#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/29/2021 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u> NMR NO.</u>	<u>0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
,		185013	B. WING _				x )1/2021
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE GROUP, LLC				STREET ADDRESS, CITY, S 55 EAST NORTH STREE MADISONVILLE, KY	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOUL CED TO THE APPROF FICIENCY)	D BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	тѕ	{F 000	)}			
	determined the fac	conducted on 03/01/2021, ility was in compliance on ged in the acceptable PoC.					
		0584					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE			(X6) DATE

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

03/16/2021

**Electronically Signed** 

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 12/16/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

		185013	B. WING		10/28/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DDIOUTÉ	N AARNERSTANS ASS	WID 11.6		55 EAST NORTH STREET	
BRIGHTO	N CORNERSTONE GRO	JUP, LLC		MADISONVILLE, KY 42431	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 000	INITIAL COMMENTS	3	F 00	00	
F 880 SS=D	was initiated on 10/2 10/28/2020 with a designed to provide a "D" The incompliance with 4 control regulations at Centers for Medicare and Centers for Dise (CDC) recommended COVID-19. Total centers for Prevention CFR(s): 483.80(a)(1) §483.80 Infection Control facility must established to provide a designed to provide a service of the facility must established to provide a designed to provide a service of the facility must established to provide a service of the facility must established to provide a service of the facility must established to provide a service of the facility must established to provide a service of the facility must established to provide a service of the facility must established to provide a service of the facility must established to provide a service of the facility of the facility of the facility must established to provide a service of the facility of the f	& Control (2)(4)(e)(f) Introl Introl Introlementalis and maintain and control program	F 88	80	11/20/20
	development and tra diseases and infection §483.80(a) Infection program. The facility must esta	nsmission of communicable ons.  prevention and control  ablish an infection prevention (IPCP) that must include, at			
	reporting, investigating and communicable distaff, volunteers, visit providing services urarrangement based conducted according accepted national staff.	upon the facility assessment to §483.70(e) and following			
ARORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
		OUT LIER REFREGERIATIVE S SIGNATURE		IIILE	
Electronic	cally Signed				11/20/2020
Anv deficiency	statement ending with an a	sterisk (*) denotes a deficiency which the ir	stitution may	be excused from correcting providing it is determined t	hat

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_

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.

NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE GROUP, LLC  (CA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FAUL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 1 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility; EIPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infections.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
BRIGHTON CORNERSTONE GROUP, LLC  (X4) ID  PREFIX TAG  CONTINUED FOR ISSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEPRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 1 procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections should be used for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease, and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a) (A) A system for recording incidents identified under the facility. IPCP and the corrective actions taken by the facility.  Personnel must handle, store, process, and transport linens so as to prevent the spread of			185013	B. WING		10/28/2020	
F 880  Continued From page 1 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (iii) When and to whom possible incidents of communicable disease or infections before they can spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (i) A requirement that the isolation, depending upon the infectious agent or organism involved, and (ii) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of					55 EAST NORTH STREET		
procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections should be reported;  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;  (iv)When and how isolation should be used for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents or their food incommunicable disease; and  (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility.  §483.80(a) Linens.  Personnel must handle, store, process, and transport linens so as to prevent the spread of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION	
§483.80(f) Annual review. The facility will conduct an annual review of its	F 880	procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility: (ii) When and to whore communicable disease reported; (iii) Standard and transto be followed to prevective (iv) When and how isconsident; including but (A) The type and durated depending upon the initial involved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected skeen contact with residents contact will transmit the vity) The hand hygiene by staff involved in direction stakes (S483.80(e) Linens. Personnel must handly transport linens so as infection.	lance designed to identify ble diseases or can spread to other in possible incidents of the or infections should be assission-based precautions ent spread of infections; blation should be used for a thou limited to: attion of the isolation, infectious agent or organism to the isolation should be the ble for the resident under the sounder which the facility bes with a communicable in lesions from direct for their food, if direct the disease; and procedures to be followed the ect resident contact.  In for recording incidents cility's IPCP and the ent by the facility.  It is store, process, and to prevent the spread of iew.	F 88			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185013	B. WING		10/	28/2020
	ROVIDER OR SUPPLIER  N CORNERSTONE GRO	JP, LLC		STREET ADDRESS, CITY, STATE ZIP CODE  55 EAST NORTH STREET  MADISONVILLE, KY 42431	8	*
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page IPCP and update their This REQUIREMENT by: Based on observation policy review, it was do to implement an effect program in place.  During meal pass on Assistant (CNA) #1 fathands between tasks involved the entry and rooms.  The findings include: Review of facility policy Precautions Employed dated, revealed if hand use alcohol based had decontaminating hand having direct contact with a resident's intactinanimate objects in the resident or whenever equipment soiled with secretions, and excre	r program, as necessary.  is not met as evidenced  n, interview, and facility letermined the facility failed tive Infection Control  the floors Certified Nursing iled to wash and sanitize for different residents which I exit to different resident  ey titled, "Standard e Information Sheet', not ds were not visibly soiled, and rub for routinely Is (up to 3 times) before with residents after contact to takin, after contact with the immediate vicinity of the in doubt. Resident care blood, body fluid, tions should be handled in a	F 88	The facility must establish and mainta an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development a transmission of communicable disease and infections.  Criteria 1: The CNA #1 serving trays during meal pass and entering/exiting resident rooms received one-on-one education and successfully passed a competency checklist assessment on 11-19-2020 by the Director of Nursing the proper procedure for handwashing hand sanitizing, and glove usage prior during, and after resident contact, to prevent the spread of infection. Infection control nurse screening visitors received one-on-one education and successfully passed a competency checklist assessment on 11-18-2020 by the DO on the proper procedure for screening	in ind ind ito, on ed y	
	and transfer of other r residents and environ Observation on 10/27 11:50 AM, revealed C (CNA) #1 served trays hands between tray d	, contamination of clothing, nicroorganisms to other		visitors to prevent the spread of infection of the control of the	on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185013	B. WING			10/	28/2020
NAME OF P	NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
BBIGUTO	N CORNEDOTONE OROI	UD 11.0		5	5 EAST NORTH STREET		
BRIGHTON CORNERSTONE GROUP, LLC		DP, LLC		N	MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 880	oominada riom paga		F 8	880			
		ed resident in bed; then			during, and after tray pass and prior to		
		Jnsampled Resident B's			during, and after resident contact, to		
	, ,	quired his/her coffee cup for			prevent the spread of infection. Infection		
		ize or wash hands between			control nurse screening visitors receive		
		hen went to meal cart #1 to			one-on-one education and successfully	1	
		by getting coffee pot from			passed a competency checklist	. 1	
	·	I not have enough to fill cup			assessment on 11-18-2020 by the DOI	ч	
		leal cart #2 and finished A #1 then took a straw			on the proper procedure for screening		•
	,	art to Unsampled Resident			visitors to prevent the spread of infection	лt.	
		hen took the coffee to			Criteria 3: CNA's have received educat	ion	
		B (Room 504-B); without			by the DON and Supervisors by	1011	
	washing or sanitizing				11-20-2020 on the compliance of infect	ion	
	recoming or carminaling				control to ensure the proper procedure		
	Interview on 10/27/20	20 at approximately 12:00			handwashing, hand sanitizing, and glove		
		ealed she should sanitize			usage prior to, during, and after meal		
		g trays and after going into			pass and entering/exiting resident room	ns	
		each activity because of			to prevent the spread of infection. RN's	į	
_	contamination.		=		and LPN's have received education by DON and Supervisors by 11-20-2020 or		
	Interview on 10/28/20	20 at 5:00 PM, with			the compliance of infection control to		
	Infection Control Nurs	se (IFCN), revealed staff			ensure the proper procedure for screer	ning	
	were required to sanit	tize hands and/or wash			visitors to prevent the spread of infection	on.	
		to any room. The IFCN			A QAPI audit tool addressing the		
		e task conscious and hand	ł		compliance of infection control to ensur		
		isibly soiled or they had			the proper procedure for handwashing,		
		idents or contaminated			hand sanitizing, and glove usage prior	to,	
	•	/ IFCN stated staff would	1		during, and after meal pass and		
		before and after delivering			entering/exiting resident rooms to preven	ent	
		viding care to another room;			the spread of infection has been		
		coffee cup should not be in			developed by the Administrator on		
	another resident's roo	т.			11-18-2020 and approved by the QAPI committee on 11-20-2020. A QAPI aud		
	2. Pavious of facility of	olicy titled. "Visitor			tool addressing the compliance of	II.	
	2. Review of facility po	, revealed visitors were to			infection control to ensure the proper		
		trance to the building and			procedure for screening visitors to prev	ent =	
		sible for the screening			the spread of infection has been	UIN	
	process and documer				developed by the Administrator on		
	p. Jeese and decentor				11-18-2020 and approved by the QAPI		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185013	B. WING		10/28/2020	
NAME OF PROVIDER OR SUPPLIER  BRIGHTON CORNERSTONE GROUP, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	STREET ADDRESS, CITY, STATE, ZIP CODE  55 EAST NORTH STREET  MADISONVILLE, KY 42431  PROVIDER'S PLAN OF CORRECTION	0	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 880	"Coronavirus (COVID revealed licensed nur Visitor must cleanse/s entering facility. Licenscreening tool for each visitor a copy of the Chandwashing-how-to."  Observation on 10/27 10:30 AM, during screvisitor was not information of sanitizing and COVID-19 or handwasheets, per facility guillaterview on 10/28/20 revealed it was her fat to sanitize hands, and forms related to hand information. IFCN stamade an error when be informed where to local sanitize hands; and, the facility guidelines for staff were to sanitize tray, when they come between patient care. She stated the staff stresident a new coffee."	screening policy titled, -19) Visitor Log", not dated, ses must follow below: sanitize hands when nsed nurse completes visitor th visitor and provides the OVID-19 and information sheets.  //2020 at approximately sening process, revealed the ed to sanitize hands and of equipment; nor provided shing-how-to information idelines for screening.  20 at 5:00 PM, with IFCN ult for not asking the visitor if she failed to provide the washing and COVID ated she slipped up and etting the visitor in.  20 at 5:31 PM, with Director realed visitors should be ated sanitizer and to the nurses should follow the screening. The DON stated thands between each meal in/out of buildings, and and peri care, if visibly dirty.	F 88	committee on 11-20-2020.  Criteria 4: The QAPI audit tool address the compliance of infection control to ensure the proper procedure for handwashing, hand sanitizing, and glo usage prior to, during, and after meal pass and entering/exiting resident room to prevent the spread of infection and QAPI audit tool addressing the compliance of infection control to ensure the proper procedure for screening visitors to prevent the spread of infection will review approximately 10% of the resident population. The QAPI audit to will be utilized by the DON/Supervisors varied shifts for 10% of the staff scheduled weekly x 4 weeks, monthly months, then quarterly thereafter as pet the established QAPI calendar, under supervision of the DON or Administrate Criteria 5:	ve ms the on ols s on x 2 er the	

PRINTED: 12/16/2020 FORM APPROVED OMB NO. 0938-0391

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A. BUILDING		
		185013	B. WING		10/28/2020
	ROVIDER OR SUPPLIER		55 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST NORTH STREET DISONVILLE, KY 42431	TM I
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFIGIENCY)	LD BE COMPLETIO
E 000	Initial Comments		E 000		
	Survey was initiat concluded on 10/2	used Emergency Preparedness ed on 10/27/2020 and 28/202. There was no deficient at 42 CFR 483.73 related to			
18					
	10				
			-		
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(x6) DATE 11/20/202

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.

Office of Inspector General

	AND PLAN OF CORRECTION  (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	COMPLETED	
		100183		B. WING		10/28/2020
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET				TE, ZIP CODE	
BRIGHTO	N CORNERSTONE GRO	OUP, LLC		NORTH STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S			LD BE COMPLETE
N 000	Initial Comments		3	N 000		
	A COVID-19 Focuser was initiated 10/27/2 10/28/2020. The fact compliance pursuant	020 and concluded ility was found not	d on to be in			
				100	5	
				- "	3	
X						

Electronically Signed

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

TITLE

(X6) DATE

11/20/20

PRINTED: 03/29/2021 FORM APPROVED

If continuation sheet 1 of 1

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 100183 03/01/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **55 EAST NORTH STREET BRIGHTON CORNERSTONE GROUP, LLC** MADISONVILLE, KY 42431 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (N 000) Initial Comments {N 000} An Onsite Revisit, conducted on 03/01/2021, determined the facility was in compliance on 11/24/2020, as alleged in the acceptable PoC. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE **Electronically Signed** 03/16/21

6KPD12

STATE FORM