

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

PRINTED: 11/09/2012
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 10/25/2012
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431
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F 000	INITIAL COMMENTS A recertification survey was conducted on 10/23/12 through 10/25/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "F."	F 000	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.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, and review of the facility's policy/procedure for Abuse Prevention and Reporting, it was determined the facility failed to protect one resident (#16), not in the selected sample, from physical abuse. Resident #16 reported to staff that he/she was hit in the back multiple times by Resident #4 when staff prepared to take a group of residents outside of the facility to smoke on 09/08/12. Findings include: Review of the facility's policy/procedure for "Abuse Prevention and Reporting," revealed any person who suspected or witnessed abuse should report the incident to the Administrator	F 224	F 224 Criteria 1: An investigation was conducted into the event involving resident #16, which included interviews of the staff, residents, and family members who may have witnessed the event. Resident #16 was interviewed by the Director of Social Services/ADM to determine that there have not been any events or concerns experienced by the resident in the last 30 days. Criteria 2: Social Services completed the CQI Quality of Life/ Resident Interview questionnaire on all residents on 11-12-12, 11-13-12, 11-14-12, and 11-15-12 to determine that investigations have been completed for all reported allegations. Individual resident care plans were reviewed and revised as indicated by interview findings. Criteria 3: All staff were provided in-service education on Resident Rights, and the Facility Abuse Policy, including but not limited to:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Vicki Hornum* TITLE: *Administrator* (X6) DATE: *11-19-12*

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

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F 224	<p>Continued From page 1</p> <p>Immediately. Physical abuse was defined as hitting, slapping, pinching, and kicking. The policy stated that the facility would implement staff supervision and interventions to prevent resident to resident physical abuse. Staff supervision was provided to identify inappropriate behaviors, and monitoring of residents with behaviors which might lead to conflict.</p> <p>Record review revealed the facility admitted Resident #4 on 08/21/07 with diagnoses to include Dementia, Depression, Anxiety, Encephalopathy, and Mental Status changes. Review of the nurses' notes revealed Resident #4 often refused care, medications, and meals. The facility implemented a Behavioral Symptom care plan for Resident #4 to address the resident's refusal of care and verbal abuse.</p> <p>Review of the facility's investigation completed by the Administrator revealed, on 09/08/12, she was notified by the Charge Nurse that the wheelchair of Resident #16 was hit by the wheelchair of Resident #4 as the resident moved past Resident #16 on the way out of the building. The report stated that Resident #16 did not complain about any injury after the event. The facility's investigation revealed Resident #16 complained about back soreness, on 09/09/12, and an x-ray of the resident's back was obtained, which showed mild to moderate Spondylosis and Osteopenia. The facility's investigation did not include any interviews from Resident #16, as well as interviews to determine if there were any witnesses to the alleged abuse. The facility's investigations included documentation of every fifteen (15) minutes checks completed for Resident #4, which began on 09/08/12 at 7:45</p>	F 224	<p>the need to investigate all allegations of abuse, neglect and misappropriation of property; the need to conduct interviews with all potential witnesses to alleged events; and the need to report all allegations to the DON and Administrator as per policy, as provided by the ADM/SDC/Social Services on 10-31-12, 11-13-12, 11-14-12, 11-15-12, and 11-16-12.</p> <p>Criteria 4: The Daily Quality Assurance Committee reviews all resident incidents from the previous 24 hours including incidents involving resident's allegation of abuse or neglect on Monday-Friday and the DON/ADM are contacted with each resident incident to review the incidents Saturday-Sunday. The ADM/DON are responsible for ensuring all allegations of abuse or neglect are immediately reported to the Office of Inspector General and Department for Community Based Services. The CQI indicator for the monitoring of compliance with the facility Abuse policy will be utilized monthly X 2 months, and then Quarterly as per the established CQI calendar, under the supervision of the ADM.</p>	11-17-12
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F 224	<p>Continued From page 2</p> <p>PM and ended on 09/11/12 at 6:30 AM. On 09/08/12 at 7:45 PM, staff documented that Resident #4 was sitting at the dining room table pounding his/her fist on the table. On 09/09/12 at 10:30 AM, staff documented that a bath was provided to Resident #4 while the resident was cursing and hitting staff, and at 10:45 AM, Resident #4 cursed the nurse as a blood glucose level was obtained and insulin was administered. On 09/10/12 at 6:30 PM, staff documented Resident #4 self-propelled in a wheelchair, banged on the outside door, and requested to go outside to smoke.</p> <p>Interview, on 10/23/12 at 6:00 PM, with Registered Nurse (RN) #1 revealed that residents complained to her about the behaviors demonstrated by Resident #4, and stated the resident became combative with other residents in the past. RN #1 stated that Resident 4 was "temperamental" and stated when staff attempted to provide cueing or care, the resident responded with abusive language (cursing) and became combative.</p> <p>Interview, on 10/25/12 at 10:45 AM, with Resident #16 detailed an accusation of physical abuse which occurred six (6) weeks ago when Resident #4 hit Resident #16 hard in the back multiple times as the resident was trying to get outside to smoke. Resident #16 stated that other residents and one family member witnessed the physical abuse. Resident #16 stated he/she tried to stay out of reach of Resident #4 and said the resident used profane (cursing) language toward residents and staff. Resident #16 stated other residents complained to Administration about the profane language and the potential threat of physical</p>	F 224			

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F 224	<p>Continued From page 3</p> <p>abuse perpetrated by Resident #4. Resident #16 stated he/she reported the abuse to the Charge Nurse and was not aware of any action taken by the facility to ensure the safety of other residents from further abuse by Resident #4.</p> <p>Interview, on 10/25/12 at 1:00 PM, with the Administrator revealed she received a call from the Charge Nurse, on 09/08/12, and was told Resident #4 accidentally hit Resident #16 in the back of his/her wheelchair as Resident #4 attempted to pass Resident #16 in his/her wheelchair. The Administrator stated the incident was not abuse, but rather an accident that was witnessed by the Charge Nurse. The Administrator stated the facility was not responsible to investigate or report the incident to the State Agency since the incident was an accident.</p> <p>Interview, on 10/25/12 at 1:30 PM, with RN #3 revealed she did not witness the incident, on 09/08/12, when Resident #16 revealed he/she was hit in the back by Resident #4. RN #3 stated that Resident #4 became very impatient while waiting to go outside to smoke. On 09/08/12, while residents were waiting to go outside to smoke, she heard Resident #16 state loudly that Resident #4 hit him/her in the lower back. RN #3 stated she observed the level of Resident #4's wheelchair at the same level as the back of Resident #16's wheelchair, and she assumed Resident #16 was accidentally hit in the back by Resident #4's wheelchair. RN #3 said she did not interview any residents or family present to determine what occurred and stated she reported the incident to the Director of Nursing (DON).</p>	F 224		

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F 224	<p>Continued From page 4</p> <p>Interview, on 10/25/12 at 3:00 PM, with Family Member #1 revealed he/she observed Resident #4 hit Resident #16 a few weeks ago in the back with a clenched fist several times. Family Member #1 said the hits were hard and caused Resident #16 to call out in pain for Resident #4 to stop hitting him/her.</p> <p>Interview, on 10/25/12 at 5:45 PM, with the Administrator revealed she did not interview any staff or residents because she was not told the incident was an allegation of abuse. The Administrator said the facility initiated visual checks of Resident #4 every fifteen (15) minutes through 09/10/12 at 6:30 AM to keep the two residents apart and to ensure that there was no further contact between Resident #4 and Resident #16.</p>	F 224		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, and review of the facility's policy for Abuse Prevention and Reporting, it was determined the facility failed to protect one resident (#16), not in the selected sample, from physical abuse. Resident #16 reported to staff that he/she was hit in the back multiple times by</p>	F 226	<p>F 226</p> <p>Criteria 1: An investigation was conducted into the event involving resident #16, which included interviews of the staff, residents, and family members who may have witnessed the event. Resident #16 was interviewed by the Director of Social Services/ADM to determine that there have not been any events or concerns experienced by the resident in the last 30 days.</p> <p>Criteria 2: Social Services completed the CQI Quality of Life Resident Interview questionnaire on</p>	

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F 226	<p>Continued From page 5</p> <p>Resident #4 as staff prepared to take a group of residents outside of the facility to smoke on 09/08/12.</p> <p>Findings include:</p> <p>Review of the facility's policy for "Abuse Prevention and Reporting," revealed any person who suspected or witnessed abuse should report the incident to the Administrator immediately. Physical abuse was defined as hitting, slapping, pinching, and kicking. The policy stated the facility would implement staff supervision and interventions to prevent resident to resident physical abuse. Staff supervision was provided to identify inappropriate behaviors, and monitoring of residents with behaviors which might lead to conflict. The policy stated any report from facility staff, residents, or other persons related to the facility that related to actual or suspected abuse was thoroughly investigated in-house by the Administrator, who was responsible to report the abuse allegations to the State Agency.</p> <p>Record review revealed the facility admitted Resident #4 on 08/21/07 with diagnoses to include Dementia, Depression, Anxiety, Encephalopathy, and Mental Status Changes. Review of the nurse's notes revealed Resident #4 refused care, medications, and meals. The facility implemented a Behavioral Symptom care plan for Resident #4 to address the resident's refusal of care and verbal abuse.</p> <p>Review of the facility's investigation completed by the Administrator revealed, on 09/08/12, she was notified by the Charge Nurse that the wheelchair of Resident #16 was hit by the wheelchair of</p>	F 226	<p>all residents on 11-12-12, 11-13-12, 11-14-12, and 11-15-12 to determine that investigations have been completed for all reported allegations. Individual resident care plans were reviewed and revised as indicated by interview findings.</p> <p>Criteria 3: All staff were provided in-service education on Resident Rights, and the Facility Abuse Policy, including but not limited to: the need to investigate all allegations of abuse, neglect and misappropriation of property; the need to conduct interviews with all potential witnesses to alleged events; and the need to report all allegations to the DON and Administrator as per policy, as provided by the ADM/SDC/Social Services on 10-31-12, 11-13-12, 11-14-12, 11-15-12, and 11-16-12.</p> <p>Criteria 4: The Daily Quality Assurance Committee reviews all resident incidents from the previous 24 hours including incidents involving resident's allegation of abuse or neglect on Monday-Friday and the DON/ADM are contacted with each resident incident to review the incidents Saturday-Sunday. The ADM/DON are responsible for</p>		

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F 226	<p>Continued From page 6</p> <p>Resident #4 as the resident moved past Resident #16 on the way out of the building to smoke. The report stated that Resident #16 did not complain about any injury after the event. The facility's investigation revealed Resident #16 complained about back soreness, on 09/09/12, and an x-ray of the resident's back was obtained, which showed mild to moderate Spondylosis and Osteopenia. The facility's investigation did not include any interviews from Resident #16, as well as interviews to determine if there were any witnesses to the alleged abuse.</p> <p>Telephone interview, on 10/25/12 at 1:30 PM, with Registered Nurse (RN) #3 revealed that she did not witness the alleged abuse reported by Resident #16. RN #3 stated she observed the level of Resident #4's wheelchair at the same level as the back of Resident #16's wheelchair, and she assumed Resident #16 was accidentally hit in the back by Resident #4's wheelchair. RN #3 said she did not interview any residents or family present to determine what occurred and stated she reported the incident to the Director of Nursing (DON).</p> <p>Interview, on 10/25/12 at 1:00 PM, with the Administrator revealed she received a call from the Charge Nurse, on 09/08/12, and was told Resident #4 accidentally hit Resident #16 in the back of his/her wheelchair, as Resident #4 attempted to pass Resident #16 in his/her wheelchair. The Administrator stated she was informed the incident was an accident, rather than abuse witnessed by the Charge Nurse. The Administrator stated the facility was not responsible to investigate or report the incident to the State Agency because the incident between</p>	F 226	ensuring all allegations of abuse or neglect are immediately reported to the Office of Inspector General and Department for Community Based Services. The CQI indicator for the monitoring of compliance with the facility Abuse policy will be utilized monthly X 2 months, and then Quarterly as per the established CQI calendar, under the supervision of the ADM.	11-17-12	

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<p>F 226</p> <p>F 241 SS=D</p>	<p>Continued From page 7</p> <p>Resident #4 and Resident #16 was an accident.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in an environment that maintained or enhanced each resident's dignity for one resident (#5), in the selected sample of fifteen residents, as evidenced by staff conducting personal conversations during the care of the resident.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure for "Resident Rights," revealed the facility would provide care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Observation, on 10/25/12 at 9:55 AM, of wound care and a skin assessment for Resident #5 provided by Licensed Practical Nurse (LPN) #2 and LPN #3, revealed they discussed an upcoming outside event (wedding) that one of the staff members planned to attend, as Resident #5 was repositioned and daily wound care was provided to the resident.</p>	<p>F 226</p> <p>F 241</p>	<p>F 241</p> <p>Criteria 1: Resident #5 is provided care in a manner that maintains or enhances the resident's dignity and respect in full recognition of her individuality. Staff speak to the resident during care about facility or current events, or topics of interest to the resident.</p> <p>Criteria 2: Residents are provided care in a manner that maintains or enhances each resident's dignity and respect in full recognition of their individuality. Staff speak to residents during care about facility or current events, or topics of interest to the residents.</p> <p>Criteria 3: Facility staff have received inservice education on the provision of care for resident's in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality, as provided by the ADM/SDC/Social Services on 10-31-12, 11-13-12, 11-14-12, 11-15-12, and 11-16-12 This included but was not limited to education for staff on speaking to residents during care</p>	
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F 241	<p>Continued From page 8</p> <p>Interview, on 10/25/12 at 1:30 PM, with Resident #5 revealed the Wound Care Nurse, who performed the resident's daily wound care, talked about her own personal challenges with her relationship to a significant other as the treatment was provided. Resident #5 stated their own challenges to heal and return home provided significant stress and worry for the resident. Resident #5 stated multiple staff members had conversed with each other while providing care to him/her, as though the resident was not in the room. Resident #5 stated the personal staff conversations held in the resident's room made the resident feel "sad and insignificant." Resident #5 previously requested staff avoid personal conversations while providing care for the resident.</p> <p>Interview, on 10/25/12 at 2:12 PM, with Charge Nurse LPN #3 revealed that Resident #5 had previously voiced to her that he/she was "tired of hearing" about LPN #2's personal life challenges. LPN #3 stated she referred the concern to Social Services and to the Marketing Director and thought Resident #5 had been satisfied with some resolution.</p> <p>Interview, on 10/25/12 at 4:10 PM, with the Assistant Director of Nursing (ADON), revealed that staff were trained to avoid personal staff conversations during provision of care to promote the dignity of the resident. The ADON stated personal staff conversations in the presence of residents could cause a resident to become concerned and uncomfortable. The ADON stated the concerns reported by Resident #5 constituted a lack of concern for</p>	F 241	<p>about facility or current events, or topics of interest to the residents.</p> <p>Criteria 4: The CQI indicator for the monitoring of staff compliance with maintaining resident dignity will be utilized monthly X 2 months and then quarterly thereafter in accordance with the scheduled CQI calendar, under the supervision of the Director of Social Services.</p>	1-17-12
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F 241	Continued From page 9 resident dignity.	F 241		
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 observation, interview, and review of the facility's policy for Glucometer Control Solution (High and Low) Testing, it was determined the facility failed to meet professional standards of quality according to accepted standards of clinical practice. Facility records and documentation of glucometer quality control checks were not completed or documented at twenty-four (24) hour intervals for two (2) of four (4) glucometers used within the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure for Glucometer Control Solution (High and Low) Test, revealed the control solution test on glucometers was to be completed every twenty-four (24) hours.</p> <p>Review of the Glucometer Quality Control log for Glucometer #1, revealed quality checks were not documented as completed on 08/01/12, 08/19/12, 08/20/12, 08/25/12, 08/31/12, 09/03/12, and 10/20/12. Further review of the Glucometer Quality Control log for Glucometer #2, revealed quality control checks were not documented as completed on 08/01/12, 08/20/12, 08/24/12,</p>	F 281	<p>F 281</p> <p>Criteria 1 & 2: The Glucometer control solution testing is conducted every 24 hours for each of the facility glucometers in accordance with the facility policy and manufacturer recommendations, as determined in weekly random monitoring completed by the Administrative nurses.</p> <p>Criteria 3: Inservice education has been provided for the licensed nursing staff on the completion of Glucometer control solution testing every 24 hours for each of the facility glucometers in accordance with facility policy and manufacturer recommendations, as provided by the ADM/SDC on 10-24-12, 10-26-12, 10-31-12, 11-12-12, 11-13-12, 11-14-12, 11-15-12,</p> <p>Criteria 4: Administrative nursing staff will monitor the completion of Glucometer control solution testing daily X 2 weeks, then weekly at random thereafter to determine ongoing compliance.</p>	11-17-12

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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	Continued From page 10 08/25/12, and 08/30/12. Interview, on 10/25/12 at 4:10 PM, with the Assistant Director of Nursing (ADON) revealed glucometer quality controls were to be performed on each glucometer in the facility every twenty-four (24) hours. The ADON stated the night shift Charge Nurse was responsible to perform the control checks, and stated this was in accordance with the facility's policy to ensure glucometers functioned efficiently to prevent reporting of inaccurate glucose values. The ADON was not aware of any audit assigned by Nursing Administration to ensure the control checks were completed and documented in accordance with the facility policy.	F 281			
F 309 SS-D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policies/procedures for Skin Care Management and Pressure Ulcer Prevention and Healing, it was determined the facility failed to provide care and services to maintain the highest practicable well-being for one resident (#5), in the selected sample of	F 309	F 309 Criteria 1: A head to toe skin assessment was completed on Resident #5 to determine that all of the current findings are documented, and skin issues are being treated appropriately in accordance with MD orders. Criteria 2: Head to toe skin assessments were completed on all residents to determine that all current findings are documented, and any identified skin issues are being treated appropriately in accordance with MD orders. Criteria 3: Licensed nursing staff have received inservice education by		

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 66 EAST NORTH STREET MADISONVILLE, KY 42431
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F 309	<p>Continued From page 11</p> <p>fifteen residents. Observation of a weekly skin assessment for Resident #5, revealed a dark spot on both middle toes of the right and left foot which was not addressed or documented on the weekly skin assessment, and was not addressed or documented by the facility since admission to the facility. An order was written by the Wound Care Advanced Practice Registered Nurse (APRN), on 10/23/12, for Resident #5 to have daily dressing changes to the right lower extremity, with an ace wrap applied. Observation of wound care provided to Resident #5 identified an ace wrap was applied to the resident's extremity with compression. Resident #5 reported multiple complaints were made to the staff that the dressing with the ace wrap was too tight and was told the dressing could not be removed.</p> <p>Findings include:</p> <p>1. Review of the facility's policy/procedure for Skin Care management, undated, revealed the Registered Nurse and/or the Licensed Practical Nurse was responsible to assess all residents upon admission and weekly. The policy/procedure stated the staff were to observe for signs and symptoms of skin breakdown and infection which was to be documented on the treatment record.</p> <p>Review of the facility chart for Resident #5 revealed no documentation of darkened areas to both middle toes of the right and left foot on the Admission Assessment or on the Weekly Skin Assessments since the resident was admitted to the facility.</p> <p>Observation, on 10/25/12 at 9:55 AM, of a</p>	F 309	<p>the DON/SDC on 11-14-12, 11-15-12, and 11-16-12 on skin assessment completion and documentation to include but not be limited to:</p> <p>Inclusion of all head to toe skin assessment findings in the weekly skin assessment documentation; determination that all identified skin issues are being treated appropriately and in accordance with MD orders.</p> <p>Criteria 4: The CQI indicator for the monitoring of skin issues will be utilized monthly X 2 months, and then quarterly thereafter in accordance with the established CQI calendar.</p>	11-21-12
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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F 309	<p>Continued From page 12</p> <p>Weekly Skin Assessment for Resident #5, performed by Licensed Practical Nurse (LPN) #2 with the Charge Nurse LPN #3 present, revealed one dark spot approximately 5 mm in circumference on the right and left middle toe of both feet.</p> <p>Interview, on 10/25/12 at 10:40 AM, with LPN #2 revealed she did not observe any skin care concerns during the Weekly Skin Assessment for Resident #5. LPN #2 stated the skin on Resident #5's feet was dry and the Advanced Practice Registered Nurse (APRN) was scheduled to make rounds on 10/26/12.</p> <p>Interview, on 10/25/12 at 1:30 PM, with LPN #2 revealed she was aware of the dark spots on Resident #5's toes, and stated the spots were present since Resident #5 was admitted to the facility. LPN #2 did not know why the spots were not documented on the Admission Assessment or the Weekly Skin Assessments since admission. LPN #2 stated the spots on Resident #5's toes represented poor circulation.</p> <p>Interview, on 10/25/12 at 1:45 PM, with the Wound Care APRN revealed the dark spots on the toes of Resident #5 were present since the resident was admitted to the facility. The APRN stated she did not know why the spots were not documented by the nursing staff, and she was not familiar with the facility's policy for documentation on the Weekly Skin Assessment. The APRN stated the dark spots represented impaired venous circulation.</p> <p>Interview, on 10/25/12 at 2:12 PM, with Charge Nurse LPN #3 revealed she was not aware</p>	F 309		
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F 309	<p>Continued From page 13</p> <p>Resident #5 had darkened spots on the toes of both feet which were not documented on the Admission Assessment or the Weekly Skin Assessment. LPN #3 stated she did not notice the darkened spots when she assisted LPN #2 to perform the Weekly Skin Assessment. LPN #3 said the dark spots should have been documented on the Weekly Skin Assessment by LPN #2.</p> <p>Interview, on 10/25/12 at 4:10 PM, with the Assistant Director of Nursing (ADON) revealed staff were trained to document all skin lesions, including pressure concerns, and areas of impaired skin integrity on the Weekly Skin Assessment. The ADON stated the dark spots on Resident #5's feet should have been documented on the Weekly Skin Assessment and on the Admission Assessment if the areas were present upon admission to the facility. The ADON stated darkened areas on the toes could represent impaired circulation and/or ischemia (cell death).</p> <p>2. Review of the facility's policy/procedure for "Pressure Ulcer Prevention and Healing," undated, revealed residents were to be assessed for pressure and skin concerns upon admission, and then weekly. The nurse was responsible to document the weekly skin assessment on the treatment record.</p> <p>Review of the physician's orders for Resident #5, revealed an order was written on 10/23/12 to wrap the right lower extremity dressing with a kerlix and to apply an ace wrap once daily. The order did not include instructions to apply compression with the ace wrap or the purpose of</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 56 EAST NORTH STREET MADISONVILLE, KY 42431
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F 309	<p>Continued From page 14 the ace wrap to the right lower extremity.</p> <p>Observation, on 10/25/12 at 9:55 AM, of wound care for Resident #5, revealed LPN #2 performed a dressing change to the right lower extremity, and wrapped the dressing with a kerlix and applied compression to the right lower extremity with the use of an ace wrap. Charge Nurse LPN #3 was present at the bedside to assist LPN #2 to lift and position Resident #5's leg for the dressing change.</p> <p>Interview, on 10/25/12 at 1:30 PM, with Resident #5 revealed the dressing applied to the right lower extremity was performed with a different procedure on 10/25/12 by LPN #2. Resident #5 stated for the last few days, the ace wrap was applied by LPN #2 without the assistance of another staff member, and stated the ace wrap was wrapped tightly. Resident #5 stated the ace wrap was applied by LPN #2 with compression so tight he/she lost sensation in the right foot. Resident #5 revealed he/she complained to multiple staff members that the ace wrap was too tight and requested the dressing be removed, but was told that the dressing could not be removed.</p> <p>Interview, on 10/25/12 at 2:12 PM, with Charge Nurse LPN #3 revealed she had no knowledge that LPN #2 performed the dressing change for Resident #5 without the assistance of another staff member. LPN #3 stated it would be difficult for LPN #2 to perform the dressing change for Resident #5 without assistance. LPN #3 was not sure if the order for the ace wrap to the wound of Resident #5, dated 10/23/12, indicated that compression should be applied with the ace wrap.</p>	F 309		
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431
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F 309	<p>Continued From page 15</p> <p>Interview, on 10/25/12 at 1:45 PM, with the Wound Care APRN revealed she intended Resident #5's ace wrap be applied to the wound with compression. The APRN stated she was aware the facility did not have the means to measure the amount of compression applied with an ace wrap, and stated she always observed the first dressing change when ordered to ensure that LPN #2 demonstrated proper procedure.</p> <p>Interview, on 10/25/12 at 2:40 PM, with Resident #5 revealed a dressing change with an ace wrap was performed by LPN #2 recently. Resident #5 stated the ace wrap was applied too tightly, and stated the resident "insisted" the staff remove the tight dressing.</p> <p>Interview, on 10/25/12 at 4:10 PM, with the Assistant Director of Nursing (ADON) revealed the order, dated 10/23/12, for application of an ace wrap to the right lower extremity of Resident #5 should have specified if compression was to be applied. The ADON stated LPN #2 should have clarified the order with the Wound Care APRN to specify the need for compression. The ADON stated after the compression was applied as ordered, the nurse was responsible to do extremity checks to ensure proper circulation, color, temperature, and movement of the extremity. The ADON stated the facility did not have any way to measure the amount of compression applied with an ace wrap.</p>	F 309		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or</p>	F 371	<p>F 371 Criteria 1: The microwave, can</p>	

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 66 EAST NORTH STREET MADISONVILLE, KY 42431	
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F 371	<p>Continued From page 16 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary condllions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy/procedure, and review of the facility's cleaning schedule, it was determined the facility failed to ensure food was prepared under sanitary conditions. The inside of the microwave, the can opener blade, and the coffee maker had a build-up of dried substances on them.</p> <p>A review of the facility's Census and Condition, dated 10/23/12, revealed 60 out of 62 residents ate food served from the kitchen.</p> <p>Findings include:</p> <p>A review of the facility's kitchen cleaning schedule, no date, revealed the dietary staff should maintain the sanitization of the Dietary Department through compliance with written, comprehensive cleaning schedules developed for the facility by the Dietary Manager. A review of the policy/procedure for the cleaning of the can opener, no date, revealed the can opener should be cleaned dally and as needed, wash in the sink with soapy water and pay special attention to the blade and moving parts. A review of the Cleaning of the Coffee Machine policy/procedure, no date, revealed staff should clean all exterior parts with</p>	F 371	<p>opener and coffee maker were sanitized.</p> <p>Criteria 2: The Dietary Supervisor inspected all other areas of the kitchen for sanitation of equipment.</p> <p>Criteria 3: The Dietary Staff were inserviced by the Dietary Supervisor on 11-14-12 and 11-15-12 detailing sanitation of equipment.</p> <p>Criteria 4: The CQI indicator for Dietary Sanitation will be utilized weekly x 4 weeks, and then monthly thereafter in accordance with the established CQI calendar under the supervision of the Administrator.</p>	11-17-12

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 65 EAST NORTH STREET MADISONVILLE, KY 42431		
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F 371	Continued From page 17 warm detergent and water dally. A review of the Cleaning of Microwave policy/procedure, not date, revealed the microwave will be kept clean, sanitized, and odor free. Wipe interior with warm soapy water and wipe exterior including door and glass. Observation during initial tour of the kitchen, on 10/23/12 at 9:30 AM, revealed: 1. There was a dry, brown and orange substance on the sides and top of the inside of the microwave. In addition, there was a dried crusted brown substance around the edges of the microwave door. 2. There was a build-up of a black sticky substance around and behind the blade of the can opener. 3. There was a build-up of a brown thick substance under the opening where the coffee comes out on the coffee maker. An interview with the Dietary Manager, on 10/23/12 at 10:00 AM, revealed the microwave, can opener, and coffee maker should be cleaned at least daily.	F 371			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F 431 Criteria 1&2: An audit was completed of all med carts and Narcotic Administration records to determine that: there are no loose pills in the med cart drawers; the med cart drawers are clean and		

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F 431	<p>Continued From page 18 reconcled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility records, and the facility policies for Medication Labels, Medication Storage, Medication Pass, and Medication Carts, it was determined the facility failed to ensure all medications were labeled in accordance with currently accepted professional principles. Three (3) medications were found loose and unlabeled in two (2) of three (3) medication carts in the</p>	F 431	<p>residue free; and all narcotic medications have been correctly signed out on the MAR and narcotic administration record, as completed by the Administrative nurses.</p> <p>Criteria 3: Inservice education was provided for the medication administrative staff by DON/SDC on 11-12-12, 11-13-12, 11-14-12, 11-15-12, and 11-16-12 on the following: monitoring of med cart drawers for loose pills and evidence of medication residue/spills and the need to immediately address these issues; and documentation of narcotic med administration on the MAR and narcotic administration record.</p> <p>Criteria 4: The CQI indicator for the monitoring of med carts and narcotic record documentation will be utilized monthly X 2 months and then quarterly thereafter as per the established CQI calendar, under the supervision of the DON.</p>	11-17-12
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F 431	<p>Continued From page 19</p> <p>facility; three (3) narcotic medications on one (1) of three (3) medication carts in the facility were not documented as given on the narcotic record on 10/24/12 at 7:00 AM; and three (3) of three (3) medication carts in the facility had a powder or sticky residue in the bottom of drawers where bottled medications were stored.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy for Medication Labels, dated 10/15/12, revealed all medications were to be labeled in accordance with Federal and State laws and standards of pharmacy practice. Review of the facility's policy for Medication Storage, dated 10/15/05, revealed medications were to be stored in a secure manner and in the container in which they were received from the pharmacy. <p>Observation, on 10/24/12 at 10:05 AM, of the 500-600 medication cart with Licensed Practical Nurse (LPN) #1, revealed one (1) red capsule and one (1) white tablet were found loose and unlabeled in the bottom of the medication cart drawers. Further observation, on 10/24/12 at 10:40 AM, of the 400 medication cart with LPN #1, revealed one (1) half of a white tablet was found loose and unlabeled in the bottom of the medication cart drawer.</p> <p>Interview, on 10/24/12 at 10:05 AM, with LPN #1 revealed third shift was responsible to audit and inventory the medication carts monthly, but was not aware of a log maintained by the facility to document the audits. LPN #1 said the loose medications could have fallen into the drawer when the medication pass was done and could</p>	F 431		
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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 431	<p>Continued From page 20</p> <p>indicate a resident did not receive all of the medications as ordered by the physician.</p> <p>Interview, on 10/25/12 at 5:00 PM, with the Staff Development Coordinator (SDC) revealed she did not believe the medications found loose and unlabeled in the bottom of the drawers on the medication carts resulted in medications not provided for residents as ordered by the physician. The SDC said if a medication was dropped into the medication cart drawer rather than the medication cup during the medication pass, the nurse would see the medication fall into the drawer and replace it with another medication.</p> <p>Interview, on 10/25/12 at 4:10 PM, with the Assistant Director of Nursing (ADON) revealed she thought the loose and unlabeled medications found in the drawers of the medication carts were a result of the medication dropped by the nurse, who did not seek to find the medication after it was dropped. The ADON stated the nurse would have obtained another capsule or tablet to provide for the resident, and did not think the loose and unlabeled medications indicated some residents did not receive all of the medications prescribed by the physician.</p> <p>2. Review of the facility's policy for Medication Pass, undated, revealed that PRN (as requested) narcotic medications must be signed out on the narcotic count sheet and the medication administration record at the time the narcotic was administered.</p> <p>Record review and observation, on 10/24/12 at 10:30 AM, with LPN #1 revealed the narcotic</p>	F 431			

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F 431	<p>Continued From page 21</p> <p>count was not accurate. The narcotic count resulted in identification of three (3) missing doses of narcotic medication which included two (2) doses of Lortab 7.5 mg and one (1) dose of Lyrica 25 mg.</p> <p>Interview, on 10/24/12 at 10:30 AM, with LPN #1 revealed she signed out two (2) doses of Lortab 7.5 mg and one (1) dose of Lyrica 25 mg on the Medication Administration Record on 10/24/12 at 7:00 AM for three unsampled residents, but neglected to document administration of each narcotic medication on the narcotic count sheet.</p> <p>Interview, on 10/25/12 at 4:10 PM, with the ADON revealed staff were trained to document narcotic medications on the narcotic count sheet when the medication was removed from the locked box on the medication cart and to document administration of the narcotic medication on the medication administration record after the medication was administered to the resident. The ADON stated that staff were trained to the facility policy to maintain count and control of scheduled narcotics.</p> <p>3. Review of the facility's policy for Medication Carts, dated 10/16/05, revealed nursing staff were responsible for keeping the carts clean. The facility detailed that contaminated or soiled medications should be withdrawn from stock, but the policy did not state how often the medication carts should be cleaned.</p> <p>Review of the North and South Cleaning schedules revealed the medication carts were cleaned by the Nurse on Wednesdays, and the Charge Nurse initialed the form and forwarded to</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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F 431	<p>Continued From page 22 the Director of Nursing at the end of each week.</p> <p>Observation, on 10/24/12 at 10:05 AM, of the 500-600 medication cart with LPN #1 revealed the bottom of the drawers where elixir and bottled medications were stored was sticky. Further observation of the 400 medication cart with LPN #1 revealed the bottom of the drawer where bottled medications were stored was covered with a white powder. Further observation, on 10/24/12 at 10:40 AM, of the South Medication Cart with CMT #1 revealed the bottom of the drawer where bottled medications were stored was covered with a white powder.</p> <p>Interview, on 10/24/12 at 10:30 AM, with LPN #1 revealed she thought the carts should be cleaned of the white powder which she thought was Miralax. LPN #1 did was not sure of the origin of the sticky substance. LPN #1 was not sure when the medication carts were cleaned last or of the frequency of the cart cleanings. Further interview, on 10/24/12 at 10:40 AM, with CMT #1 revealed she identified the white powder in the bottom of the bottled medication drawer to be Miralax, and stated the cart needed to be cleaned.</p> <p>Interview, on 10/25/12 at 4:10 PM with the ADON, revealed staff were trained to clean and inventory the medication carts to ensure the carts were kept clean and in good order, but did not know how often the medication carts were cleaned or when the carts were last cleaned.</p>	F 431		
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 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 conducted on 10/23/12. Brighton Cornerstone Health Care 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 sixty-two (62) 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lita Stornova* TITLE: *Administrator* (X6) DATE: *12-5-12*

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

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K 000	Continued From page 1	K 000		
K 029 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure nine (9) rooms with hazardous storage had the proper door closer for separation.</p> <p>The findings include: Observation, on 10/23/12 between 11:05 AM and</p>	K 029	<p>K 029</p> <p>Criteria 1&2: Door closers have been installed on the following doors: MDS Office, Director of Nursing Office, Front Office, Billing Office, Administrator's Office, Social Services Office, South Nurses Station, Medication Room South, and Activities Office.</p> <p>Criteria 3: Facility maintenance staff have received inservice on 11-19-12 education on importance of door closures for a room larger than 50 square feet with substantial combustible material.</p> <p>Criteria 4: The CQI indicator for the monitoring of facility door closures will be utilized monthly X2 months and then quarterly thereafter, under the supervision of the Administrator.</p>	11-27-12

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K 029	<p>Continued From page 2</p> <p>2:30 PM with the Maintenance Supervisor and Administrator in Training, revealed:</p> <ol style="list-style-type: none"> 1) The MDS office had substantial combustible material and did not have a door closer installed. 2) The Director of Nursing office had substantial combustible material and did not have a door closer installed. 3) The Front office had substantial combustible material and did not have a door closer installed. 4) The Billing office had substantial combustible material and did not have a door closer installed. 5) The Administrators' office had substantial combustible material and did not have a door closer installed. 6) The Social Services office had substantial combustible material and did not have a door closer installed. 7) The South Nurses' Station had substantial combustible material and did not have a door closer installed. 8) The Medication room south had substantial combustible material and did not have a door closer installed. 9) The Activities office MDS office had substantial combustible material and did not have a door closer installed. <p>Any room larger than 50 square feet with substantial combustible material must have a door that resists the passage of smoke and a closing device.</p> <p>Interview, on 10/23/12 between 11:05 AM and 2:30 PM with the Maintenance Supervisor and Administrator in Training, revealed they were not aware the areas listed above were considered hazardous storage due to storage in the area</p>	K 029			

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K 029	<p>Continued From page 3 thus requiring a door, a self-closer, and separation.</p> <p>Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the top fifteen citations of the state to conduct training on life safety code. The Administrator revealed there just is not enough training for life safety code available in the area. At the upcoming conference there is one hour committed for life safety code. She was unaware of the rooms being considered hazardous due to the large amounts of combustible storage in the areas.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 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 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.6.4. 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</p>	K 029		

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K 029	Continued From page 4 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit doors were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure exit doors were locked down with the proper method.	K 038	K 038 Criteria 1&2: All facility exit doors now have the emergency exit release code placed on the code panel. Criteria 3: All current employees that were directed by the surveyor to remove the door codes have been re-inserviced on 11-19-12 on the necessity to post the release codes. Criteria 4: The CQI indicator for the monitoring the posting of the facility emergency exit release codes on each exit door will be utilized monthly X2 months and then quarterly thereafter, under the supervision of the Administrator.	11-20-12

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K 038	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation, on 10/23/12 at 11:10 AM with the Maintenance Supervisor and Administrator In Training, revealed the egress doors throughout the facility were locked and had no code posted at the door.</p> <p>Interview, on 10/23/12 at 11:10 AM with the Maintenance Supervisor and Administrator In Training, revealed they were unaware the doors were required to have delay release or the door code posted. Further interview revealed a health surveyor from another survey had informed the facility to remove the codes from the doors to prevent an elopement from occurring.</p> <p>Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the top fifteen citations of the state to conduct training on life safety code. The Administrator revealed there just is not enough training for life safety code available in the area. At the upcoming conference there is one hour committed for life safety code. She was unaware all exits routes were not clearly marked in the facility. She also revealed the surveyor had advised the facility to remove the doors from the exits of the facility.</p> <p>Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving</p>	K 038		

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K 038	Continued From page 6 low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the	K 038		

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K 038	Continued From page 7 door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 039 SS=E	Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 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 NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure the exit corridors in the old part of the facility were four (4) feet in width. The findings include:	K 039	K 039 A FSES Form has been completed on 11-15-12. The cost to correct this deficiency would be in excess of \$600,000 which would cause great hardship to the facility.	11-16-12

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K 039	Continued From page 8 Observation, on 10/23/12 at 11:00 AM with the Maintenance Supervisor and Administrator in Training, revealed the corridors in two (2) smoke compartments to be less than four (4) feet in width. Interview, on 10/23/12 at 11:00 AM with the Maintenance Supervisor and Administrator in Training, revealed the facility uses a FSES survey to offset this requirement. Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the FSES survey to offset this deficient practice. 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. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 039			
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	K 045 Criteria 1&2: Emergency lights with 2 bulbs have been installed at the exterior exit doors numbered 8 and 10 to provide outside illumination.		

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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
K 045	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, thirty (30) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at two (2) exits. The findings include: Observation, on 10/23/12 at 2:20 PM with the Maintenance Supervisor and Administrator in Training, revealed the exterior exits at doors numbered 8 and 10 only had a single light for illumination of the outside of the exit. Interview, on 10/23/12 at 2:20 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the top fifteen citations of the state to conduct training on life safety code. The Administrator revealed there just is not enough training for life safety code available in the area. At the upcoming conference there is one hour committed for life	K 045	Criteria 3: The facility maintenance staff have received inservice education on 11-19-12 the requirement for emergency lights to have two bulbs at all exits. Criteria 4: The CQI indicator for the monitoring of emergency lights having 2 bulbs will be utilized monthly X2 months and then quarterly thereafter under the supervision of the Administrator.	1-20-12

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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 045	Continued From page 10 safety code. She believed the facility had a waiver for exterior lighting but was unable to produce a copy of the waiver letter. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure the exit paths in the old part of the facility were readily visible. The findings include: Observation, on 10/23/12 at 11:05 AM with the Maintenance Supervisor and Administrator in	K 047	K 047 Criteria 1&2: Exit and directional emergency signs will be installed in the three areas of the corridors identified. Criteria 3: The facility maintenance staff have received inservice education on the necessity of having exit and directional emergency signs on 11-19-12 by the Administrator. Criteria 4: The CQI indicator for the monitoring of exit and directional emergency signs will be utilized monthly X2 months and then quarterly thereafter under the supervision of the Administrator.	11-27-12

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K 047	Continued From page 11 Training, revealed egress paths to the exits were not clearly marked in the old part of the facility. Three areas of the corridors were identified as needing exit signs added to the facility. Interview, on 10/23/12 at 11:05 AM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware the signage was missing for the exit corridors. Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the top fifteen citations of the state to conduct training on life safety code. The Administrator revealed there just is not enough training for life safety code available in the area. At the upcoming conference there is one hour committed for life safety code. She was unaware all exits routes were not clearly marked in the facility. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are	K 050	K 050 Criteria 1&2: Fire drills are conducted quarterly at unexpected times under varied conditions. Criteria 3: Facility maintenance staff have received inservice education on the need to conduct		

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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 050	<p>Continued From page 12</p> <p>qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times. This deficiency was cited on the survey last year on 07/14/11.</p> <p>The findings include:</p> <p>Fire Drill review, on 10/23/12 at 10:45 AM with the Maintenance Supervisor and Administrator in Training, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on first shift were conducted routinely between 9:30 AM and 10:38 AM, second shift routinely around between 2:00 PM and 3:16 PM, and third shift routinely between 4:15 AM and 4:35 AM.</p> <p>Interview, on 10/23/12 at 10:45 AM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted</p>	K 050	<p>fire drills quarterly at unexpected times under varied conditions, as provided by the Administrator on 11-19-12.</p> <p>Criteria 4: The CQI indicator for the monitoring of fire drills will be utilized monthly X 3 months and then quarterly thereafter under the supervision of the Administrator.</p>	11-20-12	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 13 as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected. Further interview revealed he is in charge of conducting fire drills and has had no training on fire drills since the last survey. Interview, on 10/23/12 at 10:45 AM with the Administrator in Training, revealed he was unaware the fire drills were not being conducted as required. The Administrator in Training was unaware of the time separation on each shift to consider the times unexpected. Further interview revealed there was an in-service after last survey which covered the fact that fire drills should not be conducted on the same day of the month but time separation was not covered in the in-service. Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility held an in-service after the last survey which did cover varying the times of the fire drills but the facility was focused on not conducting drills on the same day of the month. The facility conducted meetings to ensure the fire drills were not conducted on the same day of the month each time. This is a repeat deficiency. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	K 062 Repeated Tag	

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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 062 SS=F	Continued From page 14 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 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times. This deficiency was cited on the survey last year on 07/14/11. The findings include: Fire Drill review, on 10/23/12 at 10:45 AM with the Maintenance Supervisor and Administrator in Training, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on first shift were conducted routinely between 9:30 AM and 10:38 AM, second shift routinely around between 2:00 PM and 3:16 PM, and third shift routinely between 4:15 AM and 4:35 AM. Interview, on 10/23/12 at 10:45 AM with the Maintenance Supervisor, revealed he was	K 062		

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K 062	<p>Continued From page 15</p> <p>unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected. Further interview revealed he is in charge of conducting fire drills and has had no training on fire drills since the last survey.</p> <p>Interview, on 10/23/12 at 10:45 AM with the Administrator in Training, revealed he was unaware the fire drills were not being conducted as required. The Administrator in Training was unaware of the time separation on each shift to consider the times unexpected. Further interview revealed there was an in-service after last survey which covered the fact that fire drills should not be conducted on the same day of the month but time separation was not covered in the in-service.</p> <p>Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility held an in-service after the last survey which did cover varying the times of the fire drills but the facility was focused on not conducting drills on the same day of the month. The facility conducted meetings to ensure the fire drills were not conducted on the same day of the month each time.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 062		

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K 089 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, ten (10) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure the proper signage was placed above the fire extinguisher in the kitchen area.</p> <p>The findings include:</p> <p>Observation, on 10/23/12 at 2:15 PM with the Maintenance Supervisor and Administrator in Training, revealed there was no signage stating that the hood suppression system must be used before the class K fire extinguisher in the kitchen. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>Interview, on 10/23/12 at 2:15 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware of the signage requirement.</p> <p>Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the top fifteen citations of the state to conduct training on life safety code. The Administrator revealed there</p>	K 069	<p>K 069</p> <p>Criteria 1&2: The sign has been placed above the kitchen fire extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher on 11-7-11.</p> <p>Criteria 3: Facility maintenance staff have received inservice education on the need to assure proper signage on the kitchen fire extinguisher as provided by the Administrator on 11-19-12.</p> <p>Criteria 4: The CQI indicator for the monitoring of proper signage above the kitchen fire extinguisher will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Administrator.</p>	11-20-12

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K 069	Continued From page 17 just is not enough training for life safety code available in the area. At the upcoming conference there is one hour committed for life safety code. She was unaware a sign was required over the class k extinguisher in the kitchen. Reference: NFPA 10 (1998 Edition).	K 069			
K 144 SS=F	2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure the lamps on the generator annunciator were functioning	K 144	K 144 Criteria 1&2: The annunciator panel was replaced on 10-27-12. Criteria 3: Facility maintenance staff have received inservice education on the need to perform a lamp test on the annunciator to ensure the annunciator is working properly as provided by the Administrator on 11-19-12. Criteria 4: The CQI indicator for the testing of annunciator lamp to ensure the annunciator is properly working will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Administrator.	11-20-12	

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K 144	<p>Continued From page 18 properly.</p> <p>The findings include:</p> <p>Observation, on 10/23/12 at 2:03 PM with the Maintenance Supervisor and Administrator in Training, revealed the generator annunciator was unable to perform a lamp test to ensure the annunciator was working properly.</p> <p>Interview, on 10/23/12 at 2:03 PM with the Maintenance Supervisor and Administrator in Training, revealed they were not aware the generator annunciator was not functioning properly.</p> <p>Interview, on 10/23/12 at 2:34 PM with the Administrator, revealed the facility utilizes the top fifteen citations of the state to conduct training on life safety code. The Administrator revealed there just is not enough training for life safety code available in the area. At the upcoming conference there is one hour committed for life safety code. She was unaware the generator annunciator was not functioning properly.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as</p>	K 144			

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K 144	Continued From page 19 follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144			