

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

PRINTED: 11/16/2015
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 10/30/2015
NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE GROUP, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification Survey was conducted on 10/28/15 through 10/30/15 with no deficiencies cited.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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

PRINTED: 11/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 11/23/2015
NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE GROUP, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 11/05/15, as alleged.	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185013	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 11/23/2015
Name of Facility BRIGHTON CORNERSTONE GROUP, LLC		Street Address, City, State, Zip Code 55 EAST NORTH STREET MADISONVILLE, KY 42431

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0039</u>	Correction Completed 11/05/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>LOH</u>	Date: <u>11/25/15</u>	Signature of Surveyor: <u>Deborah A. Henderson, PE</u>	Date: <u>11/25/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/28/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE GROUP, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST NORTH STREET MADISONVILLE, KY 42431	
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1957.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2005, with 28 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was initiated and concluded on 10/28/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-six (66) beds with a census of fifty-eight (58) 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>		<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Janice Brunkley* TITLE *Administrator* (X6) DATE *11-23-15*

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

PRINTED: 11/16/2015
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186013	(K2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(K3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE GROUP, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST NORTH STREET MADISONVILLE, KY 42431	
(K4) 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)	(K5) COMPLETION DATE
K 000 K 039 8S=F	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level. NFFA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, per National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, thirty-six (36) residents, staff and visitors. The findings include: Observation, on 10/28/15 at 10:30 AM with the Director of Housekeeping, revealed the corridors in two (2) smoke compartments to be less than four (4) feet in width. The corridors affected were located in the 100 Hall, 200 Hall, 300 Hall, and 400 Hall. Interview (Post Survey) with the Administrator, on 11/02/15 at 3:57 PM, revealed the facility used a Fire Safety Evaluation System (FSES) Survey to offset this requirement. NFFA 101 (2000 edition) 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving	K 039 K 039	K 039 A FSES Form has been completed on 11-4-15. The cost to correct this deficiency would be in excess of \$600,000 which would cause great hardship to the facility.	11-05-15

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE GROUP, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST NORTH STREET MADISONVILLE, KY 42431	
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K 039	Continued From page 2 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		



FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

ZONE NG 2015 OF 3 ZONES
INSPECTOR GENERAL
2000 LIFE SAFETY CODE

FACILITY Brighton Cornerstone BUILDING All
 ZONE(S) EVALUATED North
 PROVIDER/VENDOR NO. 18-5013 DATE OF SURVEY 10-28-15

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

- Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.**
 A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Risk Parameters	Risk Factors Values					
	1. Patient Mobility (M)	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	1.6	<u>3.2</u>	4.5	
2. Patient Density (D)	No. of Patients	1-5	6-10	11-30	>30	
	Risk Factor	1.0	1.2	<u>1.5</u>	2.0	
3. Zone Location (L)	Floor	1 st	2 nd or 3 rd	4 th to 6 th	7 th and Above	Basements
	Risk Factor	<u>1.1</u>	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants (T)	Patients Attendant	<u>1-2</u> 1	<u>3-5</u> 1	<u>6-10</u> 1	<u>>10</u> 1	<u>One or More</u> None
	Risk Factor	1.0	1.1	1.2	<u>1.5</u>	4.0
5. Patient Average Age (A)	Age	Under 65 Years and Over 1 year			65 Years and Over 1 Year and Younger	
	Risk Factor	1.0			<u>1.2</u>	

- Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.**
 A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
 B. Compute F by multiplying the risk factor values as indicated in Table 2.

OCCUPANCY RISK $\boxed{3.2} \times \boxed{1.5} \times \boxed{1.1} \times \boxed{1.5} \times \boxed{1.2} = \boxed{9.5}$
--

- Step 3: Compute Adjusted Building Status (R) - Use Table 2.**
 A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
 B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
 C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

$1.0 \times \boxed{F} = \boxed{R}$

$0.6 \times \boxed{9.5} = \boxed{5.7}$
--

* FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.

SURVEYOR SIGNATURE _____ TITLE _____ DATE _____
 FIRE AUTHORITY SIGNATURE Michael Allen TITLE LSCI (18939) DATE 11-4-15

Step 4: Determine Safety Parameter Values - Use Table 4.

- A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
	000	111	200	211 + 2HH	000	111	222, 332, 433
	First	-2	0	-2	0	2	2
	Second	-7	-2	-4	-2	-2	4
	Third	-8	-7	-9	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B 0(3) ^f	Class A 3				
3. Interior Finish (Rooms)	Class C -3(1) ^f	Class B 1(3) ^f	Class A 3				
4. Corridor Partitions/Walls	None or Incomplete -10(0) ^g	<1/2 hour 0	>1/2 to <1 hour 1(0) ^g	≥1 hour 2(0) ^g			
5. Doors to Corridor	No Door -10	<20 min FPR 0	≥20 min FPR 1(0) ^d	≥20 min FPR and Auto Clos. 2(0) ^d			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-8(0) ^b	-4(0) ^b	-2(0) ^b	-2(0) ^e	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	0	2(0) ^e	3(0) ^e		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0) ^g	0	3				
10. Emergency Movement Routes	<2 Routes		Multiple Routes				
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	2			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces		Total Spaces In Zone	
	0(3) ^g	2(3) ^g	3(3) ^g	4		5	
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	10				

- NOTE:**
- ^a Use (0) where parameter 5 is -10.
 - ^b Use (0) where parameter 10 is -8.
 - ^c Use (0) on floor with fewer than 31 patients (existing buildings only)
 - ^d Use (0) where parameter 4 is -10.

- ^e Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")
- ^f Use () if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.
- ^g Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

- A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as $\frac{1}{2}$ the corresponding value circled in Table 4.
- B. Add the four columns, keeping in mind that any negative numbers deduct.
- C. Transfer the resulting total values for S_1 , S_2 , S_3 , S_4 to blocks labeled S_1 , S_2 , S_3 , S_4 in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS				
Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	2		2	2
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	$10 \div 2 = 5$	10
Total Value	$S_1 = 17$	$S_2 = 15$	$S_3 = 13$	$S_4 = 22$

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)						
Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1 st story	11	5	15(12) ^a	4	8(5) ^a	1
2 nd or 3 rd story ^b	15	9	17(14) ^a	6	10(7) ^a	3
4 th story or higher	18	9	19(16) ^a	6	11(8) ^a	3

- a. Use () in zones that do not contain patient sleeping rooms.
- b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: $S_a=7$, $S_b=10$, and $S_c=7$

Step 8: Determine Mandatory Safety Requirement Values - Use Table 6.

- A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.
- B. Transfer the three circled values from Table 6 to the blocks marked S_a , S_b , and S_c in Table 7.
- C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION				Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	$S_1 - S_a = C$ 17 - 5 = 12	✓
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	$S_2 - S_b = E$ 15 - 4 = 11	✓
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	$S_3 - S_c = P$ 13 - 1 = 12	✓
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	$S_4 - R = G$ 22 - 95 = 12.5	✓

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET					
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.			Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.		✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.				✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.		✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.		✓		
E.	There are no flue-fed incinerators.		✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.		✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.		✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.		✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.		✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.		✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.				✓

CONCLUSIONS	
1.	<input type="checkbox"/> All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the <i>Life Safety Code</i> .*
2.	<input type="checkbox"/> One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the <i>Life Safety Code</i> .*
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 18-5013	FACILITY NAME Brighton Cornerstone	SURVEY DATE *K4 10-28-15
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K6 DATE OF PLAN APPROVAL 1961	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING _____	A BUILDING B WING C FLOOR D APARTMENT UNIT <input checked="" type="checkbox"/> A
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LSC FORM INDICATOR	COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21																											
<table border="1"> <tr><th colspan="3">Health Care Form</th></tr> <tr><td><input checked="" type="checkbox"/> 12</td><td>2786R</td><td>2000 EXISTING</td></tr> <tr><td><input type="checkbox"/> 13</td><td>2786R</td><td>2000 NEW</td></tr> </table> <table border="1"> <tr><th colspan="3">ASC Form</th></tr> <tr><td><input type="checkbox"/> 14</td><td>2786U</td><td>2000 EXISTING</td></tr> <tr><td><input type="checkbox"/> 15</td><td>2786U</td><td>2000 NEW</td></tr> </table> <table border="1"> <tr><th colspan="3">ICF/MR Form</th></tr> <tr><td><input type="checkbox"/> 16</td><td>2786V, W, X</td><td>2000 EXISTING</td></tr> <tr><td><input type="checkbox"/> 17</td><td>2786V, W, X</td><td>2000 NEW</td></tr> </table>	Health Care Form			<input checked="" type="checkbox"/> 12	2786R	2000 EXISTING	<input type="checkbox"/> 13	2786R	2000 NEW	ASC Form			<input type="checkbox"/> 14	2786U	2000 EXISTING	<input type="checkbox"/> 15	2786U	2000 NEW	ICF/MR Form			<input type="checkbox"/> 16	2786V, W, X	2000 EXISTING	<input type="checkbox"/> 17	2786V, W, X	2000 NEW	<p>SMALL (16 BEDS OR LESS)</p> <p>K8: <input type="checkbox"/> 1 PROMPT <input type="checkbox"/> 2 SLOW <input type="checkbox"/> 3 IMPRACTICAL</p> <hr/> <p>LARGE</p> <p>K8: <input type="checkbox"/> 4 PROMPT <input type="checkbox"/> 5 SLOW <input type="checkbox"/> 6 IMPRACTICAL</p> <hr/> <p>APARTMENT HOUSE</p> <p>K8: <input type="checkbox"/> 7 PROMPT <input type="checkbox"/> 8 SLOW <input type="checkbox"/> 9 IMPRACTICAL</p>
Health Care Form																												
<input checked="" type="checkbox"/> 12	2786R	2000 EXISTING																										
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ASC Form																												
<input type="checkbox"/> 14	2786U	2000 EXISTING																										
<input type="checkbox"/> 15	2786U	2000 NEW																										
ICF/MR Form																												
<input type="checkbox"/> 16	2786V, W, X	2000 EXISTING																										
<input type="checkbox"/> 17	2786V, W, X	2000 NEW																										
* K7 <input type="checkbox"/> SELECT NUMBER OF FORM USED FROM ABOVE																												

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)	ENTER E - SCORE HERE
K29: <input type="checkbox"/> K56: <input type="checkbox"/>	K5: <input type="checkbox"/> e.g. 2.5 F = 9.5 R = 5.7

*K9: FACILITY MEETS LSC BASED ON (Check all that apply)

A1. <input type="checkbox"/> (COMP. WITH ALL PROVISIONS)	A2. <input checked="" type="checkbox"/> (ACCEPTABLE POC)	A3. <input type="checkbox"/> (WAIVERS)	A4. <input checked="" type="checkbox"/> (FSES)	A5. <input type="checkbox"/> (PERFORMANCE BASED DESIGN)
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FACILITY DOES NOT MEET LSC	K0180	B. <input type="checkbox"/>	C. <input type="checkbox"/>
B. <input type="checkbox"/>	A. <input checked="" type="checkbox"/> FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

* MANDATORY

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY <u>Brighton Cornerstone</u>	BUILDING <u>All</u>
ZONE(S) EVALUATED <u>Middle</u>	
PROVIDER/VENDOR NO.	DATE OF SURVEY <u>10-28-15</u>

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.

- A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS						
Risk Parameters	Risk Factors Values					
	1. Patient Mobility (M)	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
Risk Factor		1.0	1.6	<u>3.2</u>	4.5	
2. Patient Density (D)	No. of Patients	1-5	6-10	11-30	>30	
	Risk Factor	1.0	1.2	<u>1.5</u>	2.0	
3. Zone Location (L)	Floor	1 st	2 nd or 3 rd	4 th to 6 th	7 th and Above	Basements
	Risk Factor	<u>1.1</u>	1.2	1.4	1.8	1.8
4. Ratio of Patients to Attendants (T)	Patients Attendant	1-2 1	3-5 1	6-10 1	≥10 1	One or More None
	Risk Factor	1.0	1.1	1.2	<u>1.5</u>	4.0
5. Patient Average Age (A)	Age	Under 65 Years and Over 1 year			65 Years and Over 1 Year and Younger	
	Risk Factor	1.0			<u>1.2</u>	

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.

- A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION						
OCCUPANCY RISK	<u>M</u>	<u>D</u>	<u>L</u>	<u>T</u>	<u>A</u>	<u>F</u>
	<u>3.2</u>	<u>1.5</u>	<u>1.1</u>	<u>1.5</u>	<u>1.2</u>	<u>9.5</u>

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

- A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)
$1.0 \times \boxed{F} = \boxed{R}$

TABLE 3B. (EXISTING BUILDINGS)
$0.6 \times \boxed{F} = \boxed{R}$

* FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.

SURVEYOR SIGNATURE	TITLE	DATE
FIRE AUTHORITY SIGNATURE <u>Michael Burn</u>	TITLE <u>LSC 1 (18939)</u>	DATE <u>11-4-15</u>

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			
	Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
	First	-2	0	(-2)	0	0	2	2
	Second	-7	-2	-4	-2	-2	2	4
	Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4	
2. Interior Finish (Corridors and Exits)	Class C	Class B		Class A				
	-5(0) ^f	(0)(3)		3				
3. Interior Finish (Rooms)	Class C	Class B		Class A				
	-3(1) ^f	(1)(3)		3				
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour		≥1/2 to <1 hour		≥1 hour		
	-10(0) ^g	0		(1)(0)		2(0) ^g		
5. Doors to Corridor	No Door	<20 min FPR		≥20 min FPR		≥20 min FPR and Auto Clos.		
	-10	0		1(0) ^d		(2)(0) ^d		
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-8(0) ^b	-4(0) ^b	-2(0) ^b	-2(0) ^g	0	1		
7. Vertical Openings	Open 4 or More Floors		Open 2 or 3 Floors		Enclosed with Indicated Fire Resist.			
	-14		-10		<1 hr	≥1 hr to <2 hr	≥2 hr	
	(0)		(0)		2(0) ^g	3(0) ^g		
8. Hazardous Areas	Double Deficiency			Single Deficiency		No Deficiencies		
	In Zone		Outside Zone	In Zone	in Adjacent Zone	(0)		
	-11		-5	-6	-2	(0)		
9. Smoke Control	No Control		Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0) ^g		(0)	3				
10. Emergency Movement Routes	<2 Routes		Multiple Routes					
	-8		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(0)		(-2)	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm			Manual Fire Alarm				
	-4			W/O F.D. Conn.	W/F.D. Conn			
	(0)			1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only		Rooms Only		Corridor and Habl. Spaces	Total Spaces In Zone	
	0(3) ^g	2(3) ^g		3(3) ^g		4	(5)	
13. Automatic Sprinklers	None	Corridor and Habl. Space		Entire Building				
	0	8		(10)				

NOTE: ^a Use (0) where parameter 5 is -10.
^b Use (0) where parameter 10 is -8.
^c Use (0) on floor with fewer than 31 patients (existing buildings only)
^d Use (0) where parameter 4 is -10.

^e Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")
^f Use () if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.
^g Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

- A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as $\frac{1}{2}$ the corresponding value circled in Table 4.
- B. Add the four columns, keeping in mind that any negative numbers deduct.
- C. Transfer the resulting total values for S₁, S₂, S₃, S₄ to blocks labeled S₁, S₂, S₃, S₄ in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS				
Safety Parameters	Containment Safety (S ₁)	Extinguishment Safety (S ₂)	People Movement Safety (S ₃)	General Safety (S ₄)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	2		2	2
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	$\div 2 =$	10
Total Value	S₁ = 17	S₂ =	S₃ =	S₄ = 22

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)						
Zone Location	Containment (S _a)		Extinguishment (S _b)		People Movement (S _c)	
	New	Exist.	New	Exist.	New	Exist.
1 st story	11	5	15(12) ^a	4	8(5) ^a	1
2 nd or 3 rd story ^b	15	9	17(14) ^a	6	10(7) ^a	3
4 th story or higher	18	9	19(16) ^a	6	11(8) ^a	3

- a. Use () in zones that do not contain patient sleeping rooms.
- b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

- A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.
- B. Transfer the three circled values from Table 6 to the blocks marked S_a , S_b , and S_c in Table 7.
- C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION				Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	$S_1 - S_a = C$ 17 - 5 = 12	✓
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	$S_2 - S_b = E$ 15 - 4 = 11	✓
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	$S_3 - S_c = P$ 13 - 1 = 12	✓
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	$S_4 - R = G$ 22 - 9.5 = 12.5	✓

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET					
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.			Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.		✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.				✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.		✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.		✓		
E.	There are no flue-fed incinerators.		✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.		✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.		✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.		✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.		✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.		✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.				✓

CONCLUSIONS	
1.	<input type="checkbox"/> All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the <i>Life Safety Code</i> .*
2.	<input type="checkbox"/> One or more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the <i>Life Safety Code</i> .*
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1	FACILITY NAME <i>Brighton Cornerstone</i>	SURVEY DATE *K4 10-28-15
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K6 DATE OF PLAN APPROVAL <i>1961</i>	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> <input checked="" type="checkbox"/> A NUMBER OF THIS BUILDING _____	A BUILDING B WING C FLOOR D APARTMENT UNIT
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LSC FORM INDICATOR

Health Care Form		
<input checked="" type="checkbox"/> 12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: 1 PROMPT
 2 SLOW
 3 IMPRACTICAL

LARGE

K8: 4 PROMPT
 5 SLOW
 6 IMPRACTICAL

APARTMENT HOUSE

K8: 7 PROMPT
 8 SLOW
 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: K56:

ENTER E - SCORE HERE

K5: e.g. 2.5
F = 9.5 R = 5.7

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. <input type="checkbox"/> (COMP. WITH ALL PROVISIONS)	A2. <input checked="" type="checkbox"/> (ACCEPTABLE POC)	A3. <input type="checkbox"/> (WAIVERS)	A4. <input checked="" type="checkbox"/> (FSSES)	A5. <input type="checkbox"/> (PERFORMANCE BASED DESIGN)
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FACILITY DOES NOT MEET LSC

B.

K0180

A. <input checked="" type="checkbox"/> FULLY SPRINKLERED <small>(All required areas are sprinklered)</small>	B. <input type="checkbox"/> PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small>	C. <input type="checkbox"/> NONE <small>(No sprinkler system)</small>
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* MANDATORY

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY <u>Brighton Cornerstone</u>	BUILDING <u>All</u>
ZONE(S) EVALUATED <u>South</u>	
PROVIDER/VENDOR NO. <u>18-5013</u>	DATE OF SURVEY <u>10-28-15</u>

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

- Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.**
 A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS						
Risk Parameters	Risk Factors Values					
	1. Patient Mobility (M)	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
Risk Factor		1.0	1.6	<u>3.2</u>	4.5	
2. Patient Density (D)	No. of Patients	1-5	6-10	11-30	>30	
	Risk Factor	1.0	1.2	<u>1.5</u>	2.0	
3. Zone Location (L)	Floor	1 st	2 nd or 3 rd	4 th to 6 th	7 th and Above	Basements
	Risk Factor	<u>1.1</u>	1.2	1.4	1.6	1.8
4. Ratio of Patients to Attendants (T)	Patients Attendant	<u>1-2</u> 1	<u>3-5</u> 1	<u>8-10</u> 1	<u>>10</u> 1	One or More None
	Risk Factor	1.0	1.1	1.2	<u>1.5</u>	4.0
5. Patient Average Age (A)	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		<u>1.2</u>		

- Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.**
 A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
 B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION						
OCCUPANCY RISK $\frac{M}{3.2} \times \frac{D}{1.5} \times \frac{L}{1.1} \times \frac{T}{1.5} \times \frac{A}{1.2} = \frac{F}{9.5}$						

- Step 3: Compute Adjusted Building Status (R) - Use Table 2.**
 A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
 B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
 C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)
$1.0 \times \frac{F}{\square} = \frac{R}{\square}$

TABLE 3B. (EXISTING BUILDINGS)
$0.6 \times \frac{F}{9.5} = \frac{R}{5.7}$

* FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.

SURVEYOR SIGNATURE	TITLE	DATE
<u>Michael [Signature]</u>	<u>LSC1 C18939</u>	<u>11-4-15</u>

Step 4: Determine Safety Parameter Values - Use Table 4.

- A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.								
Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			
	Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
	First	-2	0	-2	0	0	2	2
	Second	-7	-2	-4	-2	-2	2	4
	Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4	
2. Interior Finish (Corridors and Exits)	Class C	Class B		Class A				
	-5(0) ^a	0(3)		3				
3. Interior Finish (Rooms)	Class C	Class B		Class A				
	-3(1) ^c	1(3)		3				
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour		≥1/2 to <1 hour		≥1 hour		
	-10(0) ^a	0		1(0) ^a		2(0) ^a		
5. Doors to Corridor	No Door	<20 min FPR		≥20 min FPR		≥20 min FPR and Auto Clos.		
	-10	0		1(0) ^d		2(0) ^d		
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-8(0) ^b	-4(0) ^b	-2(0) ^b	-2(0) ^a	0	1		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14	-10	0	2(0) ^a	3(0) ^a			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11	-5	-8	-2	0			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					
	-5(0) ^a		3					
10. Emergency Movement Routes	<2 Routes		Multiple Routes					
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)			
		-2	0	1	5			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					
	-4		W/O F.D. Conn.	W/F.D. Conn				
			1	2				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			
	0(3) ^a	2(3) ^a	3(3) ^a	4	5			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					
	0	8	10					

- NOTE:**
- ^a Use (0) where parameter 5 is -10.
 - ^b Use (0) where parameter 10 is -8.
 - ^c Use (0) on floor with fewer than 31 patients (existing buildings only)
 - ^d Use (0) where parameter 4 is -10.

^a Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

¹ Use () if the area of Class B or C Interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

⁹ Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

- A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.
- B. Add the four columns, keeping in mind that any negative numbers deduct.
- C. Transfer the resulting total values for S₁, S₂, S₃, S₄ to blocks labeled S₁, S₂, S₃, S₄ in Table 7 on page 4 of this sheet.

Safety Parameters	Containment Safety (S ₁)	Extinguishment Safety (S ₂)	People Movement Safety (S ₃)	General Safety (S ₄)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	2		2	2
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S₁=	S₂=	S₃=	S₄= 22

Zone Location	Containment (S ₁)		Extinguishment (S ₂)		People Movement (S ₃)	
	New	Exist.	New	Exist.	New	Exist.
1 st story	11	5	15(12) ^a	4	8(5) ^a	1
2 nd or 3 rd story ^b	15	9	17(14) ^a	6	10(7) ^a	3
4 th story or higher	18	9	19(16) ^a	6	11(8) ^a	3

- a. Use () in zones that do not contain patient sleeping rooms.
- b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: S₁=7, S₂=10, and S₃=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

- Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.
- Transfer the three circled values from Table 6 to the blocks marked S_a , S_b , and S_c in Table 7.
- For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION				Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_c)	≥ 0	$S_1 - S_a = C$ 17 - 5 = 12	✓
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	$S_2 - S_b = E$ 15 - 4 = 11	✓
People Movement Safety (S_3)	minus	Mandatory People Movement (S_e)	≥ 0	$S_3 - S_e = P$ 13 - 1 = 12	✓
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	$S_4 - R = G$ 2.2 - 9.5 = 12.5	✓

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET					
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.			Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.		✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.				✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.				
D.	Fuel-burning space heaters and portable electrical space heaters are not used.		✓		
E.	There are no flue-fed incinerators.		✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.		✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.		✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.		✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.		✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.		✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.				✓

CONCLUSIONS	
<input checked="" type="checkbox"/>	All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the <i>Life Safety Code</i> .*
<input type="checkbox"/>	One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the <i>Life Safety Code</i> .*
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1860.

**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 18-5013	FACILITY NAME Brighton Cornerstone	SURVEY DATE K4 10-28-15
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K8 DATE OF PLAN APPROVAL 1961	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u>	<input checked="" type="checkbox"/> A BUILDING <input type="checkbox"/> B WING <input type="checkbox"/> C FLOOR <input type="checkbox"/> D APARTMENT UNIT
	NUMBER OF THIS BUILDING _____	

LSC FORM INDICATOR <table border="1"> <tr><th colspan="3">Health Care Form</th></tr> <tr><td><input checked="" type="checkbox"/> 12</td><td>2786R</td><td>2000 EXISTING</td></tr> <tr><td>13</td><td>2786R</td><td>2000 NEW</td></tr> </table> <table border="1"> <tr><th colspan="3">ASC Form</th></tr> <tr><td>14</td><td>2786U</td><td>2000 EXISTING</td></tr> <tr><td>15</td><td>2786U</td><td>2000 NEW</td></tr> </table> <table border="1"> <tr><th colspan="3">ICF/MR Form</th></tr> <tr><td>16</td><td>2786V, W, X</td><td>2000 EXISTING</td></tr> <tr><td>17</td><td>2786V, W, X</td><td>2000 NEW</td></tr> </table>	Health Care Form			<input checked="" type="checkbox"/> 12	2786R	2000 EXISTING	13	2786R	2000 NEW	ASC Form			14	2786U	2000 EXISTING	15	2786U	2000 NEW	ICF/MR Form			16	2786V, W, X	2000 EXISTING	17	2786V, W, X	2000 NEW	COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21 SMALL (16 BEDS OR LESS) K8: <input type="checkbox"/> 1 PROMPT <input type="checkbox"/> 2 SLOW <input type="checkbox"/> 3 IMPRACTICAL
	Health Care Form																											
	<input checked="" type="checkbox"/> 12	2786R	2000 EXISTING																									
	13	2786R	2000 NEW																									
ASC Form																												
14	2786U	2000 EXISTING																										
15	2786U	2000 NEW																										
ICF/MR Form																												
16	2786V, W, X	2000 EXISTING																										
17	2786V, W, X	2000 NEW																										
	LARGE K8: <input type="checkbox"/> 4 PROMPT <input type="checkbox"/> 5 SLOW <input type="checkbox"/> 6 IMPRACTICAL																											
	APARTMENT HOUSE K8: <input type="checkbox"/> 7 PROMPT <input type="checkbox"/> 8 SLOW <input type="checkbox"/> 9 IMPRACTICAL																											
*K7 <input type="checkbox"/> SELECT NUMBER OF FORM USED FROM ABOVE																												

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.) K29: <input type="checkbox"/> K56: <input type="checkbox"/>	ENTER E - SCORE HERE K5: <input type="checkbox"/> e.g. 2.5 F = 9.5 R = 5.7
--	---

*K9: FACILITY MEETS LSC BASED ON (Check all that apply)

A1. <input type="checkbox"/> (COMP. WITH ALL PROVISIONS)	A2. <input checked="" type="checkbox"/> (ACCEPTABLE POC)	A3. <input type="checkbox"/> (WAIVERS)	A4. <input checked="" type="checkbox"/> (FSSES)	A5. <input type="checkbox"/> (PERFORMANCE BASED DESIGN)
--	--	--	---	---

FACILITY DOES NOT MEET LSC B. <input type="checkbox"/>	K0180 <input checked="" type="checkbox"/> A FULLY SPRINKLERED (All required areas are sprinklered) <input type="checkbox"/> B PARTIALLY SPRINKLERED (Not all required areas are sprinklered) <input type="checkbox"/> C NONE (No sprinkler system)
---	---

* MANDATORY



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Division of Health Care
P.O. Box 2200 / 2400 Russellville Road
Hopkinsville, Kentucky 42240
Phone: (270) 889-6052
Fax: (270) 889-6089
<http://chfs.ky.ov/os/oig>

Audrey Tayse Haynes
Secretary

Maryellen B. Mynear
Inspector General

December 2, 2015

via EMAIL: Laney Brinkley (Lbrinkley@BrightonCornerstone.com)

Ms. Lainie Brinkley, Administrator
Brighton Cornerstone Health Care
55 East North Street
Madisonville, KY 42431

Dear Ms. Brinkley:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the survey completed on October 30, 2015.

We are accepting your allegation of compliance and presume that substantial compliance was achieved by November 5, 2015, as alleged in your plan of correction. Therefore, we are not recommending the remedies referred to in the initial notice dated November 16, 2015, to the Centers for Medicare and Medicaid Services Regional Office at this time. Based on implementation of your plan of correction, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX programs contingent upon approval from the appropriate agencies.

Your cooperation is appreciated. If you should have questions regarding this information, please contact our office.

Sincerely,

A handwritten signature in blue ink that reads "Kathy Perry".

Kathy Perry, RN, BSN, MA
Regional Program Manager

KDP/SWF:lef



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
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Audrey Tayse Haynes
Secretary

Maryellen B. Mynear
Inspector General

November 16, 2015

via EMAIL: Laney Brinkley (Lbrinkley@BrightonCornerstone.com)

Ms. Lainie Brinkley, Administrator
Brighton Cornerstone Health Care
55 East North Street
Madisonville, KY 42431

Dear Ms. Brinkley:

On October 30, 2015, a standard Health and Life Safety Code recertification survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567, whereby corrections are required (F).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies must be submitted **no later than ten (10) days from receipt of this letter**. Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met. Your POC, as fully implemented, will serve as your allegation of compliance.

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date,' include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed Forms CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Recommended Remedies

As a result of our finding that your facility was not in compliance with participation requirements, the State Agency reserves the right to recommend discretionary remedies to the Centers for Medicare and Medicaid Services (CMS) Regional Office if substantial compliance has not been achieved by **December 14, 2015**.

If you do not achieve substantial compliance within three (3) months from the last day of the survey identifying noncompliance, the CMS Regional Office must deny payments for new admissions.

Your provider agreement must be terminated if substantial compliance is not achieved within six (6) months from the last day of the survey identifying noncompliance.

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to **IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621**. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,



Kathy Perry, RN, BSN, MA
Regional Program Manager

KDP/SWF:lef

Enclosure

DEPARTMENT FOR MEDICAID SERVICES
PROGRAM VISIT REPORT
NURSING FACILITY

SURVEY DATE:

10/29/15

Facility Name: Brighton Cornerstone 100183

Facility Address: 55 East North St Madisonville

Nurse Aide Training Provider Number: _____

Program Coordinator: _____
(Can be Director of Nurses)

Program Instructor: _____
(Cannot be Director of Nurses)

NO Program

MOI: Yes () No () 2 years as R.N.: Yes () No () *1 year LTC experience: Yes () No ()

Yes No

- _____ Yes _____ No Course Curriculum (Adopted Mosby's Textbook for LTC Assistants July 1, 1997).
- _____ Yes _____ No Observed Classroom (i.e. necessary equipment and supplies available). ***7th Edition Book**
- _____ Yes _____ No Observed class in session. **Effective Date: 7/1/15**
- _____ Yes _____ No Observed clinicals performed.

1. Is the learning environment conducive for adult students: (i.e. well-lighted, well-ventilated, quiet)?

2. What evidence exists that the class is being conducted within submitted plan?

3. Is there sufficient number of faculty to meet ratios for classroom and clinical (maximum is 1:15)?

4. Is there documentation of staff development offered to nurse aides (12 hours/year): Yes () No ()

Yes No

- _____ Yes _____ No 5. Are performance records available to nurse aide and employer?
- _____ Yes _____ No 6. Are performance records maintained for a minimum of five (5) years?
- _____ Yes _____ No 7. Pass/Fail for last two (2) classes: Date: _____ # Pass: _____ # Fail: _____
Date: _____ # Pass: _____ # Fail: _____
- _____ Yes _____ No 8. Does facility notify Medicaid of **all** program changes within thirty (30) days?
(i.e. new administrator, classroom, coordinator, instructor)

Signature of Reviewer: *Stephen D. Ryan*

Date: 10/29/15