

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

PRINTED: 11/15/2010

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		<div style="border: 2px solid black; padding: 5px; text-align: center;"> R E C E I V E D NOV 24 2010 10/28/2010 </div>
NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF SOMERSET			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A standard health survey was conducted on October 26-28, 2010. Deficient practice was identified with the highest scope and severity at 'F' level, with no substandard quality of care identified.	F 000	DISCLAIMER: 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 provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Britthaven's response to this Statement of Deficiencies 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 refute any of the 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

TITLE

(X6) DATE

[Signature]

Admin

11/24/10

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.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the physician for one (1) of thirty-one (31) sampled residents when resident #6 exceeded his/her fluid restriction.</p> <p>The findings include:</p> <p>A review of the medical record for resident #6 revealed the resident had been admitted to the facility on July 27, 2010, with diagnoses to include End Stage Renal Disease on Hemodialysis, Diabetes Mellitus, Asthma, and Seizure Disorder. The medical record further revealed a physician's order dated October 1, 2010, for resident #6 to be required to have a 1500-milliliter (ml) fluid restriction per day. A review of the Individual Hydration Pass record for resident #6 revealed the resident had exceeded the fluid restriction on 17 days from October 1, 2010 through October 27, 2010. A review of the nurse's notes for resident #6 revealed no documentation the physician for resident #6 had been notified that resident #6 exceeded the fluid restriction on those days. In addition, review of the 24-hour report sheet for the Second Floor of the facility for October 2010 revealed no documentation reporting resident #6 exceeded the fluid restrictions.</p> <p>An observation of resident #6 on October 26, 2010, at 12:05 p.m., revealed the resident eating lunch in bed. The resident had a water pitcher sitting on the bedside table full of ice. The resident stated the staff "fill up my water pitcher</p>	F 157	<p>The Attending Physician for resident #6 of the sample was notified on 10/28/10 the resident had been non-compliant with her fluid restrictions.</p> <p>The resident care guide, intake record and chart were all more clearly marked using a neon colored sticker with notation identifying the resident's fluid restrictions. The Unit Coordinator will mark these documents for any future resident with fluid restrictions.</p> <p>Intake records for residents with fluid restrictions were reviewed on 11/15/10 by the quality assurance team. All non-compliance with fluid restrictions were reported to the resident's Attending Physician.</p> <p>Staff re-education was initiated by the Staff Development Nurse on October 26, 2010 related to checking care guides. Residents with fluid restrictions were added to the quality assurance monitoring program for weight reviews. This monitoring will be conducted per the established schedule for "weekly weights." Any non-compliance with fluid restrictions will be reported to the Attending Physician by the Unit Coordinator or designee.</p> <p>Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated.</p> <p>Date of Completion</p>	12/03/10
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F 157	Continued From page 2 with ice two or three times every day." A review of the facility's policy titled Notification of Physician, dated April 2007, revealed it is the policy of the facility to notify the physician when a significant change in a resident's condition is documented. An interview was conducted with the Unit Manager (UM) on the Second Floor of the facility on October 28, 2010, at 4:40 p.m. The Unit Manager revealed the night shift nurse is required to total the residents' intakes and outputs for the previous 24 hours and document the totals in the Hydration Pass record. The UM further stated the night shift nurse was required to document on the 24-hour report sheet for the day shift nurse to notify the physician of the resident exceeding the fluid restrictions. The UM could provide no evidence the physician of resident #8 had been notified of the resident exceeding the fluid restrictions, which had been ordered by the resident's physician. An interview was conducted with the Director of Nursing (DON) for the facility on October 28, 2010, at 4:00 p.m. The DON confirmed the night shift nurses were required to total the residents' 24-hour intakes and outputs and if residents exceeded the 24-hour fluid restriction, the night shift nurse would be expected to notify the resident's physician the same day the documentation was placed on the 24-hour report sheet.	F 157	[THIS SECTION INTENTIONALLY BLANK]	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: The facility failed to meet professional standards of quality for three (3) of thirty-one (31) sampled residents. The facility failed to follow physician's orders for residents #1, #6, and #19. Resident #6 had a physician's order for a fluid restriction; however, the facility failed to follow the physician's order. Resident #1 had a physician's order for a puree diet with nectar-thickened liquids; however, an observation of resident #1 revealed the resident had a water pitcher with thin liquids at the bedside. In addition, resident #19 had an order for oxygen at two (2) liters per nasal cannula; however, observations of the resident revealed the resident's oxygen was not turned on. The findings include: 1. An observation on October 26, 2010, at 12:05 p.m., revealed resident #6 eating lunch in bed. The resident had baked chicken, baked potato, broccoli, biscuit, peaches, and milk on the food tray. A water pitcher full of ice was sitting on the resident's overbed table. A review of the medical record for resident #6 revealed the resident had been admitted to the facility on July 27, 2010, with diagnoses to include End Stage Renal Disease on Hemodialysis, Diabetes Mellitus, Asthma, and Seizure Disorder. The medical record further revealed a physician's order dated October 1, 2010, for resident #6 to have a 1500-milliliter (ml) fluid restriction per day. A review of the Individual Hydration Pass record for resident #6 revealed the resident had exceeded the fluid restriction on 17 days from	F 281	The water pitcher and cup were immediately removed from the room of resident #1 of the sample by the staff member upon identification of their presence on 10/26/2010. The resident care guide was updated by the Director of Nursing to reflect the resident's order for nectar-thick liquids. The diet card for resident #6 of the sample was revised on 10/28/10 eliminating the "encourage fluids" directive. The Attending Physician for resident #6 of the sample was notified of the resident's non-compliance with his/her restrictions. Resident #6 of the sample was provided re-education related to her restrictions by the RN Unit Coordinator on 10/28/2010. The care guide, intake sheet and chart for resident #6 of the sample were more clearly marked using a neon sticker to indicate her restrictions. The oxygen concentrator for resident #19 of the sample was turned on at 10:20 on 10/27/2010. On 10/26/2010 the Quality Assurance Nurse identified all residents on thickened liquids, all residents with fluid restrictions, and all residents receiving oxygen therapy. The administrative nurses for each unit ensured that those residents who receive thickened liquids had no thin liquids at the bedside and verified the accuracy of the careguide on 10/26/2010. The nurse responsible for updating the resident care guide was provided re-education on 10/26/2010 by the Director of Nursing.		

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F 281	<p>Continued From page 4</p> <p>October 1, 2010 through October 27, 2010. A review of the Weekly Hydration and Vital Sign Monitoring sheet dated October 23, 2010, revealed the resident averaged 1594 milliliters for the previous seven days.</p> <p>A review of the diet card used by the dietary staff to prepare the trays for resident #6 revealed the resident was to be on a regular, consistent carbohydrate diet with no potatoes, orange juice, or bananas, and to encourage fluids.</p> <p>An interview with the Registered Dietitian (RD) on October 28, 2010, at 1:50 p.m., revealed resident #6's diet card should not state to encourage fluids and the resident should not have had a water pitcher at the bedside. The RD further stated resident #6 should not have received the baked potato, and Dietary had made a mistake while preparing the resident's tray. The RD stated during tray preparation a staff member calls out the resident's diet order to the cook, who then puts the appropriate food on the tray.</p> <p>An interview conducted with the Assistant Dietary Manager (ADM) on October 28, 2010, at 2:00 p.m., revealed the Dietary Department received a Hydration List from the Nursing Department. The ADM stated residents who are on the Hydration List will have "encourage fluids" listed on the diet card on the resident's tray. According to the ADM, resident #6 had been placed on the Hydration list on October 26, 2010.</p> <p>An interview was conducted with the Quality Assurance (QA) Nurse on October 28, 2010, at 4:15 p.m. The QA Nurse stated the Hydration List is generated by the Quality Assurance Department of the facility and then sent to the</p>	F 281	<p>The Food Service Manager verified the accuracy of the diet card for each resident with fluid restrictions on 10/27/2010. Staff re-education related to the use of the residents' first and last names during meal service was initiated by the Staff Development Nurse on 11/18/2010.</p> <p>The administrative nurses for each unit ensured that all residents with oxygen therapy were receiving oxygen per the care guide. Staff education was initiated by the Staff Development Nurse on related to reviewing and following the resident care guides and reporting to the nurse if oxygen is observed to be not applied as identified on the care guide 10/26/2010.</p> <p>The Quality Assurance Nurse or designee will select a random sample of residents who receive thickened liquids, a random sample of residents who have restricted diets and a random sample of residents who receive oxygen therapy. The Quality Assurance Nurse or designee will conduct an audit to ensure the care guides for residents in the sample are accurate to the physicians orders, and that the care and services provided to the residents' in the sample match the resident care guide.</p> <p>This audit will be conducted weekly for four weeks and then per the established qj calendar.</p> <p>Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated.</p>		

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F 281	<p>Continued From page 5</p> <p>Dietary Department. The QA Nurse further revealed the Hydration List is generated from information obtained from the Weekly Hydration and Vital Sign Monitoring form. The QA Nurse stated if the resident is below the recommended daily fluid requirement the resident would then be placed on the Hydration List and the list sent to Dietary. The QA Nurse further revealed the list the nurses were using had not been updated to reflect the fluid restriction for resident #6.</p> <p>A review of the facility policy titled Diets, with a date of December 12, 2008, revealed no water pitcher would be kept at the bedside for residents with a fluid restriction, and total daily fluids, including meals, snacks, and medication pass, were not to exceed the restricted amount.</p> <p>2. A review of the medical record revealed resident #1 was admitted to the facility on February 12, 2010, with diagnoses to include Encephalopathy, Diabetes Mellitus, Seizure Disorder, Hypertension, and Chronic Obstructive Pulmonary Disease. A review of the current physician's orders dated October 2010 revealed the resident's current diet order was for a puree diet with nectar-thickened liquids, no straws, and to drink sips of fluid from a cup.</p> <p>An interview conducted with the Speech Therapist (ST) on October 27, 2010, at 11:30 a.m., revealed the ST had conducted a dysphagia evaluation on August 30, 2010, due to the resident's recent hospital stay secondary to pneumonia. The ST stated nectar-thickened liquids had been recommended at that time due to dysphagia.</p> <p>Resident #1 was observed on October 26, 2010,</p>	F 281	Date of Completion	12/03/2010

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F 281	<p>Continued From page 6</p> <p>at 4:15 p.m., to be lying on a low bed. A water pitcher and a clear plastic cup containing thin liquid were noted to be sitting on the resident's overbed table.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #1 on October 26, 2010, at 4:35 p.m., revealed CNA #1 was aware the resident was on thickened liquids. CNA #1 stated the CNAs were required to verify a resident's diet order by checking a box kept at the nurses' station which contained all the residents' diet orders. CNA #1 stated he/she did not fill resident #1's water pitcher and cup with thin liquids.</p> <p>An interview conducted with CNA #2 on October 26, 2010, at 4:50 p.m., revealed CNA #2 was not aware the resident required thickened liquids. CNA #2 stated if a resident required thickened liquids a small cooler would be kept at the resident's bedside for thickened liquids and that the resident would not have a water pitcher. CNA #2 further stated a CNA care guide was kept inside each resident's closet; however, the CNA was not sure if thickened liquids would be identified on the care guide.</p> <p>A review of the CNA care guide revealed resident #1's diet was identified to be mechanical soft with thin liquids with sips from a cup only. There was no evidence the CNA care guide had been updated to reflect the current diet order.</p> <p>An interview conducted with the MDS Nurse on October 28, 2010, at 11:05 a.m., revealed the MDS Nurse was responsible to update the resident's care guide daily. The MDS Nurse stated when a new physician's order was obtained the MDS Nurse received a copy of the</p>	F 281	[THIS SECTION INTENTIONALLY BLANK]	

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F 281	<p>Continued From page 7</p> <p>order and updated the resident's care guide. The MDS Nurse stated he/she had failed to update resident #1's CNA care guide to reflect the current diet order.</p> <p>3. Review of the medical record revealed resident #19 was admitted to the facility on September 16, 2010, with diagnoses of Transurethral Resection of Prostate, Dyspnea, Cerebral Vascular Accident, Anemia, Benign Prostate Hypertrophy (BPH), Hypertension, Coronary Artery Disease, Anxiety, and Coronary Artery Bypass Graft.</p> <p>Review of the Minimum Data Set (MDS) dated September 21, 2010, revealed the facility assessed the resident as having both short and long-term memory problems, as requiring extensive assistance to transfer, as being unable to ambulate, as being incontinent of bladder with a Foley catheter to bedside drainage, and the use of continuous oxygen.</p> <p>Review of physician's orders dated October 4, 2010, revealed orders for oxygen at two liters per minute per nasal cannula continuous, for a diagnosis of Coronary Artery Disease.</p> <p>Observation of resident #19 on October 26, 2010, at 5:45 p.m., revealed the resident was receiving oxygen via nasal cannula at two liters per minute.</p> <p>Observation of resident #19 on October 27, 2010, at 10:20 a.m., revealed the resident was lying in bed with the nasal cannula in the nostrils; however, the oxygen concentrator was turned off.</p> <p>Observation on October 27, 2010, at 10:20 a.m., revealed State Registered Nurse Aide (SRNA) #5</p>	F 281	[THIS SECTION INTENTIONALLY BLANK]		

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F 281	Continued From page 8 was turning on the oxygen concentrator for resident #19. Interview with SRNA #5 on October 27, 2010, at 10:20 a.m., revealed SRNA #5 turned on the oxygen concentrator for resident #19 because the nurse aide care plan on the closet door stated he/she should have oxygen at all times. Interview on October 27, 2010, at 10:35 a.m., with Licensed Practical Nurse (LPN) #1, the nurse responsible for resident #19 on this date, revealed resident #19 had an order for continuous oxygen and he/she was unsure why the resident's oxygen was off or how long it had been off. The LPN revealed maybe because it had been such a busy day with the call-in but this was no excuse. According to the facility's policy for Physician's Orders, dated April 2007, on the day of admission an evaluation of the resident's immediate and long-term needs is initiated to include the following: Resident Plan of Care, Medications, Treatments, Restorative Services, Diet, Activities, Social History, and Discharge Planning. Physician's orders are in effect every 30 days for 90 days and then monthly. Telephone orders may be accepted by a licensed nurse. Further review of this policy did not address implementing physician's orders.	F 281	[THIS SECTION INTENTIONALLY BLANK]	
F 315	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	<p>Continued From page 9</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide care and services to prevent infection for (1) one of (31) thirty-one residents. Resident #19's urinary catheter tubing was observed on the floor while the resident was in the wheelchair sitting in the hallway and also while being transferred in the wheelchair from the hallway to the activity room.</p> <p>The findings include:</p> <p>Review of the medical record revealed resident #19 was admitted to the facility on September 16, 2010, with diagnoses of Transurethral Resection of Prostate, Dyspnea, Cerebral Vascular Accident, Anemia, Benign Prostate Hypertrophy (BPH), Hypertension, Coronary Artery Disease, Anxiety, and Coronary Artery Bypass Graft.</p> <p>Review of the Minimum Data Set (MDS) dated September 21, 2010, revealed the facility assessed the resident as having both short and long-term memory problems, as requiring extensive assistance to transfer, as being unable to ambulate, as being incontinent of bladder with a Foley catheter to bedside drainage, and the use of continuous oxygen.</p> <p>Review of physician's orders dated October 4, 2010, revealed orders for a Foley catheter to</p>	F 315	<p>The catheter tubing for resident #19 was repositioned on October 26, 2010 in order that it was not touching the floor.</p> <p>The Quality Assurance Nurse identified all residents with indwelling catheters. The Unit Coordinator for each unit verified that the catheter drainage system for each of these residents was applied and positioned appropriately per infection control standards.</p> <p>Staff re-education was initiated by the Staff Development Nurse on 10/27/2010 directing staff that tubing must not rest on or drag the floor, and that catheter tubing should be coiled and secured with the plastic clip as needed.</p> <p>The Quality Assurance Nurse or designee will select a random sample of residents with indwelling catheters. The Quality Assurance Nurse or designee will conduct an audit to ensure the catheter drainage systems are being maintained per infection control guidelines. This audit will be conducted weekly for four weeks and then per the established qi calendar.</p> <p>Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated.</p> <p>Date of Completion</p>	12/03/2010	

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF SOMERSET			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501	
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F 315	<p>Continued From page 10</p> <p>bedside drainage, to change every month and PRN for dislodgement, occlusion, or leakage for a diagnosis of BPH.</p> <p>Observation of resident #19 on October 26, 2010, from 5:45-6:00 p.m. revealed resident #19 was in a wheelchair sitting in the hallway with the resident's Foley catheter tubing lying on the floor and the resident kicking the tubing with his/her feet.</p> <p>Interview with the Unit Manager for the Third Floor on October 26, 2010, at 6:00 p.m., revealed, "I don't know what I am supposed to do with the extra tubing; if I raise it any more it will kink off."</p> <p>Observation of the Activity Director on October 26, 2010, at 6:00 p.m., revealed the Activity Director transferred resident #19 in the wheelchair from the hallway to the activity room. The Foley catheter tubing was observed on floor while the resident was being transferred.</p> <p>Interview with Activity Director on October 26, 2010, at 6:10 p.m., revealed he/she had not been trained regarding infection control practices with catheters. The Activity Director stated he/she did not notice the Foley catheter tubing on the floor and did not know that the resident had a Foley catheter.</p> <p>The facility policy for Closed Urinary Drainage System, dated April 2007, revealed the facility would provide continuous drainage of the obstructed or paralyzed bladder. Furthermore, the policy stated the drainage bag should be attached to the bed frame, below level of resident's bladder, not touching the floor.</p>	F 315	[THIS SECTION INTENTIONALLY BLANK]	

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F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility</p>	F 431	<p>Medications in the second floor medication storage identified as not dated were marked as opened on the date dispensed by the pharmacist and disposal protocols followed.</p> <p>On October 28, 2010 licensed nurses audited all liquid medications in carts and storage rooms and did not locate any additional medications without an open date.</p> <p>The RN Unit Coordinator and RN Charge Nurse responsible for the 2nd floor medication storage were provided reeducation on 10/28/2010 by the Director of Nursing and nurse consultant related to dating medications when opened.</p> <p>The Quality Assurance Nurse or designee will select a random sample of residents who receive liquid medications and conduct an audit to ensure the medications are dated when opened..</p> <p>This audit will be conducted weekly for four weeks and then per the established qi calendar.</p> <p>Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated.</p> <p style="text-align: right;">Date of Completion</p>	12/03/2010	

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F 431	<p>Continued From page 12</p> <p>failed to label all drugs and biologicals used in the facility in accordance with currently accepted professional principles including the expiration date when applicable. One (1) bottle of ophthalmic solution and five (5) bottles of liquid medications, stored in the second floor medication room, were opened and not dated to indicate when the medications had been opened.</p> <p>The findings include:</p> <p>Observation of the Second Floor Medication Storage Room on October 28, 2010, at 3:10 p.m., revealed one bottle of Tobramycin ophthalmic solution was opened and not dated as to when the medication had been opened. In addition, five bottles of liquid medications were opened and not dated: Ferrous Sulfate 220 mg/5 ml, Metoclopram solution 5 mg/5 ml, Dilantin 125 mg/5 ml, Centrum vitamin, and Enulose 10 gm/15 ml.</p> <p>An interview conducted with the Director of Nurses (DON) on October 28, 2010, at 3:25 p.m., revealed the facility did not have a written policy/procedure to address the labeling/dating of eye medications and liquid medications. However, the DON stated the staff had been trained to date all eye and liquid medications when initially opening these medications.</p>	F 431			
F 456 SS=F	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 456	<p>The Director of Maintenance and Food Service Manager and Registered Dietitian were immediately notified of the frost/ice build-up in dietary freezer #3. The freezer was determined to be holding temperature appropriately, and all food in the freezer was in manufacturer sealed containers. A service technician as on-site within one hour and determined the freezer condenser to have a</p>		

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F 456	<p>Continued From page 13</p> <p>by:</p> <p>Based on observation and interview, the facility failed to maintain all essential mechanical and electrical equipment in safe operating condition. The medication refrigerator/freezer on the West Wing contained heavy ice buildup. In addition, the #3 reach-in freezer in the Dietary Department contained a heavy buildup of frozen condensation/ice under/around the middle and right-end compartment(s) condenser units.</p> <p>The findings include:</p> <ol style="list-style-type: none"> During a final four conducted of the facility Dietary Department on October 28, 2010, at 11:00 a.m., the #3 reach-in freezer contained a large buildup of frost and ice on/under the motor/condenser unit of the middle and right-end compartment unit(s) as well as the ceilings of the two compartments. The frozen condensation had the potential to contaminate the frozen food products stored inside the reach-in freezer. <p>An interview conducted with the facility Assistant Dietary Manager (ADM) on October 28, 2010, revealed the ADM was unaware of the condensation buildup, and had not notified the facility Maintenance Supervisor of the problem.</p> <ol style="list-style-type: none"> Observation of the medication storage room on the West Wing on October 28, 2010, at 2:45 p.m., revealed the medication refrigerator contained a heavy buildup of ice in the freezer compartment. <p>An interview conducted with the Unit Manager (UM) on October 28, 2010, at 2:55 p.m., revealed the night shift nurse was responsible to check for defrosting the medication refrigerator each</p>	F 456	<p>clogged drain. The freezer was repaired and defrosted itself appropriately within approximately 90 minutes of the problem being identified.</p> <p>The Unit Coordinator for west wing moved the medications to another medication storage refrigerator, and an environmental services worker defrosted the medication storage refrigerator on 10/28/10.</p> <p>The Administrator and Food Service Manager reviewed the issue with freezer number three and the policy/procedure for monitoring the food service refrigeration equipment. The Administrator, two Registered Dietitians and the food service staff had audited the equipment within the 24 hours prior to the event and identified no issue with the equipment.</p> <p>The issue with the equipment is believed to have initiated following the morning check of the equipment and prior to the evening check of the equipment for proper functioning.</p> <p>Interviews and actions of the dietary staff on 10/28/2010 demonstrated appropriate knowledge and actions related to contacting maintenance and administration, and having the equipment immediately repaired.</p> <p>The Unit Coordinators checked all medication storage refrigerators and determined that no other medication storage refrigerator had ice buildup inside.</p> <p>The Quality Assurance Nurse revised the weekly audit tool used by the night shift</p>	

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F 456	Continued From page 14 Monday night. The UM stated he/she was responsible for ensuring the medication refrigerator/rooms were kept clean. The UM stated he/she had not identified the ice buildup in the medication refrigerator freezer.	F 456	nurse to report the medication room needs to the nursing administration to include the need for the refrigerator to be defrosted. The Quality Assurance Nurse or designee will randomly audit the medication storage refrigerators for ice build up, and correct any issues identified. The food service manager or designee will randomly audit the food service refrigeration equipment for ice build up and will correct any issues identified. These audits will be conducted weekly for four weeks and then per the established qi calendar. Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated. Date of Completion	12/03/2010	

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K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on October 28, 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected nine (9) of nine (9) smoke compartments, staff, and one hundred twenty-five (125) residents. The facility has the capacity for 136 beds with a census of 125 on the day of the survey.</p>	K 000	<p>DISCLAIMER:</p> <p>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 provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>K 052 Britthaven's response to this Statement of Deficiencies 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 refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>The facility's fire monitoring system contractor was contacted regarding the citation. The contractor presented the facility Administrator with a scope of work on 11/23/10 to modify electronics that control the fire doors so that they remain closed until the system is fully reset, not when the alarms are silenced. The scope was accepted on 11/24/10 and will be completed as soon as necessary parts are received. building two's fire doors remain closed until the alarm is fully reset.</p> <p>The facility administrator will oversee any modification to the fire monitoring system. The contractor was provided information on 11/19/10 regarding the citation.</p>	
K 052 SS=F		K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator 11/24/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Nov. 24, 2010 10:13PM No. 4521

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K 052	Continued From page 1 The findings include: During the Life Safety Code tour on October 28, 2010, at 11:00 a.m., with the Director of Maintenance (DOM) a test of the facility fire alarm system revealed the fire doors would close when the alarm was activated but could be reset while in the silent mode to the open position while the system was still showing fire conditions. An interview with the DOM on October 28, 2010, at 11:00 a.m., revealed the DOM was not aware fire doors should not be able to be reset while the fire alarm system was still showing fire conditions. Reference: NFPA 72 (1999 Edition). 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052	The Director of Maintenance or designee will oversee and maintain the fire detection/monitoring/extinguishing service company's inspections and system maintenance to include that fire doors function per regulation per the established maintenance and inspection schedule. Date of Completion	12/03/2010
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	A work order for removal of the canopy constructed of combustible materials was completed and removal of the canopy is scheduled for the week of 11/28/10 - 12/03/10. The Administrator reviewed all other fire exits and determined that the additional canopies are constructed of non-combustible materials. The facility Administrator provided information demonstrating that any canopies in excess of four feet which cover a fire exit must be constructed of non-combustible materials to the Director of Maintenance and	

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K 056	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a combustible canopy at the back of the facility was sprinkler protected as required. The findings include: During the Life Safety Code survey on October 28, 2010, at 9:30 a.m., with the Director of Maintenance (DOM), a combustible canopy approximately 9 feet by 12 feet, located at the back stairwell exit of the facility, was observed not to be of noncombustible construction or sprinkler protected. Combustible canopies exceeding four feet in width must be sprinkler protected. An interview with the DOM on October 28, 2010, at 9:30 a.m., revealed the DOM was not aware of this requirement. Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	Director of Environmental Services on 11/16/10. The facility Administrator or designee will review any plans for construction of awnings in excess of four feet to ensure they are constructed of appropriate materials. Date of Completion	12/03/2010
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	The direct care staff removed the items from the corridor and placed them in the appropriate storage locations. All other corridors were checked by the Unit Coordinators to ensure that equipment was not being stored in them.	

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K 072	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected three (3) of three (3) smoke compartments, staff, and twenty-nine (29) residents. The facility has the capacity for 136 beds with a census of 125 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on October 28, 2010, at 10:50 a.m., with the Director of Maintenance (DOM) a linen cart, wheelchair, two lifts, and a three-bag roller cart were noted to be not in use and unattended on the first floor corridors. On October 28, 2010, at 11:25 a.m., an interview with the (DOM) revealed staff had been made aware in the past these items were to be stored when not in use. Corridors are intended for means of egress, internal traffic, and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed. These items could also interfere with emergency services in an emergency situation. The facility was cited in 2007 and 2008 for this same deficient practice.</p>	K 072	<p>On 10/28/10 the Staff Development Nurse initiated staff reeducation related to proper storage of equipment when not in use.</p> <p>The director of environmental services or designee will conduct random audits of the corridors to ensure that equipment is returned to the proper storage location after use.</p> <p>These audits will be conducted weekly for four weeks and then per the established qi calendar.</p> <p>Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated.</p> <p style="text-align: center;">Date of Completion</p>	12/03/2010	

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF SOMERSET			STREET ADDRESS, CITY, STATE, ZIP CODE 565 BOURNE AVENUE SOMERSET, KY 42501		
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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on October 28, 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	DISCLAIMER: Brithaven 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 provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a corridor could resist the passage of smoke as required. This deficient practice affected one (1) of two (2) smoke compartments, staff, and approximately twenty (20) residents. The facility has the capacity for 30 beds with a census of 28 on the day of the survey. The findings include: During the Life Safety Code tour on October 28, 2010, at 11:30 a.m., with the Director of Maintenance (DOM) a ventilation grill was observed in the bottom half of a corridor door to	K 018	Brithaven's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Brithaven reserves the right to refute any of the 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

TITLE

(X6) DATE

[Signature]

Administrator

11/24/10

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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185152	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF SOMERSET			STREET ADDRESS, CITY, STATE, ZIP CODE 555 BOURNE AVENUE SOMERSET, KY 42501		
(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 018	Continued From page 1 the Nourishment Room. This grill is not an approved device for this type of room. An interview on October 28, 2010, at 11:30 a.m., with the DOM revealed the grill was put there to help cool off equipment located in the room. The DOM was unaware this type of grill was not an approved device. Reference: NFPA 101 (2000 Edition), 19.3.6.3 Corridor Doors. 19.3.6.4 Transfer Grilles. Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in these walls or doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall be permitted to have ventilating louvers or to be undercut. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches	K 018	A metal plate was placed over the ventilation grille in the door to the nourishment room. All doors opening to corridors used for emergency exit by from resident rooms were inspected and determined not to have ventilation grilles. The facility Administrator provided information to the Director of Maintenance on 11/16/10 related to transfer grilles. The facility Administrator will review and approve any future modification to doors that access patient care areas or paths of egress. Date of Completion	12/03/2010	
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	K 052	The facility's fire monitoring system contractor was contacted regarding the citation. The alarm systems are interconnected and are capable of simultaneous full load operation without degradaion of the required overall system		

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NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF SOMERSET			STREET ADDRESS, CITY, STATE, ZIP CODE 655 BOURNE AVENUE SOMERSET, KY 42501		
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K 052	<p>Continued From page 2</p> <p>and testing program complying with applicable requirements of NFPA 70 and 72. . 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected two (2) of two (2) smoke compartments, staff, and twenty-eight (28) residents. The facility has the capacity for 30 beds with a census of 28 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on October 28, 2010, at 11:40 a.m., an interview with the Director of Maintenance revealed the West Wing (new building) fire alarm panel was not interconnected to the fire alarm panel of the existing facility. The Director of Maintenance stated the fire alarm contractor stated since the West Wing was separated from the existing facility by a two-hour fire barrier the West Wing fire alarm system could function independently from the existing facility. The fire alarm systems of these two buildings are required to function as a single system.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>5-5.2.1.3 For multiple building premises, the requirements of 1-5.7.4 shall apply to the alarm, supervisory, and trouble signals transmitted to the supervising</p>	K 052	<p>performance. The fire monitoring system contractor will install a component card into the fire alarm system which will activate the audio/visual components of both alarms regardless of which is triggered.</p> <p>The building two components already trigger building one components. The facility Administrator will oversee any modification to The fire monitoring system. The contractor was provided information on 11/19/10 regarding the citation.</p> <p>The Director of Maintenance or designee will oversee and maintain the fire detection/monitoring/extinguishing service company's inspections and system maintenance to include that each system will activate the other per the established maintenance and inspection schedule. Date of Completion</p>	12/03/2010	

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K 052	Continued From page 3 station. 1-5.7.4 If the system serves more than one building, each building shall be indicated separately. 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 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 stand alone 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	[THIS SECTION INTENTIONALLY BLANK]	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected two (2) of two (2) smoke compartments, staff, and twenty-eight (28) residents. The facility has the capacity for 30	K 072		

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K 072	Continued From page 4 beds with a census of 28 on the day of the survey. The findings include: During the Life Safety Code tour on October 28, 2010, at 11:50 a.m., with the Director of Maintenance, a linen cart and two lifts were observed in the corridor. An interview with a staff member on October 28, 2010, at 11:50 a.m., revealed these types of items are routinely left to one side of the corridor throughout the facility. The staff member stated residents had the option to use the handrail at the opposite side of the corridor if the resident needed to use the handrail. The staff member stated that he/she had never been instructed to store these items when they are not in use. Corridors are intended for means of egress, internal traffic, and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the handrails by occupants of the building when needed. These items could also interfere with emergency services in an emergency situation. The facility was cited in 2007 and 2008 for this same deficient practice.	K 072	The direct care staff removed the items from the corridor and placed them in the appropriate storage locations. All other corridors were checked by the Unit Coordinators to ensure that equipment was not being stored in them. On 10/28/10 the Staff Development Nurse initiated staff reeducation related to proper storage of equipment when not in use. The Director of Environmental services or designee will conduct random audits of the corridors to ensure that equipment is returned to the proper storage location after use. These audits will be conducted weekly for four weeks and then per the established qi calendar. Results of these audits will be presented to the quality improvement team based on the established schedule. Identified issues will be corrected and addressed as indicated. Date of Completion	12/03/2010