staff have received inservice education by the Staff Development Coordinator on the meal tray pass, including closing the cart door after removing trays on 9-15-14, 9-16-14, 9-17-14, 9-18-14, 9-19-14, 9-20-14, 9-21-14, 9-22-14, and 9-23-14.  <b>Criteria 4:</b> -The CQI indicator for the monitoring of food temperatures will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager. -Residents will be asked about food temperatures in the monthly resident council meeting to determine effectiveness of the new interventions.	10-1-14	

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 364	Continued From page 5  A group meeting with four (4) facility identified interviewable residents, on 09/09/14 at 2:00 PM, revealed the residents attending the meeting had complaints about the hot food being cold and the cold food being hot. Temperatures in the kitchen were measured on 09/09/14 during a lunch meal with no concerns identified. However, a test tray sampled on 09/10/14 at 11:30 AM during a lunch meal revealed riblet patties on buns were being served and the temperature of the riblet patty was eighty (80) degrees F, cole slaw temperature measured fifty (50) degrees F, baked beans temperature measured one-hundred twenty- four (124) degrees F, and the pudding measured forty-three (43) degrees F.  Interview with the Dietary Manager, on 09/11/14 at 2:30 PM, revealed the riblet patty should have been at one-hundred twenty (120) degrees F when served. She stated the reason for the change in the temperature of the patty was the patty cooled quicker because it did not have gravy on it because the gravy would have kept it warmer longer. Additionally, she revealed no resident had complained about the temperature of the patty being cold and a solution for this not to reoccur would be to take the item off of the menu.  Interview with Registered Dietitian, on 09/10/14 at 12:15 PM, revealed the temperature on the riblet patty should have been one-hundred twenty (120) degrees F. She revealed the patty may have cooled off quickly related to opening and closing the cart doors.	F 364			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441 Criteria 1: Administrative nursing		

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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
F 441	Continued From page 6  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 transport linens so as to prevent the spread of infection.	F 441	observations conducted on 9-18-14 indicate nursing staff perform handwashing and changing of gloves in accordance with infection control standards of practice when providing perineal care for residents #5 and #7.  <b>Criteria 2:</b> Administrative nursing observations conducted on 9-18-14, 9-20-14, 9-21-14, 9-22-14, 9-23-14, 10-1-14, 10-2-14, and 10-3-14 indicate that nursing staff perform handwashing and changing of gloves during perineal care in accordance with infection control standards of practice  <b>Criteria 3:</b> Nursing staff have received inservice education on the provision of resident care, including but not limited to perineal care, to include handwashing and changing of gloves in accordance with infection control standards of practice as provided by the Staff Development Coordinator/designee on 9-18-14, 9-20-14, 9-21-14, 9-22-14, 9-23-14, 10-1-14, 10-2-14, and 10-3-14.  <b>Criteria 4:</b> The CQI indicator for the monitoring infection control standards/handwashing/glove changing during care will be utilized monthly X 2 months and then every six months in accordance with the established CQI calendar under the supervision of the DON.	10-4-14

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 66 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 441	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy and procedures it was determined the facility failed to ensure an infection control program was designed to provide a sanitary environment and to help prevent the development and transmission of disease and infection related to the failure to change gloves and wash hands during perineal care for two (2) of fifteen (15) sampled residents (Resident #5 and Resident #7).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Perineal Care", not dated, revealed staff should wash hands, wear gloves and follow Standard Precautions. If heavy soiling is present, use tissues or wipes to remove heavy soiling prior to perineal care. If necessary, use additional clean washcloths, towels, linen, basins and water. Then remove/discard gloves and wash hands. Wash hands and put on clean gloves for perineal care.</p> <p>7. Gently wash, rinse, and dry perineal area, wiping from "clean" urethral area toward "dirty" rectal area to avoid contaminating urethral area with germs from rectal area.</p> <p>1. Record review revealed the facility admitted Resident #7 on 05/16/14 with diagnosis which included Hemorrhage Intracerebral Strokes, Hypertension, Diabetes, and Epilepsy/recurring seizures.</p> <p>Observation of incontinent and perineal care to Resident #7, on 09/10/14 at 9:40 AM revealed Certified Nursing Assistant (CNA) #1 applied gloves without washing hands. Further</p>	F 441		

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 441	<p>Continued From page 8</p> <p>observation revealed CNA #1 provided perineal care and failed to remove gloves, wash hands, and apply a clean pair of gloves prior to providing incontinent care.</p> <p>Interview with CNA #1 on 09/10/14 at 10:00 A.M. revealed to clean hands prior to applying gloves when providing incontinent and/or perineal care. Further interview revealed he should have washed his hands and changed gloves before applying a clean incontinent brief on resident.</p> <p>2. Record review revealed the facility admitted Resident #5 on 02/13/13 with diagnosis which included Hypertension, Osteoarthritis, and Diabetes.</p> <p>Observations of incontinent and perineal care to Resident #5, on 09/10/14 at 10:50 AM revealed CNA #2 and CNA #3 positioned the resident on his/her right side, removed the incontinent brief, and CNA #2 washed the resident's rectal area. The incontinent brief was soiled with urine and feces. CNA #2 and #3 then positioned resident onto his/her back and washed the resident's perineal area with the same wash cloth without removing soiled gloves, washing hands, and applying a clean pair of gloves.</p> <p>Interview with CNA #2, on 09/10/14 at 1:30 PM revealed her and CNA #3 used the same wash cloth to provide incontinent and perineal care and failed to change their gloves between the two tasks.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 09/10/14 at 1:40 PM revealed she expected staff to use a clean washcloth when providing incontinent care and again when providing</p>	F 441			

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(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 441	Continued From page 9 perineal care. Further interview revealed gloves should be changed between each task.  Interview, on 09/10/14 at 2:20 PM with Director of Nursing (DON), revealed incontinent and perineal care should be performed "per policy front to back". She stated, "Hands are cleaned prior to beginning procedure, gloves applied, and gloves should be changed between each task".	F 441			

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 56 EAST NORTH STREET MADISONVILLE, KY 42431
--	---

(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1957.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2005, with 28 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was initiated on 09/09/14 and concluded on 09/10/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-six (66) beds with a census of fifty nine(59) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> 	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wick Thompson TITLE: Administrator (X6) DATE: 10-3-14

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

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431	
(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	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The decency had the potential to affect two (2) of three (3) smoke compartments, fifty-one (51) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 09/10/14 at 8:39 AM, with the Director of Housekeeping, revealed the smoke barrier located in the attic of the 400 Hall contained unsealed penetrations. Interview, with the Director of Housekeeping, revealed maintenance staff inspects smoke barriers quarterly for penetrations and that the unsealed</p>	<p>K 025</p> <p><b>Criteria 1:</b> The penetrations in the smoke barriers in the attic of the 400 Hall were sealed in accordance with the Life Safety Code Standard requirements.</p> <p><b>Criteria 2:</b> The smoke barriers in the attic area were inspected for any unsealed penetrations, with no further issues identified.</p> <p><b>Criteria 3:</b> The maintenance staff have received inservice education on the need to inspect the smoke barriers in the attic area for any unsealed areas on a quarterly basis, when contractors or employees preform work around the smoke barrier that may affect the seal of the smoke barrier and to seal any areas identified. as provided by the Administrator on 9-16-14.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of unsealed penetrations in the attic will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance.</p>	9-17-14	

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 025	<p>Continued From page 2</p> <p>penetrations found during the survey were not identified during the quarterly inspections.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 edition) 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:</p>	K 025		

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 025	Continued From page 3 a. It shall be made on either side of the smoke partitions.  b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 029 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, fifty-one (51) residents, staff and visitors.  The findings include:  Observation on 09/10/2014 at 8:55 AM, with the Director of Housekeeping, revealed the furnace rooms of the 500 Hall and 600 Hall had multiple unsealed penetrations of the smoke partition	K 029	<b>K 029</b>  <b>Criteria 1:</b> The penetrations in the smoke barriers in the furnace rooms of the 500 and 600 Hall were sealed in accordance with the Life Safety Code Standard requirements.  <b>Criteria 2:</b> The smoke barriers in the furnace rooms of the 500 and 600 Hall were inspected for any unsealed penetrations, with no further issues identified.  <b>Criteria 3:</b> The maintenance staff have received inservice education on the need to inspect the smoke barriers in the furnace room areas for any unsealed areas on a quarterly basis, and to seal any areas identified as provided by the Administrator on 9-16-14.  <b>Criteria 4:</b> The CQI indicator for the monitoring of unsealed penetrations in the attic will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance.	9-17-14

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 029	<p>Continued From page 4</p> <p>walls. Interview, with the Director of Housekeeping, revealed maintenance staff inspects hazardous areas quarterly for penetrations and that the unsealed penetrations found during the survey were not identified during the quarterly inspections.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 edition) 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke.</p> <p>8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces.</p> <p>Exception:* Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met:</p> <p>(a) The ceiling system forms a continuous membrane.</p> <p>(b) A smoke tight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling.</p> <p>(c) The space above the ceiling is not used as a plenum.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided</p>	K 029		

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 029	Continued From page 5 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.  Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3	K 039	<b>K 039</b> A FSES Form has been completed on 10-1-14. The cost to correct this deficiency would be in excess of \$600,000 which would cause great hardship to the facility.	10-2-14

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 039	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, per National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, thirty-six (36) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 09/11/14 at 9:09 AM with the Director of Housekeeping, revealed the corridors in two (2) smoke compartments to be less than four (4) feet in width. The corridors affected were located in the 100 Hall, 200 Hall, 300 Hall, and 400 Hall. Interview, with the Director of Housekeeping, revealed the facility used a Fire Safety Evaluation System (FSSES) survey to offset this requirement.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>NFPA 101 (2000 edition) 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width.</p>	K 039		

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 039	Continued From page 7	K 039		
K 062 SS=D	<p>Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating 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 the automatic sprinkler system was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, fifteen (15) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 09/10/14 at 8:44 AM, with the Director of Housekeeping, revealed the automatic sprinkler piping in the attic above the 300 Hall had duct work attached to it. Interview, with the Maintenance Director, revealed the facility relied on an outside contractor to ensure the automatic sprinkler system was maintained and the contractor had never indicated this was a problem.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p>	K 062	<p><b>K 062</b></p> <p><b>Criteria 1:</b> The duct work has been removed from the automatic sprinkler piping in the attic above the 300 Hall.</p> <p><b>Criteria 2:</b> The automatic sprinkler piping was inspected where accessible by the Maintenance staff and duct work was removed from the automatic sprinkler piping as necessary.</p> <p><b>Criteria 3:</b> The maintenance staff were provided inservice education on the NFPA 25 requirements by the Administrator on 9-16-14.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of the automatic sprinkler systems requirements will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Administrator.</p>	9-17-14

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

PRINTED: 09/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2014
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431	
(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	Continued From page 8 Reference: NFPA 25 (1998 edition) 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe.  Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection.  Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		