

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

PRINTED: 07/12/2011
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 07/14/2011 |
|--|--|--|--|

| | |
|--|---|
| 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 000 | <p>INITIAL COMMENTS</p> <p>An annual survey was conducted on 07/12/11 through 07/14/11 and a Life Safety Code survey was conducted on 07/14/11, to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F".</p> | F 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 Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws.</p> | |
| F 281 SS=D | <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure services provided by the facility met professional standards of quality related to not following the physician's orders during a medication pass for two residents (#2 and #10), in the selected sample of fifteen (15).</p> <p>The findings include: A review of the facility's policy "Administration of Medications", revised 04/01/06, revealed "if a medication required dosing outside the defined facility medication administration times, the nurse was responsible for obtaining an order clarification from the prescriber." 1. A record review revealed Resident #10 was admitted to the facility on 02/22/10 with diagnoses to include Peripheral Vascular Disease and Diabetes Mellitus.</p> | F 281 | <p>F281</p> <p>Criteria 1: The orders and Medication Administration Records for residents #2 and #10 have been reviewed/clarified with the attending physicians to specify the medication administration times, as completed by the DON.</p> <p>Criteria 2: The orders and Medication Administration Records for the current residents have been reviewed/clarified with the attending physicians to specify the medication administration times, as completed by the DON and Staff Development Coordinator.</p> <p>Criteria 3: Inservice education has been provided for medication administration staff including but not limited to: medication administration time requirements, verification of physician orders with medication administration records, and the facility policy on medication pass times, as provided by the DON to each Med Nurse and CMT on 7/19, 20, 22, 28, 29, 31/11. Medication administration observations have been completed on facility medication administration staff by the DON and Staff Development Coordinator. Summary recap physician orders and medication administration records will be reviewed by</p> | |

| | | |
|--|------------------------|---------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 8-1-11 |
|--|------------------------|---------------------|

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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: 07/14/2011
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 07/14/2011 |
|--|--|--|--|----------------------|--|
| 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 281 | Continued From page 1 A review of the physician's order sheets, dated July 2011, revealed an order for Neurontin 600 milligrams (mg) by mouth (po) three times a day (TID) at 9:00 AM, 1:00 PM and 9:00 PM. A review of the medication administration record (MAR), dated July 2011, revealed the administration times of the Neurontin were at 9:00 AM, 3:00 PM and 9:00 PM. An observation of a medication pass, on 07/12/11 at 4:33 PM, revealed Certified Medication Tech (CMT) #1 administered Neurontin 600 mg po to Resident #10. An interview with CMT #1, on 07/12/11 at 4:50 PM, revealed the Neurontin for Resident #10 was not administered within the proper time frame according to the medication record and the physician's order sheets. / | F 281 | physician orders and medication administration records will be reviewed by the DON/ ADON/Staff Development Coordinator or Administrative LPN for accuracy and consistency when received from the pharmacy. Any changes in medication administration times will be reviewed with the attending physician and consulting pharmacist before implementation by the DON/ADON/Staff Development Coordinator or Administrative LPN. Criteria 4: Physician orders and medication administration records will be checked weekly X 4 weeks, then every 2 weeks X 4 weeks, and then monthly thereafter to determine accuracy and consistency of medication administration times. The CQI indicator for the monitoring of medication pass accuracy will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON. | 8-2-11 | |
| | 2. A record review revealed Resident #2 was admitted to the facility on 02/24/09, with diagnoses to include Subdural Hematoma, Diabetes Mellitus and Prostate Cancer. A review of the physician's order sheets, dated July 2011, revealed an order for Glimepiride 2 mg po once daily at 7:00 AM. A review of the MAR, dated July 2011, revealed the administration time of the Glimepiride 2 mg | | | | |

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

PRINTED: 07/21/2011
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 07/14/2011 |
|--|---|--|---|

| | |
|---|---|
| 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 281 | <p>Continued From page 2 po was at 9:00 AM.</p> <p>An observation of a medication pass, on 07/13/11 at 8:55 AM, revealed CMT #2 administered Glimepiride 2 mg po to Resident #2.</p> <p>An interview with CMT #2, on 07/13/11 at 9:15 AM, revealed she administered the medication according to the time specified on the MAR, but not according to the time specified on the physician's order sheet.</p> <p>An interview with the Staff Development Coordinator, on 07/14/11 at 10:05 AM, revealed she expected the MAR to reflect the physician's orders.</p> <p>A review of a reminder signed by the Director of Nursing (DON), undated, revealed nursing staff were to update the physician's order sheets if a medication administration time was changed on the medication record.</p> <p>An interview with the DON, on 07/14/11 at 9:40 AM, revealed she expected the nurses to update the physician's order sheets when changing administration times on the medication record. The residents' medications should be administered per the physician's orders.</p> | F 281 | | |
| F 332 SS=E | <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced</p> | F 332 | <p>F332</p> <p>Criteria 1: The orders and Medication Administration Records for residents #2 and #10 have been reviewed/clarified with the attending physicians to specify the medication administration times, as completed by the DON.</p> <p>Criteria 2: The orders and Medication Administration Records for the current</p> | |

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

PRINTED: 07/14/2011
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 07/14/2011 |
|--|--|--|--|

| | |
|--|---|
| 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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|-------|---|-------|--|--|
| F 332 | <p>Continued From page 3</p> <p>by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure it was free of a medication error rate of five percent or greater for two residents (#2 and #10), in the selected sample of fifteen (15). There was a total of 46 opportunities with five medication errors, which resulted in a 10% medication error rate.</p> <p>The findings include:</p> <p>A review of the facility's policy "Administration of Medications", revised 04/01/06, revealed "medications would be administered at the time ordered, or within 60 minutes before or after the designated time. If a medication required dosing outside the defined facility medication administration times, the nurse was responsible for obtaining an order clarification from the prescriber."</p> <p>1. A record review revealed Resident #2 was admitted to the facility on 02/24/09, with diagnoses to include Subdural Hematoma, Diabetes Mellitus and Prostate Cancer.</p> <p>A review of the physician's order sheets, dated July 2011, revealed an order for Synthroid 25 micrograms (mcg) once daily by mouth (po) at 7:00 AM, Folic Acid 1 milligram (mg) po once daily at 7:00 AM with breakfast, Potassium Chloride 20 milliequivalents (meq) po once daily at 7:00 AM, and Glimepiride 2 mg po once daily at 7:00 AM.</p> <p>A review of the Medication Administration (MAR), dated July 2011, revealed the administration time</p> | F 332 | <p>residents have been reviewed/clarified with the attending physicians to specify the medication administration times, as completed by the DON and Staff Development Coordinator.</p> <p>Criteria 3: Inservice education has been Provided for each medication administration staff including but not limited to: medication administration time requirements, verification of physician orders with medication administration records, and the facility policy on medication pass times, as provided by the DON on 7/19, 20, 22, 28, 29, 31/11. Medication administration observations have been completed on facility medication administration staff by the DON and Staff Development Coordinator. Summary recap physician orders and medication administration records will be reviewed by DON/ADON/Staff Development or Administrative LPN for accuracy and consistency when received from the pharmacy. Any changes in medication administration times will be reviewed with the attending physician and consulting pharmacist before implementation by the DON/ADON/Staff Development Coordinator or Administrative LPN.</p> <p>Criteria 4: Physician orders and medication administration records will be checked weekly X 4 weeks, then every 2 weeks X 4 weeks, and then monthly thereafter to determine accuracy and consistency of medication administration times. The CQI indicator for the monitoring of medication pass accuracy will be utilized monthly X 2 months, and</p> | |
|-------|---|-------|--|--|

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

PRINTED: 07/12/2011
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 07/14/2011 |
|--|--|---|---|
| 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 332 | <p>Continued From page 4</p> <p>of the Synthroid 25 mcg po was at 7:00 AM, Folic Acid 1 mg po at 7:00 AM with breakfast, Potassium Chloride 20 meq po at 7:00 AM with breakfast, and Glimepiride 2 mg po at 9:00 AM.</p> <p>An observation of the medication pass, on 07/13/11 at 8:55 AM, revealed Certified Medication Technician (CMT) #2 administered Synthroid 25 mcg po, Folic Acid 1 mg po, Potassium Chloride 20 meq po, and Glimepiride 2 mg po to Resident #2.</p> <p>An interview with CMT #2, on 07/13/11 at 9:15 AM, revealed she administered the medications late and medications should be administered at the times specified.</p> <p>2. A record review revealed Resident #10 was admitted to the facility on 02/22/10 with diagnoses to include Peripheral Vascular Disease and Diabetes Mellitus.</p> <p>A review of the physician's order sheets, dated July 2011, revealed an order for Neurontin 600 mg po three times a day (TID) at 9:00 AM, 1:00 PM and 9:00 PM.</p> <p>A review of the MAR, dated July 2011, revealed the administration times of the Neurontin was at 9:00 AM, 3:00 PM and 9:00 PM.</p> <p>An observation of the medication pass, on 07/12/11 at 4:33 PM, revealed CMT #1 administered Neurontin 600 mg po to Resident #10.</p> <p>An Interview with CMT #1, on 07/12/11 at 4:50</p> | F 332 | <p>then quarterly thereafter under the supervision of the DON.</p> <p>8-2-11</p> |

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

PRINTED: 07/14/2011
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 07/14/2011 |
|--|--|--|--|

| | |
|--|---|
| 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 332 | <p>Continued From page 5</p> <p>PM, revealed the Neurontin for Resident #10 was administered late, according to the MAR and the physician's order sheets. She revealed the policy of the facility was to administer medications within one hour before or after the scheduled time.</p> <p>A review of a reminder signed by the Director of Nursing (DON), undated, revealed nursing staff were to update the physician's order sheets if a medication administration time was changed on the medication record.</p> <p>An interview with the DON, on 07/14/11 at 9:40 AM, revealed she expected the nurses to update the physician's order sheets when changing administration times on the MAR. The residents' medications should be administered per the physician's orders.</p> | F 332 | | |
| F 514 SS=D | <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 514 | <p>F514</p> <p>Criteria 1: Residents #1, 2, and 6 have had skin assessments completed by the skin/treatment nurse with current findings verified by the DON and documented on the skin/wound assessment forms.</p> <p>Criteria 2: Skin assessments were completed on all current residents by the facility's Wound Nurse. Any wounds identified were assessed and documented by the skin/treatment nurse and verified by the DON.</p> <p>Criteria 3: Inservice education was provided for the licensed nurses on skin and wound assessments including but not limited to: the use the standardized measuring tool, MDS 3.0 wound terminology, wound staging in accordance with current clinical standards of care, and wound documentation as provided by the</p> | |

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

PRINTED: 07/27/2011
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 07/14/2011 |
|--|---|--|--|--|
| 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 514 | <p>Continued From page 6</p> <p>Based on observations, record reviews and interview, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are accurately documented for three residents (#1, #2, and #6), in the selected sample of fifteen (15), related to wound documentation.</p> <p>The findings include:</p> <p>1. A record review revealed Resident #6 was admitted to the facility on 09/22/10 with diagnoses to include Venous Stasis Ulcers, Diabetes with Peripheral Circulatory Disorders and Fibromyalgia.</p> <p>Observation of a skin assessment, completed by Licensed Practical Nurse (LPN) #1, on 07/13/11 at 10:05 AM, revealed Resident #6 had four areas on the left lateral aspect of the right shin. Wound #1 measured 1.0 centimeter (cm) in length by 1.2 cm in width. Inferior to wound #1 was wound #2, which measured 2.0 cm in length by 2.6 cm in width. Inferior to wound #2 was wound #3, which measured 0.6 cm in length by 0.4 cm in width. To the right of wound #3 was wound #4, which measured 1.2 cm in length by 0.6 cm in width. Three open areas were identified on the left lateral aspect of the left leg. Wound #5 measured 1.8 cm in length by 0.4 cm in width. Inferior to wound #5 was wound #6, which measured 1.1 cm in length by 0.3 cm in width. Inferior to wound #6 was wound #7, which measured 2.3 cm in length by 1.0 cm in width. Two open areas were identified during the skin assessment on the right lateral aspect of the left shin. Wound #8 measured 2.0 cm in length by</p> | F 514 | <p>DON or Certified Wound Nurse Consultant on 7-28-11, 7-29-11, 7-30-11, 7-31-11 and 8-1-11.</p> <p>Criteria 4: The CQI indicator for the monitoring of skin/wound assessment and documentation compliance will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON.</p> | 8-2-11 |

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

PRINTED: 07/27/2011
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 07/14/2011 |
|---|--|---|---|---|
| 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 514 | <p>Continued From page 7</p> <p>1.6 cm in width. Inferior to wound #8 was wound #9, which measured 1.5 cm in length by 1.5 cm in width.</p> <p>A review of the "Weekly Ulcer Progress Report," dated 07/13/11, revealed the measurements documented by LPN #1 did not reflect the skin assessment completed on 07/13/11.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 04/01/11 with diagnoses to include Diabetes Mellitus and Chronic Stage III Kidney Disease.</p> <p>Observation of a skin assessment, completed by LPN #1, on 07/13/11 at 9:20 AM, revealed Resident #2 had an open area to the crease of the right foot which measured 1.0 cm in length by 1.0 cm in width. The depth of the area measured 0.4 cm.</p> <p>A review of the "Weekly Ulcer Progress Report," dated 07/13/11, revealed LPN #1 documented the measurements of the open area as 0.6 cm in length by 0.8 cm in width. The depth was documented as superficial.</p> <p>3. A record review revealed Resident #1 was admitted to the facility on 05/14/09 with diagnoses to include COPD with cachexia, Coronary Artery Disease and Transient Cerebral Ischemia.</p> <p>An observation of a skin assessment, completed by LPN #1, on 07/13/11 at 11:20 AM, revealed Resident #1 had an open area on his/her coccyx which measured 1.7 cm in length by 1.1 cm in width, with no depth.</p> | F 514 | | |

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

PRINTED: 07/12/2011
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 07/14/2011 |
|--|--|--|--|

| | |
|--|---|
| 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 514 | <p>Continued From page 8</p> <p>A review of the "Weekly Ulcer Progress Report," dated 07/13/11, revealed LPN #1 documented the measurements of the open area to be 0.3 cm in length by 0.2 cm in width, with no depth.</p> <p>An interview with LPN #1, on 07/14/11 at 9:30 AM, revealed she did not document the measurements immediately after the assessment was completed; therefore, the measurements documented on 07/13/11 were inaccurate.</p> <p>An interview with the Director of Nursing (DON), on 07/14/11 at 9:40 AM, revealed wound measurements and skin assessments should be documented immediately to avoid discrepancies.</p> | F 514 | | |

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

PRINTED: 08/25/2010
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 08/10/2010 |
| 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 062 | Continued From page 1 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. | K 062 | | |
| K 073 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 08/10/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. The findings include: Observations during the Life Safety Code tour, conducted on 08/10/10, at 1:15 PM, revealed doors throughout the facility were decorated with wreaths. An interview conducted with the Maintenance Director, on 08/10/10 at 1:30 PM, revealed the wreaths had been put on the doors by family members, the facility did not have any documentation that would indicate the flame rating of the wreaths on the doors. | K 073 | K073 Criteria 1&2: All decorative wreaths have been treated with flame retardant and tagged with the date of the treatment. Criteria 3: The Social Services Director will notify all newly admitted residents of the need for decorative wreaths to be treated with flame retardant prior to use, and the need to notify the facility staff when these are brought into the facility. The Social Service Director will be responsible for taking all new decorative wreaths to the Housekeeping or Maintenance Supervisor for flame retardant treatment and date tagging. Criteria 4: The Maintenance Supervisor will audit all decorative wreaths monthly to determine that they have been treated with flame retardant. | 7-5-10 |

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

PRINTED: 08/25/2010
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 08/10/2010 |
|--|--|--|---|----------------------|--|
| 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 | |
| | | | | | |

| | | | |
|--|--|--|--|
| 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 06/10/2010 |
|--|--|--|--|

| | |
|--|---|
| 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 | INITIAL COMMENTS | K 000 | | |
| K 062 SS=F | <p>A Life Safety Code survey was initiated and conducted on 06/10/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an F.</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 staff interview conducted on 06/10/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25 1999 Edition.</p> <p>The findings to include:</p> <p>A tour of the facility conducted 06/10/10 at 10:30 AM, revealed sprinkler heads throughout the facility were stained with a brown substance.</p> <p>An interview with the Administrator and Maintenance Director on 06/10/10 at 10:35 AM, revealed the sprinkler heads were at least twenty years old.</p> <p>Reference to: NFPA 25 1999 Edition</p> | K 062 | <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 Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws.</p> <p>Criteria 1& 2: Premier Fire Protection Company has taken a sample of 4 sprinkler heads on 6-25-10 to be inspected and tested. If one of the 4 sprinkler heads fail testing, all of the sprinkler heads will be replaced throughout the Facility</p> <p>Criteria 3: The Maintenance Supervisor has received inservice education on the inspection of sprinkler heads for discoloration and/or corrosion as provided by Administrator on 6-25-10.</p> <p>Criteria 4: The CQI indicator for the monitoring of sprinkler heads will be utilized monthly X 2 months and then quarterly under the supervision of the Maintenance Supervisor.</p> | 7-5-10 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Wili Thomason* TITLE: *Administrator* (X6) DATE: *7-2-10*

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: 06/25/2010
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 06/10/2010 |
|--|--|--|---|----------------------|--|
| 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 062 | Continued From page 1 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. | K 062 | | | |
| K 073 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/10/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. The findings include: Observations during the Life Safety Code tour, conducted on 06/10/10, at 1:15 PM, revealed doors throughout the facility were decorated with wreaths. An interview conducted with the Maintenance Director, on 06/10/10 at 1:30 PM, revealed the wreaths had been put on the doors by family members, the facility did not have any documentation that would indicate the flame rating of the wreaths on the doors. | K 073 | K073 Criteria 1&2: All decorative wreaths have been treated with flame retardant and tagged with the date of the treatment. Criteria 3: The Social Services Director will notify all newly admitted residents of the need for decorative wreaths to be treated with flame retardant prior to use, and the need to notify the facility staff when these are brought into the facility. The Social Service Director will be responsible for taking all new decorative wreaths to the Housekeeping or Maintenance Supervisor for flame retardant treatment and date tagging. Criteria 4: The Maintenance Supervisor will audit all decorative wreaths monthly to determine that they have been treated with flame retardant. | 7-5-10 | |

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

PRINTED: 06/25/2010
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 06/10/2010 |
|--|--|--|---|----------------------|--|
| 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 | |
| | | | | | |