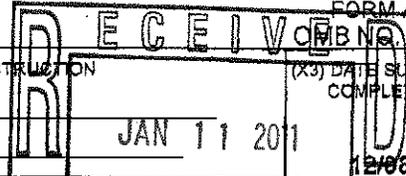


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2010

FORM APPROVED

OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977 Division of Health Care Southern Enforcement Branch
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 18</p> <p>The findings include:</p> <p>Observation on December 7, 2010, at 2:00 p.m., of the facility's medication rooms/carts revealed a bottle of Nitroglycerin 1/150 SL with an expiration date of August 2010 was available for resident use.</p> <p>Continued observation revealed three bottles of liquid Megace, three bottles of liquid Docusate Sodium, one bottle of Gerianta, two bottles of Rulox Suspension, two bottles of Milk of Magnesia, one bottle of Promethazine, one bottle of Lactulose, one bottle of Codinal, one bottle of Centrum, and one bottle of Potassium Chloride 10% solution had been opened but were not dated to indicate when the bottles were opened.</p> <p>Interview on December 7, 2010, at 2:30 p.m., with the Director of Nursing (DON) revealed all liquids and multi-dose vials were required to be dated when opened.</p> <p>The facility failed to provide a policy regarding the requirement of dating liquid medications.</p>	F 431		
F 465 SS=E	<p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and</p>	F 465		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

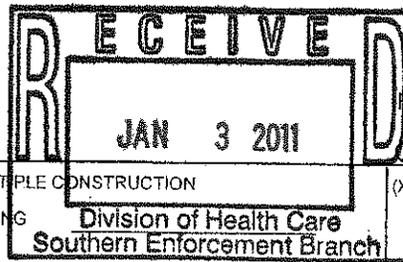
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 465	<p>Continued From page 19</p> <p>the public. The East Wing fire doors were splintered and chipped on the edges. Two (2) electric wheelchairs in use by residents were observed to be soiled and dirty. The door into the kitchen and the door out to the gazebo were observed to be very scarred, soiled, and missing paint. Two (2) sitter chairs in resident room 143 were observed to be chipped/scarred and have missing paint on the arms and legs. The resident restroom between resident rooms 130 and 132 was observed to be soiled with a strong urine odor in the room. The floor tile in resident room 141 was broken and stained. The pulls on the closet and drawers in resident room 155 were broken. The overbed reading light in resident room 138 did not have a switch that was accessible to the resident.</p> <p>The findings include:</p> <p>During the environmental tour conducted on December 8, 2010, the following items were observed:</p> <ol style="list-style-type: none"> <li>1. The East Wing fire doors were splintered with sharp edges.</li> <li>2. Two electric wheelchairs were observed to be soiled and in need of cleaning.</li> <li>3. The door leading to the kitchen and the door out to the gazebo were observed to be very scarred and soiled.</li> <li>4. Two sitter chairs in resident room 143 were observed to be chipped and have large areas of missing paint on the chair arms and legs.</li> <li>5. The resident restroom between rooms 130</li> </ol>	F 465	<p><u>F 465</u></p> <p>East wing fire door was sanded, cleaned and stained on 12/28/2010 by the Maintenance Staff.</p> <p>2 electric wheelchairs cleaned on 12/8/2010 by the nursing staff.</p> <p>Door into the kitchen &amp; door out to the gazebo – painted 12/09/2010 by Maintenance Staff.</p> <p>2 sitter chairs in room 143 were thrown away by the Maintenance Director when identified on 12/8/10.</p> <p>Resident restrooms between rooms 130 &amp; 132 were cleaned &amp; deodorized by the Housekeeper when identified on 12/8/10.</p> <p>Floor tile in room 141 was replaced on 12/9/2010 by Maintenance Staff.</p> <p>Pulls on closet &amp; drawers in room 155 were replaced on 12/09/2010 by Maintenance Staff.</p> <p>Over bed light in room 138 cord was replaced on 12/28/2010 by Maintenance Staff.</p> <p>Rounds were conducted on December 9, 2010 by the Administrator and Director of Maintenance to identify any areas that were not safe, functional, sanitary &amp; comfortable for residents, staff &amp; the public. Work orders for maintenance were completed as needed. Routine</p>	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 465	Continued From page 20 and 132 was observed to be soiled with a strong urine odor in the room.  6. The floor tile in resident room 141 was broken and stained.  7. The pulls on the closet and drawers in resident room 155 were broken.  8. The overbed reading light in room 138 did not have a switch that was accessible to the resident.  An interview conducted with the Maintenance Supervisor (MS) and Housekeeping Supervisor (HS) on December 8, 2010, during the environmental tour revealed the MS and HS make routine rounds to check for areas needing attention in the facility. The MS stated staff was also to place written work orders in the Maintenance mailbox when an area needing attention was discovered.	F 465	CDMT monthly QI rounds will continue to be made by the QI safety committee to ensure any areas identified as not safe, functional, sanitary & comfortable for residents, staff & the public have had maintenance work orders completed as necessary. Safety Committee consists of a representative from the medical and or nursing staff, maintenance, housekeeping/laundry, dietary and other applicable staff as determined by the administrator.  Facility Staff were re-educated by the Staff Development Coordinator on Jan 6, 2011 on completion of the work order process to alert maintenance of areas needing to be addressed.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	Monthly rounds will be conducted by the QI safety committee to identify any areas that are not safe, functional, sanitary & comfortable for residents, staff & the public. The results of these audits will be reviewed with the Administrator & Director of Nursing in the monthly QI Committee meeting. These results will be compiled & assessed for any trends & actions taken based on these assessments. Trends & the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.	01/22/11

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



PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED  12/08/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977
---	--

(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	Britthaven acknowledges receipt of the Statement of Deficiencies and purposes 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 provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Britthaven's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement screening procedures related to abuse, neglect, mistreatment, and misappropriation of property for newly hired staff. There was no evidence that the facility conducted or attempted to obtain work reference screening for five (5) of the five (5) employee files reviewed.  The findings include:  A record review of five newly hired employees was conducted on December 8, 2010, at 4:00 p.m. The employee record review revealed no evidence of a work reference screening for five of the five newly hired employees (two Licensed Practical Nurses, one Certified Nurse Assistant, one Housekeeper, and one Maintenance worker).  An interview conducted on December 8, 2010, at 4:10 p.m., with the Director of Nursing (DON) revealed it was the responsibility of the DON to perform reference checks for the newly hired	F 226	Work related reference screens were completed on December 9, 2010 by Administrator for the 2 LPNs, CNA, House keeper & Maintenance worker identified during the survey.  An audit was conducted by the Administrator on December 13, 2010 of employees hired since December 8, 2010 to ensure work related reference screens had been conducted per facility policy. Employees will continue to have work related reference screens completed using the facility screening forms prior to hire.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Heely M. Goodwin* TITLE: \_\_\_\_\_ (X9) DATE: 12-31-10

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

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 226	Continued From page 1 licensed staff. The DON further revealed he/she had not obtained work employment references for the two Licensed Practical Nurses (LPNs). The DON stated newly hired employees were screened with a personal reference screening but added no work reference employment screening was obtained on the LPNs.  An interview conducted on December 8, 2010, at 4:30 p.m., with the Administrator revealed he/she was responsible for performing reference screening for newly hired staff. The Administrator stated work employment screening was not obtained for the two LPNs, CNA, Housekeeper, and the Maintenance Worker.	F 226	Re-education was provided on December 13, 2010 by the Facility Consultant to the Administrator, Director of Nursing & Staff Development Coordinator on conducting work related reference screening on new employees per facility policy using the facility reference screening forms. The Staff Development Coordinator will be responsible for conducting work related reference screens on new job applicants. Once completed these screening forms & applications will be reviewed by the Administrator to ensure all areas of the application process have been completed fully per facility policy. Department Heads were re-educated on December 13, 2010 by the Administrator & Director of Nursing regarding the facility application process including the completion of work related reference screens prior to hire. New applicants for hire will continue to have work related reference screens completed per facility policy.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for three (3) of nineteen (19) sampled residents (residents #1, #7, and #12). Resident #1 had a physician's order for a psychiatric consultation. However, there was no evidence the facility referred the consultation in a timely manner. Resident #7's family member was diagnosed with a terminal diagnosis, however, there was no evidence that	F 250	CON'T A monthly QI audit will be conducted by the QI Nurse using the QI audit tool to ensure newly hired employees have had work related reference screens completed prior to hire. Any discrepancies identified will be addressed at that time. The results of	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 250	Continued From page 2 resident #7 was offered services to assist with the grieving process. Resident #12 required assistance with obtaining dentures, however, there was no evidence the facility pursued the provision of this service.  The findings include:  1. A review of the medical record for resident #1 revealed the resident was admitted to the facility on November 19, 2010, with medical diagnoses which included History of CVAs/ TIA, Syncope, Diabetes Mellitus, Short Bowel Syndrome, History of Hypokalemia, Hypertension, Tobacco Abuse, Chronic Anxiety, and Lumbosacral Disc Disease. A physician's order was received on November 29, 2010, for a Psychiatric Evaluation for resident #1.  Record review of a progress note for resident #1 dated November 20, 2010, revealed the resident was fearful of nursing home placement and missed his/her ten-year-old son. The progress note further revealed on November 24 through November 25, 2010, the resident refused care and medications.  Additional record review of resident #1's Mood/Behavior Assessment revealed the following behaviors: on November 21 through November 29, 2010, resident #1 cried, refused medication, and resisted care. Additional review of resident #1's Mood/Behavior Assessment for December 1 through December 8 revealed behaviors of "recurrent statements that something terrible" was about to happen and "wandering."  An interview conducted on December 7, 2010, at	F 250	these audits will be reviewed with the Administrator & Director of Nursing in the weekly QI Committee meeting. These results will be compiled & assessed for any trends & actions taken based on these assessments. Trends & the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.  Completion date: 01-22-2011  <u>F250</u>  Resident #1 has a psychiatric evaluation scheduled on 01-14-2011 the appropriate changes will be made to the plan of care. Social Worker spoke with Resident #7 on December 7, 2010 and the plan of care was updated to assist her with the grieving process. Resident #12 was discharged home on 12/8/10.  Current residents have been reviewed on December 23, 2010 by the Administrative nursing team to identify any issues/concerns that have not been addressed by the Social Worker. Residents will continue to	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 250	<p>Continued From page 3</p> <p>10:35 a.m., with the Social Services Director (SSD) revealed he/she was verbally notified by the staff nurse of resident #1's behaviors. The SSD stated a physician's order was obtained on November 29, 2010, for a Psychiatric Evaluation. However the referral was not made until December 7, 2010, eight days later.</p> <p>Additional interview conducted on December 7, 2010, at 4:15 p.m., with Certified Nurse Assistant (CNA) #1 revealed resident #1 cries more now than when he/she was admitted to the facility. An interview conducted on December 7, 2010, at 2:10 p.m., with CNA #2 revealed resident #1 has refused care and an additional interview conducted at 4:25 p.m., revealed resident #1 "seemed depressed."</p> <p>2. An interview was conducted with a Registered Nurse (RN) during the initial tour at 10:45 a.m. on December 6, 2010. The RN stated that resident #7 had been depressed recently due to becoming aware that a son had been diagnosed with terminal cancer, and the life expectancy was less than six months.</p> <p>An interview was conducted with resident #7 at 4:00 p.m. on December 7, 2010. The resident stated that she/he had been more nervous recently. Further interview with the resident revealed he/she had recently found out that one of his/her sons had terminal cancer, and that he had less than six months to live. The resident stated that her/his nerves were worse at times, and the doctor had recently increased the resident's "nerve medicine."</p> <p>A review of the medical record for resident #7 revealed the resident had a psychiatric</p>	F 250	<p><del>CONT.</del></p> <p>receive medically related social services provided by the facility as needed to attain or maintain the highest practicable physical, mental &amp; psychosocial well being.</p> <p>The Social Worker was re-educated on December 29, 2010 by the Director of Nursing on timely response to identified resident needs &amp; requests to ensure medically related social services are provided. An outline was developed by the Administrator on 12/23/10 for use in the morning Department Head meetings to document any issues or concerns brought up during the meeting. This outline will be reviewed in the meeting the following day to ensure issues/concerns brought up the previous day have been addressed. Staff will be re-educated by the Director of Nursing on Jan 6, 2011 to ensure that any resident needs/concerns are documented on the 24 hour report to ensure that the Social Worker is aware of any issues involving residents that may need to be addressed.</p> <p>A weekly QI audit will be conducted by the Administrator to include Resident #1 and #7 using the QI audit tool to ensure that medically related social service issues/concerns</p>	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 250	<p>Continued From page 4</p> <p>consultation on November 7, 2010, because the resident had become more depressed, had increased anxiety, increased somatic complaints, and a decrease in appetite. The psychiatrist recommended that the resident's anti-anxiety medication be increased to Xanax 0.5 milligrams (mg) two times daily, and to start Trazodone 5 mg at night, and Celexa 20 mg every day.</p> <p>A review of the medication administration record (MAR) for resident #7 revealed the resident's Xanax was increased on November 9, 2010, and the Trazodone and Celexa was started on November 9, 2010.</p> <p>A review of the social services progress notes documentation revealed the social worker had reviewed resident #7's record on November 17, 2010 and November 24, 2010. However, the social worker failed to address resident #7's increased depression and anxiety related to the news of the son having terminal cancer with less than six months to live. Furthermore, there was no evidence the facility offered services to assist with the grieving process.</p> <p>An interview was conducted with the social worker at 3:50 p.m. on December 8, 2010. The social worker stated that yesterday (December 7, 2010) was the first time he/she knew about resident #7's son having terminal cancer. The social worker stated that he/she attended the care plan conference on November 24, 2010, for resident #7 but the social worker did not remember a discussion regarding resident #7's son having terminal cancer.</p> <p>3. An interview was conducted with resident #12 at 2:00 p.m. on December 7, 2010. The resident</p>	F 250	<p>CON't.</p> <p>identified in the morning meeting and on the 24 hour reports have been documented &amp; addressed as indicated. The results of these audits will be reviewed with the Director of Nursing &amp; Social Worker in the weekly QI Committee meeting. These results will be compiled &amp; assessed for any trends &amp; actions taken based on these assessments. Trends &amp; the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.</p> <p>Completion date: 01-22-2011</p>	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 250	Continued From page 5 stated his/her lower dentures were lost while a patient at a hospital in Lexington prior to being admitted to this facility on November 12, 2010. Resident #7 stated that he/she had told the social worker about the loss of the lower dentures while at the Lexington hospital and according to the resident, the social worker checked on the dentures. Furthermore, resident #7 stated that he/she told the social worker that he/she wanted a dental consultation. However, resident #7 stated that the social worker had not requested a dental consultation as of this date.  Review of a dietary progress note dated November 22, 2010, revealed resident #12 had stated that the resident's lower dentures were lost prior to admission to the facility on November 12, 2010, and that the resident had stated he/she would like to have the dentures replaced.  A review of the social services progress notes documentation revealed the social worker had reviewed the medical record for resident #12 on November 15, 2010 and November 24, 2010. However, there was no evidence documented in the social services progress notes regarding resident #12's lower dentures missing or that the resident had requested a dental consultation.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	F279  Resident #2 had his plan of care updated on December 8, 2010 by MDS Coordinator to reflect noncompliance with personal hygiene & the lesion on the L temporal area. Resident #7 has had her plan of care updated on December 7, 2010 by MDS Coordinator to address the grieving process.	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 279	Continued From page 6 needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop a comprehensive care plan for two (2) of nineteen (19) sampled residents. Resident #2 was observed to be in need of a shave and nail care and the resident frequently refused to allow staff to provide these care needs. In addition, resident #2 was observed to have a lesion on the left temporal area and was receiving daily wound care. However, there was no evidence the facility had developed a plan of care to address resident #2's noncompliance with personal hygiene or the lesion on the left temporal area. Resident #7 had recently learned that a loved one was diagnosed with cancer; however, there was no evidence the facility had identified this concern for resident #7 and failed to develop a plan of care to address the grieving of the resident.  The findings include:  1. A review of the medical record revealed	F 279	CON'T Current residents were reviewed by the MDS Coordinator & the care plan team on December 29, 2010 to ensure that the plan of care has been updated to include measureable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that have been identified in the comprehensive assessment. Residents will continue to have comprehensive care plans developed that include services that are needed to attain or maintain the highest practicable physical, mental and psychosocial well being.  An outline has been developed by the Administrator on 12/23/10 for use in the morning Department Head meetings to document any issues/concerns brought up during the meeting. This outline will be reviewed in the meeting the following day to ensure issues/concerns brought up the previous day have been addressed. The Treatment Nurse was re-educated by the Director of Nursing on December 24, 2010 that any abnormal skin areas are to be discussed in the weekly wound QI meeting & placed on the weekly wound QI sheets. A copy of the weekly wound meeting QI sheets will be provided to the MDS Coordinators.	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 279	<p>Continued From page 7</p> <p>resident #2 was admitted to the facility on May 9, 2009, with diagnoses of Congestive Heart Failure, Anxiety, Chronic Obstructive Bronchitis, and Dementia with Behaviors. A review of the comprehensive assessment completed on March 4, 2010, revealed resident #2 was assessed to be alert/oriented with modified independence with decision-making skills. The resident was further assessed to have no behaviors and to require extensive assistance of staff for personal hygiene and bathing.</p> <p>A review of the comprehensive care plan for resident #2 dated August 24, 2010, revealed the facility identified a problem related to personal grooming needs with interventions to provide assistance with bathing/hygiene, to encourage the resident to participate in self care, and to ensure the resident's nails are manicured.</p> <p>Resident #2 was observed on December 6, 2010, at 3:00 p.m., to be dressed in street clothing and to be sitting in a wheelchair. The resident was noted to have a heavy growth of facial hair and to have long/dirty fingernails. The resident was again observed on December 7, 2010, at 9:30 a.m., 11:00 a.m., 1:50 p.m., and 3:50 p.m. Resident #2 continued to have a heavy growth of facial hair and long/dirty fingernails during each of these observations. In addition, wound care was observed to be provided to an open skin lesion on the resident's left temporal area on December 6, 2010, at 3:05 p.m.</p> <p>An interview conducted with resident #2 on December 6, 2010, at 3:30 p.m., revealed the resident stated he/she required assistance by the direct care staff for bathing, shaving, and nail care. Resident #2 stated sometimes he did not</p>	F 279	<p><b>CONT.</b></p> <p>The MDS Coordinators were re-educated on December 24, 2010 by the Director of Nursing on reviewing BOP sheets &amp; the 24 hour report sheets on a routine basis to identify behaviors or needs that need to be addressed on the plan of care. Staff will be re-educated on Jan 6, 2011 by the Director of Nursing to document any issues involving residents that may need to be addressed by the Social Worker on the 24 hour report sheet.</p> <p>A weekly QI audit to include Resident #2 and #8, residents identified on the 24 hour report sheet &amp; morning department head meeting sheet will be conducted by the Administrator using the QI audit tool to ensure the plan of care has been updated to include measureable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that have been identified. The results of these audits will be reviewed with the Director of Nursing &amp; social Worker in the weekly QI Committee meeting. These results will be compiled &amp; assessed for any trends &amp; actions taken based on these assessments. Trends &amp; the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining</p>	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 279	<p>Continued From page 8</p> <p>allow the staff to perform shaving and/or nail care because "it hurt."</p> <p>Interview conducted with the shower aide on December 7, 2010, at 3:30 p.m., revealed resident #2 was scheduled to receive a shower bi-weekly with nail care and shaving to be provided daily or as needed. The shower aide stated the resident frequently refused showers, nail care, and shaving. The shower aide stated the resident's refusal had been reported to the charge nurses.</p> <p>An interview conducted with the MDS Coordinator on December 8, 2010, at 11:00 a.m., revealed he/she was responsible to develop a plan of care for each resident. The MDS Coordinator stated he/she was not aware the resident was noncompliant with personal hygiene needs. The MDS Coordinator further stated he/she attended the weekly wound meetings; however, the temporal lesion had not been discussed, and he/she was not aware the resident required treatment of this area. The MDS Coordinator stated a plan of care had not been developed to address resident #2's noncompliance with personal hygiene and the skin lesion on the resident's left temporal area.</p> <p>A review of the facility policy/procedure related to resident care plans (dated April 2007) revealed a written plan of care was required to be developed based on an assessment of the resident's needs. The policy/procedure further noted the resident care plan would be an ongoing process and would include current problems and/or needs identified from a resident assessment, and any new problem identified between scheduled resident assessments would also be included on</p>	F 279	<p>CON'L.</p> <p>or other such intervention implemented as necessary.</p> <p>Completion date: 01-22-2011</p>	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 279	Continued From page 9 the resident care plan.  2. A review of the medical record revealed that resident #7 had a psychiatric consultation on November 7, 2010, related to increased depression and anxiety due to receiving news that her/his son had terminal cancer and the son's life expectancy was less than six months. The psychiatrist recommended the resident's anti-anxiety medication be increased, and to start the resident on Trazodone and Celexa for the increased depression.  A review of the medication administration record revealed resident #7's anxiety and depression medication was started on November 9, 2010.  An interview was conducted with resident #7 at 4:00 p.m. on December 7, 2010. The resident states that she/he had been more nervous recently since the resident became aware of a son having a terminal illness.  An interview was conducted with the social worker at 3:50 p.m. on December 8, 2010. The social worker stated that she/he had not developed a care plan to address the increase in depression and anxiety for resident #7 after the resident was informed of a son having a terminal illness. The social worker stated she/he would have developed a care plan to address resident #7's terminal illness if she/he had known about the resident's son. However, the social worker stated that she/he was not aware of resident #7's terminal illness until "yesterday" (December 7, 2010).	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 10</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services to meet professional standards of quality for one (1) of nineteen (19) sampled residents. Resident #2 had a physician's order for wound care to be provided to the resident's right ankle. The physician's order included to clean the wound with Silvermed cleanser and apply "SSD" foam dressing daily and as needed. However, the facility staff failed to clean the wound with Silvermed cleanser prior to the application of the foam dressing during wound care provided on December 6, 2010.</p> <p>The findings include:</p> <p>A review of the medical record revealed resident #2 was admitted to the facility on May 9, 2009, with diagnoses of Congestive Heart Failure, Anxiety, Chronic Obstructive Bronchitis, and Dementia with Behaviors. A review of the physician's orders dated November 26, 2010, revealed a physician's order to clean the resident's right ankle with Silvermed cleanser and to apply "SSD" foam dressing daily and as needed.</p> <p>An observation of wound care to resident #2's right ankle conducted on December 6, 2010, at 3:05 p.m., revealed the Wound Care Nurse (WCN) was observed to clean the open wound on the resident's right ankle with gauze soaked with Normal Saline. The WCN was then observed to</p>	F 281	<p><u>F 281</u></p> <p>Resident #2 – MD was notified on December 7, 2010 by the Treatment nurse &amp; the order was clarified for treatment of the right ankle wound.</p> <p>Current treatment orders were reviewed by the Treatment Nurse &amp; Director of Nursing on December 8, 2010 to ensure wound treatments were being provided as ordered. Residents will continue to receive wound treatment as ordered.</p> <p>The Treatment Nurse was re-educated by the Director of Nursing on December 24, 2010 in providing wound care treatments as ordered.</p> <p>weekly QI audits to include Resident #2 will be conducted by the Director of Nursing during wound care using the QI audit tool to ensure treatments are being provided as ordered. Discrepancies will be addressed at that time as indicated. The results of these audits will be reviewed with the Administrator in the weekly wound QI Committee meeting. These results will be compiled &amp; assessed for any trends &amp; actions taken based on these assessments. Trends &amp; the</p>	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11 cover the open area with the "SSD" foam dressing.  An interview conducted with the WCN on December 7, 2010, at 3:50 p.m., revealed Silvermed had not been used to cleanse the resident's ankle wound as ordered by the physician. The WCN stated the error was an oversight and the wound should have been cleansed with Silvermed.	F 281	accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.  Completion date: 01-22-2011	1/22/11
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334	<u>F 334</u>  Resident #17 expired on 12/6/10. Resident #14 received the pneumonia vaccine on December 8, 2010.  An audit was completed of current residents on December 22, 2010 by the Staff Development Coordinator to ensure pneumonia vaccine had been offered & provided as needed. Residents will continue to receive pneumonia vaccine on admission if eligible & as ordered.  The Staff Development Coordinator was re-educated on December 29, 2010 by the Director of Nursing that residents who are eligible to receive the pneumonia vaccine receive the vaccine on admission. The Admissions Coordinator was re-educated on December 29, 2010 by the Director of Nursing on obtaining	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 334	Continued From page 12  The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.  This REQUIREMENT is not met as evidenced by:	F 334	verification of any previous vaccination & placing in the medical record.  A monthly QI audit of newly admitted residents will be conducted by the QI Coordinator using the QI tool to ensure those who are eligible to receive the pneumonia vaccine have been administered and that evidence is present in the medical record of any immunizations that were received prior to admission to the facility. Discrepancies will be addressed at that time as indicated. The results of these audits will be reviewed with the Administrator & Director of Nursing in the weekly QI Committee meeting. These results will be compiled & assessed for any trends & actions taken based on these assessments. Trends & the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.  Completion date: 01-22-2011	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 334	<p>Continued From page 13</p> <p>Based on record review and interview, it was determined the facility failed to ensure that the pneumococcal vaccine was provided for (2) two of nineteen (19) sampled residents (residents #14 and #17).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review of resident #17's record revealed an admission date of September 14, 2010, and a discharge date of December 6, 2010. The resident was admitted with the following diagnoses: End Stage Renal Disease, Anemia, Protein-Calorie Malnutrition, Renal Dialysis Status, Diabetic, Hypertension, Chronic Airway Obstruction, and Aortic Valve Disorder. Further record review revealed a consent form signed by resident #17 on September 14, 2010, for the Pneumonia Vaccine to be administered by the facility. In addition, resident #17 had an admission physician's order that stated "may give pneumococcal vaccine on admission according to acceptable standards of clinical practices or unless medically contraindicated (consent at admission)."</li> </ol> <p>However, record review of resident #17's Immunization Report/Record revealed a pneumococcal vaccine had not been administered.</p> <p>Interview on December 8, 2010, at 3:10 p.m., with the Licensed Practical Nurse responsible for having the consent signed on admission to the facility and administering the vaccine to the resident voiced the resident had received the vaccine at the dialysis center and a copy would be provided to the surveyor.</p>	F 334		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185243</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/08/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF PINEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977</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 334	<p>Continued From page 14</p> <p>However, record review of fax copy received on December 9, 2010, at 4:18 p.m., revealed resident #17 had not received the pneumococcal vaccine at the dialysis center.</p> <p>2. A review of the medical record revealed resident #14 was admitted to the facility on November 10, 2010, with diagnoses to include Cerebrovascular Accident (CVA), Asthma, Depression, Hypertension, and Psychosis.</p> <p>Further record review revealed a consent/release form dated November 10, 2010, was signed by the resident's responsible party (R/P) regarding the risks/benefits for the flu/pneumococcal vaccines. The document contained evidence the resident's R/P had given authorization for the vaccines to be administered to resident #14.</p> <p>A review of the immunization record for resident #14 revealed the flu vaccine had been administered to resident #14 on October 18, 2010, at the local Health Department prior to admission to the facility. However, there was no evidence the resident had received the pneumococcal vaccine prior to or after being admitted to the facility.</p> <p>An interview conducted with the Staff Development Coordinator (SDC) on December 8, 2010, at 3:10 p.m., revealed the SDC was responsible to ensure/monitor the immunization records for the facility residents. The SDC stated the pneumococcal vaccine had not been administered to resident #14 due to an oversight.</p> <p>A review of the facility's policy/procedure related to Infection Control (dated August 2005) revealed vaccinations were required to be administered to</p>	F 334			

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 334	Continued From page 15 the residents as part of the facility's infection control program and/or as ordered by the resident's physician. The policy/procedure further noted education regarding the vaccines would be provided to the resident and/or the resident's R/P upon admission to the facility and consent for the administration of the vaccines would be obtained/documented. In addition, the policy/procedure stated administration of the vaccines/immunizations would be documented on the Resident Immunization Record.	F 334		
F 364 SS=B	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve food at a palatable temperature. In addition, the meat (ham) that was served to the residents was tough.  The findings include:  Observation of the lunch meal at 11:30 a.m. on December 6, 2010, revealed a food cart was delivered to the West Unit. Further observation revealed the last tray was removed and served at 12:02 p.m. A test tray was removed from the food cart at that time in order to check the food temperatures, and to conduct a palatability test of the food after the food cart sat on the unit for 32	F 364	<u>F 364</u> West Unit staff were re-educated on 12/6/10 by the Director of Nursing that meals are to be passed timely when arriving on the floor & that if problems arise the Administrator or Director of Nursing is to be notified.  Daily QI meal audits will be conducted by the Dietary Manager using the QI tool to monitor time trays arrived on the floor, temperature of the test tray & an interview with random residents on palatability, attractiveness & temperature of food served. Actions will be taken based on these audits.  The results of these audits will be reviewed with the Administrator in the weekly QI Committee meeting. These results will be compiled & assessed for any trends & actions taken based on these assessments. Trends & the	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 364	Continued From page 16 minutes. The food temperatures revealed the ham was 103.2 degrees Fahrenheit, sweet potatoes were 96.5 degrees Fahrenheit, greens were 97.8 degrees Fahrenheit, and ice cream was 26.9 degrees Fahrenheit. A palatability test was conducted and revealed the ham was cold and tough, and the margarine would not melt on the sweet potatoes due to them being cold and not palatable. The greens were also cold and not palatable, and the ice cream was partially melted.  An interview was conducted with resident #7 at 11:55 a.m. on December 6, 2010. The resident stated that the food was cold and the ham was tough to eat. The resident further stated that the food was served cold most of the time.  A review of the temperatures from the kitchen's steam table revealed the food temperatures ranged from 142 degrees Fahrenheit to 189 degrees Fahrenheit (within normal holding temperatures) when the food was served from the kitchen.	F 364	<u>CONF</u>  accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.  Completion date: 01-22-2011	1/22/11
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	<u>F 431</u>  Medications identified during survey audit were discarded & re-ordered from the pharmacy on December 6, 2010.  An audit of medication rooms & medication carts was conducted by the Staff Development Coordinator & QI Nurse on 12/7/10 to ensure no expired medications were available for resident use & that all open bottles of medications were dated when opened. Drugs & biological used in the facility	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 17  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Sixteen bottles of liquid medication had been opened and available for use; however, the medications were not dated to indicate the date the bottles were opened. In addition, a bottle of Nitroglycerin SL with an expiration date of August 2010 was available for resident use.	F 431	<b>CONT.</b>  will continue to be labeled in accordance with currently accepted professional principles.  Staff will be re-educated by the Staff Development Coordinator on Jan 6, 2011 that drugs & biological used in the facility must be dated when opened & that drugs & biological must be checked on a routine basis for expiration date.  A monthly QI audit will be conducted by the QI Coordinator using a QI tool to ensure that drugs & biological used in the facility are dated with opened & that expired medications are not available for resident use. The results of these audits will be reviewed with the Administrator & Director of Nursing in the monthly QI Committee meeting. These results will be compiled & assessed for any trends & actions taken based on these assessments. Trends & the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.  Completion date: 01-22-2011	12/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 18 The findings include:  Observation on December 7, 2010, at 2:00 p.m., of the facility's medication rooms/carts revealed a bottle of Nitroglycerin 1/150 SL with an expiration date of August 2010 was available for resident use.  Continued observation revealed three bottles of liquid Megace, three bottles of liquid Docusate Sodium, one bottle of Gerilanta, two bottles of Rulox Suspension, two bottles of Milk of Magnesia, one bottle of Promethazine, one bottle of Lactulose, one bottle of Codinal, one bottle of Centrum, and one bottle of Potassium Chloride 10% solution had been opened but were not dated to indicate when the bottles were opened.  Interview on December 7, 2010, at 2:30 p.m., with the Director of Nursing (DON) revealed all liquids and multi-dose vials were required to be dated when opened.	F 431		
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 and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and	F 465	<u>F 465</u> East wing fire door – 12/28/2010 2 electric wheelchairs – 12/8/2010 Door into the kitchen & door out to the gazebo – painted 12/09/2010 2 sitter chairs in room 143 were thrown away by the Maintenance Director when identified on 12/8/10. Resident restrooms between rooms 130 & 132 were cleaned & deodorized by the Housekeeper when identified on 12/8/10. Floor tile in room 141 – 12/9/2010 Pulls on closet & drawers in room 155 – 12/09/2010 Over bed light in room 138 - 12/28/2010	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 465	Continued From page 19 the public. The East Wing fire doors were splintered and chipped on the edges. Two (2) electric wheelchairs in use by residents were observed to be soiled and dirty. The door into the kitchen and the door out to the gazebo were observed to be very scarred, soiled, and missing paint. Two (2) sitter chairs in resident room 143 were observed to be chipped/scarred and have missing paint on the arms and legs. The resident restroom between resident rooms 130 and 132 was observed to be soiled with a strong urine odor in the room. The floor tile in resident room 141 was broken and stained. The pulls on the closet and drawers in resident room 155 were broken. The overbed reading light in resident room 138 did not have a switch that was accessible to the resident.  The findings include:  During the environmental tour conducted on December 8, 2010, the following items were observed:  1. The East Wing fire doors were splintered with sharp edges.  2. Two electric wheelchairs were observed to be soiled and in need of cleaning.  3. The door leading to the kitchen and the door out to the gazebo were observed to be very scarred and soiled.  4. Two sitter chairs in resident room 143 were observed to be chipped and have large areas of missing paint on the chair arms and legs.  5. The resident restroom between rooms 130	F 465	CON4. Rounds were conducted on December 9, 2010 by the Administrator and Director of Maintenance to identify any areas that were not safe, functional, sanitary & comfortable for residents, staff & the public. Work orders for maintenance were completed as needed. Routine monthly QI rounds will continue to be made by the QI safety committee to ensure any areas identified as not safe, functional, sanitary & comfortable for residents, staff & the public have had maintenance work orders completed as necessary.  Staff will be re-educated by the Staff Development Coordinator on Jan 6, 2011 on completion of the work order process to alert maintenance of areas needing to be addressed.  Monthly rounds will be conducted by the QI safety committee to identify any areas that are not safe, functional, sanitary & comfortable for residents, staff & the public. The results of these audits will be reviewed with the Administrator & Director of Nursing in the monthly QI Committee meeting. These results will be compiled & assessed for any trends & actions taken based on these assessments. Trends & the	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 465	Continued From page 20 and 132 was observed to be soiled with a strong urine odor in the room.  6. The floor tile in resident room 141 was broken and stained.  7. The pulls on the closet and drawers in resident room 155 were broken.  8. The overbed reading light in room 138 did not have a switch that was accessible to the resident.  An interview conducted with the Maintenance Supervisor (MS) and Housekeeping Supervisor (HS) on December 8, 2010, during the environmental tour revealed the MS and HS make routine rounds to check for areas needing attention in the facility. The MS stated staff was also to place written work orders in the Maintenance mailbox when an area needing attention was discovered.	F 465	<u>CONT.</u> accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.  Completion date: 01-22-2011	1/22/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	<u>F 514</u> Resident #2 - MD was notified & orders were updated to include a current order for treatment to the open lesion on his left temporal area.  An audit was conducted by the Treatment Nurse on 12/8/10 to ensure resident's receiving wound treatments had a current order in place. Residents will continue to have a current MD order in place for wound treatments.	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

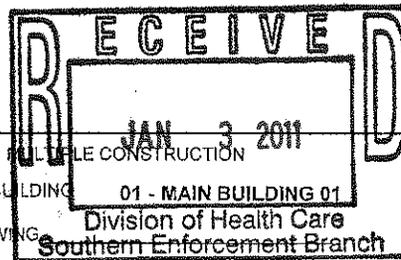
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to ensure the clinical record was accurately maintained for one (1) of nineteen (19) sampled residents. Resident #2 was observed to have an open lesion of the left temporal area. A physician's order was obtained on September 20, 2010, to provide wound care for the area. However, the treatment order was not included in the current physician's orders dated November 26, 2010.</p> <p>The findings include:</p> <p>Observation revealed the Wound Care Nurse (WCN) provided wound care to resident #2's left temporal area on December 6, 2010, at 3:05 p.m. The WCN was observed to cleanse the open lesion on the resident's left temporal area with normal saline, and to apply Wound Gel with a dry dressing to the area.</p> <p>Review of the medical record revealed resident #2 was assessed by facility staff on September 15, 2010, to have a lesion on the side of the resident's face (temporal area) and a physician's order was noted to refer the resident to a surgeon for further evaluation/treatment. Further record review revealed a physician's order was obtained on September 20, 2010, to clean the left temporal wound with normal saline (N/S) and to apply Wound Gel with a dry dressing daily, and as needed. However, a review of the current physician's orders (dated November 26, 2010) revealed there was no evidence the treatment order for the temporal area had been included in the November 2010 physician's orders.</p>	F 514	<p>CONT.</p> <p>The Treatment Nurse &amp; Administrative Nurses were re-educated by the Director of Nursing on December 29, 2010 on facility procedures to check the pre-printed physician orders each month to ensure orders are accurate.</p> <p>A QI audit will be conducted monthly to include Resident # 2 by the QI Coordinator using the QI tool to ensure current treatment orders are accurate on the pre-printed physician's orders.</p> <p>The results of these audits will be reviewed with the Administrator &amp; Director of Nursing in the monthly QI Committee meeting. These results will be compiled &amp; assessed for any trends &amp; actions taken based on these assessments. Trends &amp; the accompanying actions will be reviewed quarterly by the Executive QI Committee with further retraining or other such intervention implemented as necessary.</p> <p>Completion date: 01-22-2011</p>	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 22</p> <p>A review of the December 2010 Treatment Administration Record (TAR) revealed an order was handwritten (no date) on the pre-printed TAR to clean the left temporal area with N/S and to apply Wound Gel with a dry dressing daily and as needed. The treatment was initiated daily to indicate the treatment had been provided for resident #2.</p> <p>Interview conducted with the WCN on December 7, 2010, at 3:50 p.m., revealed the WCN was responsible to verify that the physician's orders and TAR corresponded each month. The WCN stated he/she had not identified that the November 2010 physician's orders failed to include an order for treatment to the resident's left temporal area.</p> <p>An interview conducted with the Director of Nurses (DON) on December 7, 2010, at 4:30 p.m., revealed the DON and the Administrative Nurses were responsible to check the pre-printed physician's orders each month to ensure the orders were accurate. However, the DON stated the facility staff had not identified that the treatment order had been omitted from the current physician's orders.</p>	F 514			

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



PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING: Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED  12/07/2010
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977
---	--

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

K 000	INITIAL COMMENTS  A life safety code survey was initiated and concluded on December 7, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	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.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. In addition, the facility failed to ensure that penetrations above fire/smoke barrier doors were properly sealed. This deficient practice affected five (5) of five (5) smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.	K 025	Britt haven'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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Kelly M. Goodwin</i>	TITLE  12-31-10	(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: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 025	<p>Continued From page 1</p> <p>The findings include:</p> <p>During the Life Safety Code survey on December 7, 2010, at 11:00 a.m., with the Director of Maintenance (DOM), a large portion of the fire/smoke barrier wall was observed to be missing above the cross-corridor doors at the short East Hall corridor. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. During the survey three other fire/smoke barrier walls were determined not to be maintained. An interview with the DOM on December 7, 2010, at 11:00 a.m., revealed heat/air and data cable contractors breeched the fire/smoke barrier walls about six months ago and the DOM was not aware the fire/smoke barrier walls should be maintained.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed</li> </ol>	K 025	<p><b><u>ID Prefix Tag K025</u></b></p> <p>Fire/smoke barrier wall above the cross corridor door on East short hall was replaced.</p> <p>The Director of Maintenance will make a tour of the facility and assess for areas that are not properly maintained. Based on findings appropriate actions will be taken to seal any areas to resist fire/smoke.</p> <p>Maintenance Director and Assistant were in serviced by Administrator on NFPA 101 Life Safety Code Standards Specifically K025.</p> <p>The Physical Plant QI Team will make monthly rounds to assess for needed repairs for the next 12 months to ensure deficient practice does not recur. If no problems are noted rounds will be made quarterly, any problems identified will be sealed to resist fire/smoke.</p> <p>January 22, 2011</p>	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 025	Continued From page 2 for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that cross-corridor fire doors were able to resist the passage of fire and smoke. This deficient practice affected four (4) of five (5) smoke compartments, staff, and approximately sixty-five (65) residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.  The findings include:  During the Life Safety Code tour on December 7, 2010, at 10:00 a.m., with the Director of Maintenance (DOM), a set of cross-corridor fire/smoke barrier doors located next to resident rooms 114 and 142 were observed not to close all	K 027	<u><b>ID Prefix Tag K027</b></u>  Repairs were made to the cross corridor fire/smoke barrier doors next to resident rooms 114 and 142 on December 28, 2010. The doors now close all the way.  The Director of Maintenance inspected all of the cross corridor fire doors to ensure they close all the way.  The Director of Maintenance and Assistant were in serviced on NFPA 80 Life Safety Code Standards specifically K027.  The Physical Plant QI Team will make monthly rounds to assess for any cross corridor doors that do not close all the way.  January 22, 2011	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010	
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(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 027	<p>Continued From page 3</p> <p>the way when tested. These doors must close all the way to help prevent fire/smoke from reaching other parts of the building in a fire situation. An interview with the DOM on December 7, 2010, at 10:00 a.m., revealed these doors were last checked for proper operation about two months earlier. The DOM was aware these doors needed to operate properly.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>15-1.4 Repairs. Repairs shall be made and defects that could interfere with operation shall be corrected immediately.</p> <p>15-2.1.1* Hardware shall be examined frequently and any parts found to be inoperative shall be replaced immediately.</p> <p>15-2.4.1 Self-closing devices shall be kept in proper working condition at all times.</p>	K 027		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One-hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>	K 029		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977
---	--

(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 029	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors to hazardous areas were equipped with door closing devices as required. This deficient practice affected two (2) of five (5) smoke compartments, staff, and approximately twenty (20) residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on November 10, 2010, at 9:20 a.m., with the Director of Maintenance (DOM), a corridor door to the central supply room was observed not to have a self-closing device as required. In addition, the mechanical and medical records room doors were observed not to have a self-closing device. An interview with the DOM on November 10, 2010, at 9:20 a.m., revealed the DOM was unaware which corridor doors were required to have a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be</p>	K 029	<p><u>ID Prefix Tag K 029</u></p> <p>Self closing devices were added to the central supply, medical records and mechanical room doors.</p> <p>The Director of Maintenance inspected the facility to ensure all corridor doors that required self closing devices had them and were working properly.</p> <p>Director of Maintenance was in serviced on NFPA Life Safety Code Standards specifically K029.</p> <p>The Physical Plant QI team will make monthly rounds and make sure all corridor doors with self closers work properly and are in place.</p> <p>January 22, 2011</p>	1/22/11
-------	---	-------	---	---------

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 029	Continued From page 5 self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by:	K 050	<b><u>Id Prefix Tag K 050</u></b>  The facility will hold fire drills at unexpected times and varying conditions.  The Director of Maintenance will conduct fire drills at unexpected times and varying conditions and reeducate staff as needed regarding response to incidence under different staffing levels and conditions to include resident alertness.	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 6 Based on an interview and record review, the facility failed to perform the minimum number of fire drills as required. This condition affected all second shift staff and all of the residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.  The findings include:  During the Life Safety Code survey on December 7, 2010, at 11:20 a.m., with the Director of Maintenance (DOM), a record review revealed the facility had two fire drills on the second shift from September 2009 to May 2010. An interview with the DOM on December 7, 2010, at 11:20 a.m., revealed the DOM was unsure how often fire drills should be performed.	K 050	CONT. Director and Assistant Director of Maintenance were in serviced by Administrator on conducting fire drills correctly as required.  The Administrator and Director of Maintenance will review monthly the fire drill results to ensure continued correctness.  January 22, 2011	1/22/11
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 052	<u>ID Prefix Tag K052</u>  Simplex Grinnell has been contacted to install a new dialer with a remote annunciater next to the fire alarm panel at the nurses station.  Maintenance Supervisor will test the fire alarm dialer monthly to ensure it can be heard at the continuously occupied location.	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 052	Continued From page 7 failed to ensure that the building fire alarm system functioned as required by NFPA standards. This deficient practice affected five (5) of five (5) smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.  The findings include:  During the Life Safety Code survey on December 7, 2010, at 9:45 a.m., with the Director of Maintenance (DOM), a test of the fire alarm automatic dialer panel revealed when the panel was placed in trouble from phone line failure, the offsite monitoring station received the signal; however, the unit did not send a trouble signal to a continuously occupied location within the facility. Observation of the main fire alarm control panel showed that all systems were normal. While the dialer panel did emit an audible trouble signal, this signal was not in an area where it was likely to be heard. An interview with the DOM on December 7, 2010, at 10:05 a.m., revealed the DOM was not aware the phone line trouble signal should be in an area where it is likely to be heard.  Reference: NFPA 72 (1999 Edition).  1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.  1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by	K 052	CON4.  Director of Maintenance was in serviced on NFPA standards, specifically K052.  Administrator will review monthly log for 3 months and if no problems identified, Administrator or designee will review quarterly for the next 12 months.  January 22, 2011	1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 052	<p>Continued From page 8</p> <p>distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> <p>3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single</p>	K 052		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977
---	--

(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 052 Continued From page 9  
system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.

K 052

K 062  
SS=F  
NFFPA 101 LIFE SAFETY CODE STANDARD  
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFFPA 13, NFFPA 25, 9.7.5

K 062

This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that sprinkler heads were maintained and unobstructed. In addition, the facility failed to provide documentation of an interior pipe inspection of the sprinkler system. This deficient practice affected five (5) of five (5) smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.

The findings include:

1. During the Life Safety Code survey on December 7, 2010, at 9:25 a.m., with the Director of Maintenance (DOM), paint or caulking was noted on a sprinkler head in room 150. Foreign matter on sprinkler heads decreases their ability

**ID Prefix Tag K062**

Sprinkler Heads located in room 150, 114, corridor next to room 113, employee break room, SDC office, nourishment room and kitchen area were cleaned on December 9, 2010. The storage in the kitchen and central supply areas that was within 18 inches of the sprinkler heads was removed on December 9, 2010. Copy of the 5 year interior pipe inspection report was faxed to OIG office.

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062	<p>Continued From page 10</p> <p>to react as intended in a fire situation. During the survey dirty sprinkler heads were observed in the corridor next to room 113, resident room 114, employee break room, staff development office, nourishment room, and the kitchen area. The facility was cited for the same deficient practice in October 2008.</p> <p>In addition, at 9:30 a.m. on December 7, 2010, storage was noted within 18 inches of the sprinkler head in the central supply room and kitchen storage area. A proper distance must be maintained from sprinkler heads for proper operation.</p> <p>An interview with the DOM on December 7, 2010, at 9:25 a.m. and 9:30 a.m., revealed the DOM was not aware foreign matter should be kept off of sprinkler heads. In addition, the DOM stated he had made staff aware items in the storage areas were stored too close to the sprinkler heads and the items needed to be moved; however, staff did not follow the DOM's advice.</p> <p>2. A record review with the DOM on December 7, 2010, at 11:20 a.m., revealed no documentation of a required interior pipe inspection. This inspection ensures the sprinkler system reacts as intended. The DOM stated the DOM would contact the sprinkler contractor and attain a copy of the report to provide the surveyor; however, a copy of the inspection report was not provided.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper</p>	K 062	<p><b>CONF.</b></p> <p>Director of Maintenance will make rounds of facility and review all sprinklers heads for dust or paint. Any sprinklers heads found to have paint or dust on them will be cleaned and/or replaced. Director of Maintenance will make rounds of the facility and review all storage areas to ensure there is nothing within 18 inches of the sprinkler heads.</p> <p>Director and Assistant Director of Maintenance were in serviced by Administrator on continuously maintaining sprinklers keeping them free from corrosion and foreign materials and keeping storage items the proper distance from sprinkler heads.</p> <p>The Physical Plant QI Team will make monthly rounds to assess for any needed repairs for the next 12 months to ensure deficient practice does not recur.</p> <p>January 22, 2011</p>	1/22/11	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185243</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF PINEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977</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
K 062	<p>Continued From page 11</p> <p>orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-6.6* Clearance to Storage (Standard Pendent and Upright Spray Sprinklers). The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Exception: Where other standards specify greater minimums, they shall be followed.</p> <p>A-5-6.6 The 18-in. (0.46-mm) dimension is not intended to limit the height of shelving on a wall or shelving against a wall in accordance with 5-6.6. Where</p>	K 062		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 12 shelving is installed on a wall and is not directly below sprinklers, the shelves, including storage thereon, can extend above the level of a plane located 18 in. (0.46 mm) below ceiling sprinkler deflectors. Shelving, and any storage thereon, directly below the sprinklers cannot extend above a plane located 18 in. (0.46 mm) below the ceiling sprinkler deflectors.	K 062		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain oxygen storage rooms as required. This deficient practice affected two (2) of five (5) smoke compartments, staff, and approximately forty-five (45) residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.  The findings include:  During the Life Safety Code survey on December 7, 2010, at 9:30 a.m., with the Director of	K 076	<b><u>ID Prefix Tag K076</u></b>  Oxygen storage signs were place on the East and West Oxygen Storage rooms. All oxygen tanks were secured and separated on December 8, 2010.  The Director of Maintenance will make a tour of the facility and check for any oxygen tanks not in the labeled storage areas. Based on the findings appropriate actions will be taken to put the tanks in the appropriate label area.  All staff will be in serviced on January 6, 2011 on placing oxygen tanks in the correct secured and labeled storage areas.	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977		
(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 076	Continued From page 13 Maintenance (DOM), four oxygen cylinders were observed to be unsecured at the West oxygen storage room. The full and empty oxygen cylinders were also noted not to be separated and with the proper signage as required. In addition the East Wing oxygen storage room was observed to have an unsecured oxygen tank and no signage on the corridor door to indicate the room was an oxygen storage area. An interview with the DOM on December 7, 2010, at 9:30 a.m., revealed the nurses and nurse aides were responsible for securing the oxygen tanks. The DOM stated the facility had been remodeling and the proper signage was not replaced after the remodeling.  Reference: NFPA 99 (1999 Edition).  4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.  4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.  4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.  8-3.1.11.3 Signs.	K 076	CONT.  The safety committee will make monthly rounds to assess for any oxygen tanks not in the correct areas, and to ensure all areas are properly labeled. Findings will be reported at the monthly QI meeting.  January 22, 2011	1/22/11	

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 076	Continued From page 14 A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076	<p><b><u>ID Prefix Tag K147</u></b></p> <p>Installation of a permanent generator will begin on January 17, 2011 by CTE, Inc.</p> <p>The Director of Maintenance inspected the facility for any other extension cords/flexible cords/cables used as a substitute for permanent wiring.</p> <p>The Maintenance Department was in serviced by the Administrator on December 29, 2010 on Life Safety Code Standards specifically K 147.</p> <p>The Safety Committee will make monthly rounds to ensure there are no flexible cords/cables being used as a substitute for permanent wiring.</p> <p>January 22, 2011</p>	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical wiring and standards met NFPA requirements. This deficient practice affected five (5) of five (5) smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey.  The findings include:  During the Life Safety Code tour on December 7, 2010, at 10:20 a.m., with the Director of Maintenance (DOM), three extension cords were noted to be utilized for components associated with the exterior emergency generator set. These components are essential for the proper operation of the emergency generator. The extension cords were observed to be in a walkway making them prone to damage. One extension cord was observed to be damaged by passing through a doorway. Extension cords are	K 147		

1/22/11

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2010
NAME OF PROVIDER OR SUPPLIER  BRITTHAVEN OF PINEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 147	<p>Continued From page 15</p> <p>not a substitute for required permanent wiring. An interview with the DOM on December 7, 2010, at 10:20 a.m., revealed the generator had been connected by extension cords this way for about two years. The DOM stated the DOM was not aware the generator should not be permanently connected by extension cords.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted</p> <p>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces</li> </ol> <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <ol style="list-style-type: none"> <li>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>6. Where installed in raceways, except as otherwise permitted in this Code</li> </ol> <p>Reference: NFPA 101 (2000 Edition).</p> <p>4.5.7 Maintenance.</p> <p>Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such</p>	K 147		

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

PRINTED: 12/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185243</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/07/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRITTHAVEN OF PINEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977</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	
K 147	Continued From page 16 device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.	K 147			