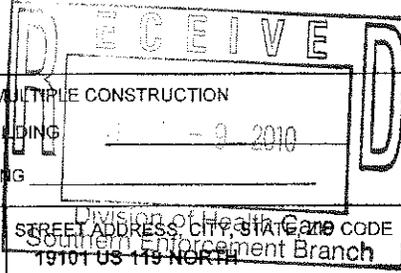


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF TRI-CITIES</b>	STREET ADDRESS, CITY, STATE AND ZIP CODE <b>19101 US-119 NORTH CUMBERLAND, KY 40823</b>
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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
F 000	INITIAL COMMENTS	F 000	<b>Britthaven 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 applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.</b>	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced	F 164	<b>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 informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</b>  <b><u>ID Prefix Tag F 164</u></b>  <b>The facility will continue to provide personal privacy and confidentiality of his or her personal and clinical records. The care guides/care plans for resident #7 were reviewed and documentation added to the resident's care plan/care</b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/CLIA REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <b>Administrator</b>	(X6) DATE <b>11/5/10</b>
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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 164	<p>Continued From page 1</p> <p>by: Based on observation and interview, it was determined the facility failed to provide personal privacy for one (1) of seventeen (17) sampled residents. Full visual privacy was not afforded for resident #7 who was unnecessarily exposed after the provision of care.</p> <p>The findings include:</p> <p>Record review revealed resident #7 was admitted to the facility on September 9, 2004, with medical diagnoses to include Alzheimer's, Brain Syndrome, Hypertension, Dementia, Hypothyroidism, and Parkinson's Disease.</p> <p>An observation conducted on October 12, 2010, at 2:20 p.m., revealed resident #7 resting in bed with the lower body undraped. The resident was observed wearing an attends and socks. Additional observation conducted on October 12, 2010, at 4:30 p.m., revealed the resident's lower body was undraped, clothed in socks and attends. During both the observations, the resident's room door was open and the resident could be viewed from the hallway through the open door.</p> <p>An interview conducted on October 12, 2010, at 4:40 p.m., with the Certified Nurse Assistant (CNA) on the South Wing revealed incontinence care was provided for resident #7 earlier that day. The CNA revealed she/he failed to redress the resident after the incontinence care was provided. The CNA stated the resident should have been dressed and draped, and leaving the resident exposed was a failure to provide the resident the right of privacy.</p>	F 164	<p>guide that resident is to always have proper clothing put on each day and after peri care. The resident will have her door closed and drapes drawn to provide privacy during changing at all times.</p> <p>The Administrative Nurses did 100% audit on residents care plans/care guides and identified residents who were at high risk for exposure. The residents care plans/care guides were revised to provide privacy during changing and to have proper attire on at all times.</p> <p>The Licensed staff/SRNA's will be In-serviced by DON, on 11-1-10, regarding resident privacy rights, preventing exposure and providing proper clothing at all times, to prevent exposure. Staff will be instructed to close all residents' doors during care and to provide proper draping at all times. Any staff not in attendance will be in-serviced by SDC on first day of return to work.</p> <p>Residents will be randomly audited by the QI nurse or SDC to identify residents who are not being provided privacy during care.</p> <p>The QI nurse or SDC will complete random audits on six residents per week x one month then three residents per</p>		

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F 164	Continued From page 2	F 164	<b>week x one month then one resident weekly x one month. Any concerns identified will be corrected immediately and findings reported to the DON.</b>	
F 221 SS=D	<p>Review of the facility's policy on resident rights (dated February 1998) revealed all residents have the right to privacy with personal care, the right to live with dignity and to be treated with respect.</p> <p><b>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</b></p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that residents remained free of physical restraints for one (1) of seventeen (17) sampled residents (resident #1). Resident #1 was observed wearing Posey mitt restraints on October 12, 2010; however, there was no documented evidence that the facility evaluated the use of the restraint to determine the medical justification for the use of the Posey mitts or assessed risk factors/benefits of the Posey mitts for the resident.</p> <p>The findings include:</p> <p>Observations of resident #1 on October 12, 2010, at 10:20 a.m., revealed resident #1 to be wearing Posey mitt restraints to both hands, and at 12:30 p.m., to be wearing a Posey mitt restraint to the right hand. Observations of resident #1 on October 12, 2010, at 2:15 p.m., 3:30 p.m., and 5:45 p.m., and on October 13, 2010, at 8:30 a.m., 10:30 a.m., 12:30 p.m., and 2:30 p.m., revealed no Posey mitts to be in place for resident #1.</p>	F 221	<p><b>The DON and Administrator will review the QI studies to ensure residents are being provided privacy during care and clothed appropriately to prevent exposure.</b></p> <p><b><u>ID Prefix Tag F 221</u></b></p> <p><b>The facility will continue to ensure that the resident has the right to be free from any physical restraints imposed for purpose of discipline or convenience and not required to treat the resident's medical symptoms.</b></p> <p><b>Resident #1 was re-evaluated on October 12, 2010 and found that the resident did not have an MD order/consent for use of mitts. The resident would continually remove mitts and display behaviors of digging in her wound. The mitts were removed and resident #1 was provided with pajama pants and the treatment nurse will cover resident #1's abdomen and back with burn meshing to protect dressing over wound area.</b></p>	<i>11/5/10</i>

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F 221	Continued From page 3  An interview with the Director of Nursing (DON) on October 12, 2010, at 10:20 a.m., revealed resident #1 was wearing Posey mitts to prevent the resident from scratching at decubitus wounds on the left hip and coccyx area.  An interview with the wound nurse on October 12, 2010, at 3:30 p.m., revealed resident #1 would pick and scratch at bandages over the left hip and coccyx areas, and the Posey mitts assisted resident #1 to not pick and scratch.  A review of the medical record for resident #1 revealed diagnoses that included Diabetes, Dysphagia, Hypertension, Advanced Dementia, Osteoporosis, Peripheral Vascular Disease, and a history of a Fractured Humerus (February 2010). Further review of resident #1's medical record revealed no documented evidence the facility assessed the resident for the use of Posey mitts including the medical justification for the use of the restraint and risks/benefits of the restraint use. In addition, there was no physician's order for the Posey mitt restraints, and no evidence the resident's responsible party was contacted related to the restraint use.  An interview with the Quality Assurance (QA) Coordinator on October 13, 2010, at 2:00 p.m., revealed the treatment nurse had tried Posey hand mitts on resident #1 on the afternoon of October 10, 2010, and resident #1 would not leave the Posey mitts on. According to the QA Coordinator, no physician's order was obtained for the Posey mitts. The QA Coordinator stated that prior to utilizing a restraint for a resident an evaluation for restraints was completed, which included medical diagnosis, informed consents,	F 221	<b>The Administrative Nurses did 100% audit in facility and made sure no other resident had on restraints without an order/consent.</b>  <b>In-services were provided by DON to Licensed staff/SRNA on Restraint use and the need for MD orders/ RP consent and removing restraints from room if not needed on 10-13-2010. Any staff that was not in attendance will be in-serviced on their first day of return to work by SDC.</b>  <b>Residents will be randomly audited by the QI nurse to identify residents at risk for improper restraint use.</b>  <b>The QI nurse will complete random audits weekly x one month then every other week x one month then monthly x three months. Any concerns identified will be corrected immediately and findings reported to the DON.</b>  <b>The DON and Administrator will review the audits results to ensure that no resident is being restrained without an MD order/RP consent, and completed Restraint Evaluation for need.</b>	11/5/10

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F 221	Continued From page 4 previous interventions tried, and risks/benefits of the restraint. The QA Coordinator stated since the Posey mitts were tried on resident #1 on a Sunday and not on Monday an evaluation was not completed for resident #1. The QA Coordinator stated the Posey mitts must have remained in resident #1's room on October 12, 2010, and the CNAs caring for resident #1 just put them on the resident. The QA Coordinator was not sure why the Posey mitts were on resident #1 on October 12, 2010.	F 221	<b><u>ID Prefix Tag F280</u></b>  The resident has the right unless judged incompetent or otherwise to be incapacitated in planning care and treatment or changes in care and treatment.  Resident #3 chart/care plan was reviewed October 13, 2010 and the residents care plan was revised to include interventions regarding significant weight gain. Further review of chart revealed MD/RP notified of significant weight gain 9-13-10, RD reviewed resident on 8-30-10. On October 4, 2010 dietary manager had documented note. The resident was discharged home on October 25, 2010.  The Administrative Nurses completed 100% audit on all residents to assure all other significant weight changes had interventions made to care plan.  In-services provided by DON to MDS staff, ADON, Dietary regarding the need to revise care plan with interventions when this occurs. The ADON will send a report when a resident triggers a significant weight change and will then make sure the care plan has been revised.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 280			

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F 280	<p>Continued From page 5</p> <p>review, it was determined that the facility failed to review/revise the comprehensive care plan for one (1) of seventeen (17) sampled residents. Resident #3 had a twenty-four pound weight gain within twenty-one days, from the time of admission on August 27, 2010, until September 17, 2010. However, there was no evidence that the facility reviewed/revise the care plan interventions to address the significant weight gain and edema for resident #3.</p> <p>The findings include:</p> <p>A review of the medical record revealed that resident #3 was admitted to the facility on August 27, 2010, with diagnoses of Hypertension, Compression Fracture of the Right Lateral Tibia, Chronic Obstructive Pulmonary Disease, Venous Insufficiency, Uterine Prolapse, Muscle Weakness, and Chronic Ulcers to both lower extremities.</p> <p>A review of the weight records for resident #3 revealed the resident weighed 176 pounds on August 27, 2010. The record further revealed the weight for resident #3 to be 200 pounds on September 17, 2010.</p> <p>A review of the admission comprehensive assessment for resident #3 dated September 7, 2010, revealed edema was present during the assessment period.</p> <p>A review of the Dietary Progress note for resident #3 dated October 4, 2010, revealed the resident had sustained a significant weight gain since admission of 13.6 percent within 30 days due to edema.</p>	F 280	<p>The QI nurse or ADON will complete random audits to identify residents who have triggered a significant weight change.</p> <p>The QI nurse or ADON will complete random audits weekly x eight weeks them every other week x one month then monthly x one month. Any concerns identified will be corrected immediately and findings reported to the DON.</p> <p>The DON/Administrator and Weight Committee will review the audits to ensure care plans are being current and reflecting resident weight changes.</p> <p><b><u>ID Prefix Tag F281</u></b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Resident #3 chart/care plan was reviewed on October 13, 2010 and revealed that the resident did not have an order for TED stockings. The resident insisted on wearing one stocking on her left leg. The MD was notified and an order was obtained for the stocking on 10-13-10.</p> <p>100% audit on all residents was completed by Administrative nurses to</p>	11/5/10

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F 280	Continued From page 6 A review of the care plan for resident #3 dated September 9, 2010, revealed no interventions were in place to address the weight gain and edema for resident #3.  A review of the facility's policy for Comprehensive Care Plans revealed the facility had adopted CMS's RAI Version 3.0 Manual dated June 2010. Pages 4-8 revealed the care plan must be reviewed and revised periodically and the services must be consistent with each resident's written plan of care. The manual further revealed on pages 4-10 the care plan should be based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up, and should be reviewed and revised as needed by key staff or by the interdisciplinary Team (IDT).  An interview with the MDS Coordinator for the facility revealed he/she was aware of the significant weight change for resident #3 and was responsible for initiating the care plan for resident #3. The MDS Coordinator further revealed he/she would expect to see interventions for a resident with a significant weight gain and with edema. The MDS Coordinator stated he/she was unsure why he/she had not put interventions in place to address the weight gain and edema for resident #3.	F 280	<b>assure no other residents had TED stockings on without an order.</b>  An in-service was conducted by DON, for nursing staff, on 10-13-2010, regarding the need for an MD order before applying any type of stocking to residents. Staff is to check chart for an order before applying the stockings.  The QI nurse or Treatment Nurse will do random audits to assure no other residents have TED stockings applied without an order.  The QI nurse or Treatment Nurse will do weekly audits x one month, then every other week x one month, then monthly for three months. Any concerns identified will be corrected immediately and findings reported to the DON.  The DON/Administrator will review the QI study results to assure professional standards of care are being delivered.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:	F 281	<b><u>ID Prefix Tag F309</u></b>  The facility will continue to ensure that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and	11/5/10	

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F 281	<p>Continued From page 7</p> <p>Based on observation, interview, and record review, it was determined the facility failed to provide services to meet professional standards of quality for one (1) of seventeen (17) sampled residents. Resident #3 was observed on October 13, 2010, to be wearing anti-embolism knee-high stockings. However, there was no evidence the resident had a physician's order for the stockings. The facility applied anti-embolism knee-high stockings on resident #3 without a physician's order to do so.</p> <p>The findings include:</p> <p>An observation of resident #3 on October 13, 2010, at 2:10 p.m., revealed the resident to have an anti-embolism stocking on the left leg. The resident stated the wound care nurse had applied the stocking that morning. The resident further revealed another wound care nurse had told the resident he/she needed to be using the anti-embolism stockings. The resident stated his/her family had purchased the stockings, and brought them to the facility, and the wound care nurse had applied them for the first time approximately two weeks ago.</p> <p>A review of the medical record for resident #3 revealed the resident did not have a physician's order for anti-embolism stockings to be applied.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) for the facility on October 13, 2010, at 2:25 p.m. The ADON revealed he/she was unaware resident #3 had an anti-embolism stocking on the left leg. The ADON further stated the stocking had not been measured to assure the right fit for the resident, and the facility would prefer the resident use an</p>	F 281	<p><b>psychosocial well being, in accordance with the comprehensive assessment and plan of care.</b></p> <p>Review of resident #1 chart revealed that the resident had Darvocet N 100 one po q4hrs prn for pain. The resident had not had any pain medication since October 3, 2010. The resident was re-evaluated for pain, the MD notified and a new order for Lortab 7.5/500mg one po q6hrs. prn for pain was obtained. The medication is being given 30 minutes prior to wound care as alerted by treatment nurse.</p> <p>100% audited was completed by Administrative Staff on residents with wounds, and pain assessments were redone. All residents who experienced pain had their medications reviewed and changed as needed per MD orders.</p> <p>The treatment nurses and licensed staff were in serviced by DON on 10-13-10 regarding the need to medicate any resident with medication prior to treatments as indicated.</p> <p>The QI nurse or ADON will do random audits on residents receiving treatments.</p> <p>The QI nurse or ADON will complete random audits on residents during</p>	

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F 281	Continued From page 8 anti-embolism stocking obtained by the facility. The ADON further stated the resident needed a physician's order prior to applying the stocking and was unsure why the wound care nurse had applied the stocking. According to the ADON, the wound care nurse that applied the stocking on October 13, 2010, had only been employed by the facility for two weeks. The ADON went on to say the treatment nurse should not have applied the anti-embolism stocking before obtaining a physician's order to do so. The ADON further stated after obtaining a physician's order the nurse would be expected to place the order on the treatment sheets. The wound care nurse who had told the resident he/she needed to wear the anti-embolism stocking, and had applied the stocking initially, was not available for interview due to being off with a family illness.	F 281	<b>treatments to ensure pain medication is effective on three residents a week x one month then two residents a week every other week, then one resident monthly x three months. Any concerns identified will be addressed immediately and findings reported to the DON.</b>  <b>The DON/Administrator and Wound Care Committee will review QI study results to ensure continued management of pain during wound care.</b>		
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, and record review, it was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well being for one (1) of seventeen (17) sampled residents (resident #1). Observation and interviews revealed resident #1	F 309	<b>ID Prefix Tag F371</b>  <b>The facility will continue to store and serve food under sanitary conditions.</b>  <b>The employee replaced the hair net on 10-12-10.</b>  <b>The employee working the tray line washed and regloved when the difficient practice was brought to her attention on 10-12-10</b>  <b>The food items in question were immediately destroyed on 10-14-10.</b>  <b>After being informed by the surveyor, the kitchen manager immediately inserviced the employees in regards to proper hand washing methods, use of</b>	<b>11/5/10</b>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF TRI-CITIES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US 119 NORTH CUMBERLAND, KY 40823</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 309	<p>Continued From page 9</p> <p>experienced pain during dressing changes to pressure areas. Resident #1 was prescribed pain medication as needed, however, was not given pain medication prior to the wound dressing change.</p> <p>The findings include:</p> <p>Observations of resident #1 on October 12, 2010, at 3:30 p.m., during a wound dressing change revealed three pressure ulcers-a Stage III area to the left heel, a Stage IV area to the coccyx, and a Stage III area to the left hip. Observation revealed the resident complained of pain when the left hip dressing was cleaned with normal saline. The resident grimaced and complained to the wound nurse of pain.</p> <p>An interview with the wound nurse on October 12, 2010, at 3:00 p.m., during the dressing change, revealed the wound nurse stated resident #1 had routine pain medication ordered for 2:00 p.m. every day. The wound nurse stated the resident frequently complained when the dressing was changed and the wound cleaned to the left hip. The wound nurse stated she did not give any pain medication to resident #1.</p> <p>An interview with the charge nurse for the North Hall on October 13, 2010, at 2:45 p.m., revealed resident #1 rarely received pain medication. The resident did not ask for pain medications when the medication nurse passed medications.</p> <p>A review of the medication record for resident #1 revealed diagnoses that included Decubitus to left heel, left hip, and coccyx areas. The physician's orders revealed an order for Darvocet N-100 pain medication as needed. A review of the</p>	F 309	<p><b>hair nets, and observing for ice build-up on stock in the freezer.</b></p> <p>An inservice was held on 10-20-10 with all dietary employees regarding proper hand sanitization requirements, hair net use and ice build-up in freezer.</p> <p>On 10-28-10, the refrigeration repair company completed repairs to the freezer including resetting the "four" automated defrost cycles.</p> <p>The kitchen manager will make random weekly audits for one month and monthly audits x2 to ensure proper hand sanitization, hair net use and to observe for any ice build-up in the freezer.</p> <p>The Administrator will review the audits results to ensure continued correctness. 10/28/10</p> <p><b>ID Prefix Tag F372</b></p> <p>The facility will continue to dispose of garbage and refuse properly.</p> <p>The maintenance supervisor contacted the waste company on 10-15-10 to get the broken lid replaced.</p>

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NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF TRI-CITIES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US 119 NORTH CUMBERLAND, KY 40823</b>	
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F 309	Continued From page 10 medication administration record for October 2010 revealed October 3, 2010, at 5:00 p.m., to be the last recorded pain medication administration for resident #1. Further review of the physician's orders revealed the dressings for the three pressure areas required daily cleaning and dressing changes and as needed.  An interview with the Assistant Director of Nursing (ADON) on October 13, 2010, at 3:45 p.m., revealed the wound nurse should notify the medication nurse when any resident requires pain medication before a treatment is performed.	F 309	<b>On 10-15-10 the maintenance supervisor assessed all other dumpster lids to be working properly.</b>  <b>The waste company notified the maintenance supervisor on 11-1-10 that a new lid had been ordered and should arrive in the next few days.</b>  <b>An inservice was held on 10-20-10 with all dietary employees and on 10-18, 10-22 and 11-4-10 with all housekeeping employees regarding proper dumpster use.</b>  <b>The maintenance supervisor will make random weekly audits for one month monthly audits x2 to ensure proper dumpster use.</b>  <b>The Administrator will review the audits results to ensure continued correctness.</b>	
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 and interview, it was determined the facility failed to store and serve food under sanitary conditions. Observations during the kitchen tour revealed a dietary staff member without a hair net, improper handwashing was observed during the tray line service, and a buildup of ice was observed in the walk-in freezer.  The findings include:	F 371	<b><u>ID Prefix Tag F425</u></b>  <b>The facility will continue to provide routine and emergency drugs and biologicals to its residents and provide pharmaceutical services (including procedures that assure the accurate</b>	<b>11/12/10</b>

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NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF TRI-CITIES		STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US 119 NORTH CUMBERLAND, KY 40823		
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F 371	<p>Continued From page 11</p> <p>1. Observations on October 12, 2010, revealed a kitchen staff member putting food supplies away in the walk-in cooler without a hair restraint in place. Further observation of the tray line service at 11:30 a.m., revealed a kitchen employee dipping food from the steam table, then raising the garbage can lid and throwing away trash, and then returning to the steam table to dip food without changing gloves and washing his/her hands.</p> <p>An interview with the kitchen staff regarding hair restraints and hand washing revealed the kitchen staff was aware hair restraints were required at all times while in the kitchen, and was aware gloves were required to be changed and hands washed after touching anything dirty and returning to serve food.</p> <p>2. Observation of the walk-in freezer on October 14, 2010, at 10:00 a.m., revealed icicles on the top of the walk-in freezer over the fans, and a buildup of ice on five boxes of food below the icicles. The boxes contained chopped spinach, pancakes, cauliflower, broccoli cuts, and juice cups. The ice extended to the floor of the walk-in freezer where there was an area of ice buildup approximately ten inches in diameter. The temperature for the walk-in freezer was -1 degree Fahrenheit.</p> <p>An interview with the Dietary Manager (DM) on October 14, 2010, at 10:15 a.m., revealed the ice buildup had occurred in the past and the maintenance staff was aware and was using a blow dryer to defrost the ice buildup about every week. The DM further stated that hair restraints were to be worn by all kitchen employees and</p>	F 371	<p><b>acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</b></p> <p><b>The expired IV fluids were removed from the south wing medication room.</b></p> <p><b>The medication rooms on both nursing units were checked for any further expired fluids and/or medications and none were found.</b></p> <p><b>The DON in- serviced licensed staff, on (10-14-2010), regarding the need to check for expired fluids/medications in their cabinets daily and dispose of any that are expired immediately. Any licensed staff not in attendance will be re-trained on first day of return to work.</b></p> <p><b>The QI nurse or SDC will do random audits in medication rooms to check for expired fluids/medications.</b></p> <p><b>The QI nurse or SDC will do monthly audits weekly x one month, then every other week x one month, then monthly x three months. Any concerns will be corrected immediately and findings reported to the DON.</b></p> <p><b>The DON/Administrator and Pharmacy Consultant will review QI study results</b></p>	

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NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF TRI-CITIES		STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US 119 NORTH CUMBERLAND, KY 40823	
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F 371	Continued From page 12 hands were to be washed when anything dirty was touched.  An interview with the Maintenance Supervisor on October 14, 2010, at 10:30 a.m., revealed the freezer was being defrosted four times daily. In addition, the Maintenance Supervisor stated heat tape had been applied to the pipes that take the defrosted water outside of the building. The Maintenance Supervisor stated the regular repairman for the freezer had an accident and was killed; however, a new repair company had been obtained and the needed repairs could be completed.	F 371	to ensure that any expired fluids/medications are being disposed of and not used on residents. <i>11/5/10</i>
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of garbage and refuse properly. The facility dumpsters were observed open during the survey and one dumpster was observed to have a missing lid; and the dumpster contents could not be fully covered.  The findings include:  Observations of the facility dumpsters conducted on October 12, 2010, at 4:40 p.m., and on October 14, 2010, at 12:45 p.m., revealed the facility dumpsters were open and one dumpster was observed to have a missing lid and could not be closed.	F 372	<b>ID Prefix Tag F465</b>  The facility will continue to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  1) Leaking sinks were repaired on 10-20-10. Sinks with corrosive build-up were cleaned on 10-14-10.  All faucets were assessed for leaks and corrosive build-up and cleaned and/or repaired as needed on 10-20-10.  The housekeeping staff was inserviced on properly cleaning and reporting leaking faucets on 10-18, 22 and 11-4-10.  The Housekeeping Supervisor will monitor faucets weekly for one month then monthly for three months.  The Administrator and Housekeeping Supervisor will review monthly the

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NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF TRI-CITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US 119 NORTH CUMBERLAND, KY 40823	
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F 372	Continued From page 13	F 372	<b>audit results to ensure continued correctness.</b>	
F 425 SS=D	<p>An interview conducted with the Maintenance Director on October 14, 2010, at 12:45 p.m., revealed that the dumpster lid had been missing since August 2010 and the waste company had been contacted to replace the lid. Further interview with the Maintenance Director revealed the Maintenance Director had not followed up with the waste company and was not aware when the dumpster lid would be replaced.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store and discard</p>	F 425	<p>2) The north hall water fountain was cleaned of corrosive build-up on 11-4-10</p> <p>All water fountains were assessed for corrosive build-up on 11-4-10.</p> <p>The housekeeping staff was inserviced on properly cleaning water fountains 11-4-10.</p> <p>The Housekeeping Supervisor will monitor water fountains weekly for one month then monthly for three months.</p> <p>The Administrator and Housekeeping Supervisor will review monthly the audit results to ensure continued correctness.</p> <p>3) The torn privacy curtain was repaired on 11-04-10.</p> <p>On 11-04-10, all privacy curtains were checked for tears.</p> <p>The environmental staff was inserviced by 11-04-10 to properly notify the</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF TRI-CITIES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US 119 NORTH CUMBERLAND, KY 40823</b>	
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F 425	Continued From page 14 drugs and biologicals in accordance with currently accepted professional principles. Three (3) bottles of IV fluids with outdated expiration dates were observed in the South Wing medication room available for use.  The findings include:  An observation of the medication room on October 14, 2010, on the South Wing revealed the following intravenous fluids available for use:  -5% Dextrose 250 ml bag with an expiration date of September 2010. -0.9% Sodium Chloride 250 ml with expiration date of September 2010. -0.9% Sodium Chloride 100 ml with expiration date of September 2010.  An interview with the South Hall charge nurse on October 14, 2010, at 2:00 p.m., revealed the medication nurse would be the person responsible for ensuring all medications were not expired prior to administration. The Charge Nurse did not know why the expired medications were in the medication room available for use.	F 425	<b>supervisor of issues such as torn privacy curtains.</b>  <b>The Housekeeping Supervisor will monitor the privacy curtains monthly for three months.</b>  <b>The Administrator and Housekeeping Supervisor will review monthly the audit results to ensure continued correctness.</b>  4) <b>The walls in rooms 207, 319, the rehab room and the north hall bath were repaired on 11-02-10.</b>  <b>All rooms were assessed for holes and/or torn wallpaper on 10-18-10.</b>  <b>The environmental staff will be inserviced on reporting walls in disrepair.</b>	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 465	<b>The Maintenance Supervisor will monitor walls monthly for three months.</b>  <b>The Administrator and Maintenance Supervisor will review monthly the audit results to ensure continued correctness.</b>  5)	

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NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF TRI-CITIES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US 119 NORTH CUMBERLAND, KY 40823</b>		
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F 465	<p>Continued From page 15</p> <p>provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. -Leaky faucets with buildup were observed in resident rooms and care areas, torn/loose wallpaper and scarred walls were observed in resident rooms and care areas, and chipped/broken tiles and a crack in the floor was observed in the resident smoke room. In addition, a privacy curtain was ripped/torn in a resident room.</p> <p>The findings include:</p> <p>Observation of the facility during the environmental tour on October 14, 2010, at 12:45 p.m., revealed the following items were in need of repair/cleaning:</p> <ul style="list-style-type: none"> <li>-sinks in rooms 300, 308, and the rehab room, were observed with leaky faucets and corrosive buildup.</li> <li>-the North Hall water fountain was observed with corrosive buildup.</li> <li>-a privacy curtain in room 200 was torn and would not close completely.</li> <li>-walls in rooms 207, 319, the rehab room, and the North Hall bath were observed with holes, loose/torn wallpaper, and/or scarring.</li> <li>-a crack was observed in the floor of the resident smoke room and chipped/cracked tiles were observed on the South Hallway.</li> </ul> <p>An interview conducted with the Maintenance Director on October 14, 2010, at 12:45 p.m., revealed the Maintenance Director was made aware of items in need of repair by work orders. According to the Maintenance Director, there were no outstanding work orders and the Maintenance Director was not aware of the items</p>	F 465	<p><b>All chipped/cracked tiles listed were repaired on 11-9-10.</b></p> <p>On 11-3-10, all rooms were checked for chipped/cracked tiles.</p> <p>The environmental staff was inserviced on 11-4-10 to properly notify the maintenance department of issues such as chipped/cracked tiles.</p> <p>The Maintenance Director will monitor for chipped/cracked tiles monthly for three months.</p> <p>The Administrator and Maintenance Director will review monthly the audit results to ensure continued correctness.</p>	11/10/10	

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NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF TRI-CITIES			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US 119 NORTH CUMBERLAND, KY 40823		
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F 465	Continued From page 16 in need of repair.  An interview conducted with the evening housekeeper on October 13, 2010, at 4:45 p.m., revealed the housekeeper had not cleaned the sink in the rehab room and was not aware who was responsible to clean the rehab room. Further interview with the housekeeper revealed the housekeeper was not aware who was responsible to clean the corrosive buildup from the sinks and faucets.  A review of the evening housekeeping schedule revealed the rehab room was to be cleaned daily from 4:00-5:00 p.m.	F 465			

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NAME OF PROVIDER OR SUPPLIER  <b>TRI-CITIES NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823</b>		
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K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on October 14, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 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.