

RECEIVED

APR 14 2010

PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

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

OFFICE OF INSPECTOR GENERAL  
(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/25/2010
--	--	------------------------------------	--

NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF SOUTH LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS  A standard health survey was conducted 03/23/10 through 03/25/10 and a Life Safety Code survey was 03/24/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	Britthaven of South Louisville acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provision of quality care of the residents. The plan of correction is submitted as a written allegation of compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to distribute and serve food under sanitary conditions. A dietary food server failed to change gloves or sanitize her hands during tray line service after the server handled and touched contaminated items then served eleven (11) hot dog buns to residents.  The findings include:  Observation of the noon meal on 03/23/10 at 11:45am in the dining room revealed Dietary Worker #1 placed a total of eleven (11) hot dog buns on eleven (11) different resident plates	F 371	Britthaven's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through formal appeal procedures and/or any other administrative or legal proceeding.  F-371 <u>483.35(i) Food Procure, Store/Prepare/ Serve - Sanitary</u>  The facility will ensure that food is stored, prepared, distributed, and served under sanitary conditions.	3/26/10

RECEIVED  
APR 21 2010  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K Robert [Signature]</i>	TITLE <i>K Administrator</i>	(X6) DATE <i>K 4/13/10</i>
--	---------------------------------	-------------------------------

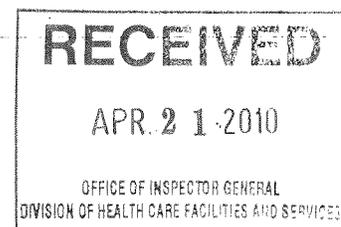
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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.

PB

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

PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

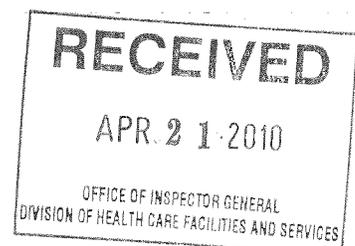
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/25/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272	
(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 371	<p>Continued From page 1</p> <p>without properly changing her gloves when moving from clean to dirty items and handling food. The worker touched and laid her gloved hands on the tray line counter, wiped her face, pushed up her glasses, then handled/served hot dog buns to residents without changing gloves, or sanitizing her hands. At 11:50am, Dietary Worker #2 instructed Dietary Worker #1 to change her gloves. After Dietary Worker #1 changed gloves, she was again observed to touch her nose with her gloved hands, place her gloved hands on the counter, and then served individual pouches of cookies to various residents, opened a bag of hot dog buns and served resident's hot dog buns without changing gloves or sanitizing her hands.</p> <p>Interview with the Dietary Manager on 03/25/10 at 1:30pm revealed Dietary Worker #1 should have served the hot dog buns on the residents' plates with a tong in order to prevent the transmission of germs. The Manager further stated that the Dietary Staff were in-serviced periodically throughout the year on Infection Control, and that the facility expectation is that the employees would not touch or handle the residents' food with dirty gloves.</p> <p>Interview with Dietary Worker #2 on 03/25/10 at 1:30pm revealed she instructed Dietary Worker #1 to change her contaminated gloves on 03/23/10 at 11:50am because she had observed Dietary Worker #1 touch the counter with her gloved hands while she served the hot dogs buns to the residents. Dietary Worker #2 stated that the dietary staff had been trained to change gloves, wash hands, and put on new gloves once contamination had occurred. She also stated the hot dog buns should have been served using a tong.</p>	F-371	<p>Dietary worker #1 has received additional education regarding the proper methods to serve food under sanitary conditions. In addition, all dietary staff workers have received additional education regarding the proper methods of serve food under sanitary conditions. This educartional training was completed on 3/26/10. All new employees hired for the dietary department will receive educational training on sanitation and demonstrate competency prior to handling any food items. The Dietary Manager, or designee, will perform random monthly QA audits of dietary workers to ensure that food is stored, prepared, distributed, and served under sanitary conditions. All QA audits will be reviewed by the Administrator and any identified concerns will be addressed by the appropriate QA committee. Ongoing education of dietary staff will occur through formal inservice training sessions with a focus on sanitation. All dietary staff will demonstrate knowledge of proper sanitation practices during the facility's annual skills day event.</p>	



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

PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/25/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF SOUTH LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272</b>	
(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 371	Continued From page 2	F 371		
F 463 SS=D	<p>Telephone interview with Dietary Worker #1 on 03/25/10 at 3:00pm revealed tongs should have been used to serve the hot dog buns. The dietary staff had been trained on infection control in the past and that gloves should have been changed when moving from dirty to clean items to prevent the possible transmission of infection to the residents.</p> <p>Record Review on 03/25/10 at 3:30pm of the facility's Hand Washing Policy and Procedure revealed an employee should wash their hands after handling contaminated items.</p> <p><b>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</b></p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure four (4) unlocked public restrooms, accessible to residents, were equipped with a call system to alert staff of emergency needs.</p> <p>The findings include: Observations on 03/23/10 at 9:29am and 03/24/10 at 8:49am revealed the restroom located next door to the beauty shop was unlocked, and even though it was accessible to the residents it did not have an emergency call system in place for residents to use.</p>	F 463	<p>F-463</p> <p><u>483.70(f) Resident Call System - Rooms/Toilet/Bath</u></p> <p>The facility will ensure that the nurse's station is equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>All identified restrooms, formerly designated as visitor restrooms, were immediately equipped with audible alarms on 3/24/10. Permanent emergency pull station alarms will be installed in all identified restrooms by 4/23/10. The call light system will be checked and maintained on a routine basis by the Maintenance department to ensure proper functional order. Resident safety will continue to be monitored through the facility's QA program to identify and correct any identified safety concerns.</p>	4/23/10





Apr. 21. 2010 2:17PM

No. 8065 P. 2

PRINTED: 04/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/24/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 8800 LAMBORNE BOULEVARD LOUISVILLE, KY 40272	
(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  A Life Safety Code survey was initiated and concluded on 03/24/10 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at a Scope/Severity of "F". <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.	K 000	Britthaven of South Louisville acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provision of quality care of the residents. The plan of correction is submitted as a written allegation of compliance.	
K 144 58#E	* This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to comply with <u>NFPA 110 6-1.2</u> . A portable or alternate source of power shall be provided when the emergency generator is out of service on a temporary basis. (short period of time)  The findings include:  Observation on 03/24/10 at 1:00pm revealed a portable generator was connected to the facility. A review of records revealed the portable generator was installed on 09/14/08 and the facility had been using the portable generator for 18 months. However, the intent of the regulation	K 144	Britthaven's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through formal appeal procedures and/or any other administrative or legal proceeding.  K-144 <u>NFPA 101 Life Safety Code Standard</u>  The statement of deficiencies stated that "generators are to be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1...it was determined that the facility failed to comply with NFPA 110 6-1.2. A portable or alternate source of power shall be provided when the emergency generator is out of service on a temporary basis."	4/26/10 mzy see attached  6/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Deach TITLE: Administrator DATE: 04/26/10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the facility 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.

Apr. 21. 2010 2:17PM

No. 0065 P. 3

PRINTED: 04/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  03/24/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAMBORNE BOULEVARD LOUISVILLE, KY 40272		
(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 144	Continued From page 1 was to allow the use of a portable generator temporarily (short period of time) when the main generator was out of service, as required by NFPA 110 6-1.2.  An interview conducted with the Maintenance Director on 03/24/10 at 1:00pm revealed the main generator had been out of service for at least a year and the facility had been using the portable generator for at least a year.	K 144	Our facility has been working with our corporate office since the loss of our primary generator and we have received quotes from vendors, the electric company, and have also discussed plans with the state Fire Marshal's office. The replacement of such equipment is very costly and we have to ensure that we utilize our facility resources in a responsible manner. Our latest quote is for \$141,340.71 and this has been forwarded to our corporate office for approval.  All facility nurses have been trained on procedures for a power outage as it relates to the temporary generator. All residents utilizing medical equipment that cannot be interrupted have the equipment plugged into the red emergency outlets in case of a power loss. The facility respectfully requests a time allotment to allow for ordering, shipping and installation services of the new generator.  May need an extension granted depending on the vendor's time needs to obtain and install the ordered equipment.		

