

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

PRINTED: 06/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2011
NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031	
(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 An annual survey was conducted on 05/31/11 through 06/03/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S being "D". An abbreviated survey (KY # 16062) conducted in conjunction with the recertification survey was found to be substantiated with regulatory violations identified.	F 000	Resident #11 is no longer in the facility. Residents #6 and #7 have been interviewed by Life Style Coordinator and both residents #6 and #7 state they are satisfied with their care and do not feel mistreated, neglected, or abused. All other residents with allegations of abuse have been reviewed and found that the facility followed policy and procedure .	
F 226 SS=D	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 interviews and record reviews, it was determined the facility failed to implement written policies and procedures related to the identification, investigation, protection, and reporting of resident abuse for three residents (#6, #7, and #11), in the selected sample of eleven. Findings include: A review of the "Abuse Policy Procedures", dated revised 07/13/10, revealed a failure to report potential or actual abuse by staff was the same as if they had committed abuse and did not report the act, and were reasons for job dismissal. All incidents of resident abuse would be investigated by the Administrator or designee. Any employee reported for resident abuse would be directly	F 226	Policy and procedure for abuse reporting have been reviewed and found to be appropriate on 6-7-2011. Any allegations of abuse will be investigated promptly by Administrator and or designee. Any employee reported for alleged resident abuse will be immediately removed from resident care and suspended from work during the investigation. All abuse allegations will be reported by Administrator or designee to the survey agency, adult protection and other agencies if applicable, the responsible party and physician. All staff was in-serviced on 06/24/11 by Director of Nursing and/or designee regarding the facility procedures to report potential or actual abuse. All new employees will be in-serviced during orientation by the department supervisor. QA will be completed on 06/27/11 by Director of Nursing . QA will be completed monthly for 3 months and quarterly for 1 year by Director of Nursing or designee.	6/28/11

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

William B. Adams

TITLE

Administrator

(X8) DATE

6/24/11

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 226	<p>Continued From page 1</p> <p>removed from resident care or suspended in order to protect all residents and the employee during the investigation. This will be done immediately by the employee's supervisor. All employees who became aware of or suspected an alleged incident of abuse would immediately report the incident to their supervisor and fill out a potential abuse report. All abuse allegations would be reported by the Administrator or designee to the survey agency, adult protection agency, other agencies if applicable, the resident's responsible party and the resident's physician.</p> <p>1. A closed record review revealed Resident #11 was admitted to the facility on 10/16/01 and readmitted on 05/13/11. A review of the quarterly Minimum Data Set (MDS) dated 04/13/11, revealed the facility identified the resident as severely cognitively impaired and had trouble sleeping, some depression, and little interests.</p> <p>A review of the statement written by the Housekeeping Supervisor, undated, revealed she witnessed a conversation between Resident #11 and Registered Nurse (RN) #1, on 10/20/10. The statement revealed that RN #1 made the comment, "Ne Na Na Na, I had a bad dream." The resident asked RN #1 if she was making fun of him/her, and RN #1 replied, "Yes." The resident called RN #1 a "smart ass" and RN #1 replied, "You are."</p> <p>An interview with the Housekeeping Supervisor, on 06/02/11 at 2:25 PM, revealed she reported the incident to the Director of Nursing (DON) on 10/20/10, the day it occurred. The Housekeeping Supervisor felt the incident was representative of</p>	F 226		

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F 226	<p>Continued From page 2 verbal abuse.</p> <p>An interview with RN #1, on 06/03/11, revealed the DON spoke with her regarding the incident with Resident #11, a day or two after the incident. She stated the DON told her to, "watch what she said around people" and "do not worry about it".</p> <p>An interview with the DON, on 06/02/11 at 2:30 PM, revealed she was informed by the Housekeeping Supervisor of a conversation which occurred between Resident #11 and RN #2. She stated the Housekeeping Supervisor reported the incident several hours after it occurred, so the DON did not think it was a "big issue." She stated that an investigation was not initiated at the time of the report and RN #1 continued to provide resident care, during the completion of the investigation.</p> <p>A review of the time sheet for RN #1, dated 10/17/10 through 10/23/10, revealed RN #1 worked a complete shift on 10/20/10, 10/21/10, and 10/22/10. An investigation was initiated, on 10/22/10, related to the Housekeeping Supervisor's statement.</p> <p>An interview with the Lifestyle Coordinator, on 06/03/11 at 11:20 AM, revealed the Housekeeping Supervisor reported the incident to her on 10/22/10, which was the date the statement was written and taken to the Administrator.</p> <p>An interview with the Administrator, on 06/03/11 at 10:30 AM, revealed he was not aware of the allegation of abuse, until 10/22/10. He was not aware the Housekeeping Supervisor reported the</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>incident, on 10/20/10. He expected all staff to report allegations of abuse to him as soon as possible.</p> <p>2. A record review revealed Resident #6 was admitted to the facility on 03/08/04 with diagnoses to include Cerebrovascular Accident, Depressive Disorder, and Hemiplegia. A review of the annual Minimum Data Set (MDS), dated 04/24/11, revealed the facility identified the resident as cognitively intact and required extensive assistance with transfers.</p> <p>A review of the "Resident Incident Report", dated 01/23/11 at 10:00 AM, revealed the resident sustained a fall during transfer from the wheelchair to the bed.</p> <p>An interview with Resident #6's family member, on 06/03/11 at 9:55 AM, revealed she received a call from the resident, on 01/23/11, and the resident was "very upset." She stated he/she had fallen and RN #1 had threatened to use the lift if he/she could not stand up and she stated the nurse was "hateful". She stated she reported the resident's complaint to the Administrator the next day, on 01/24/11.</p> <p>A review of the time sheet for RN #1, dated 01/23/11 through 01/29/11, revealed RN #1 worked a complete shift on 01/23/11, on 01/25/11 and on 01/26/11.</p> <p>A review of the "Employee Counseling Statement", dated 01/26/11, revealed a written warning was given to RN #1 related to her "blunt attitude and actions" which had offended residents and employees.</p>	F 226		

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F 226	<p>Continued From page 4</p> <p>An interview with the DON, on 06/02/11 at 2:30 PM, revealed RN #1 was given the written notice, on 01/26/11, because of the altercation with Resident #6, on 01/23/11. She stated RN #1 was "too blunt" with the resident and the situation could have been handled differently. She revealed RN #1 continued to provide resident care while the investigation was completed.</p> <p>An interview with the Administrator, on 06/03/11 at 10:30 AM, revealed an investigation was conducted related to the complaint received from Resident #6's family member. However, documented evidence of the investigation was not provided. He stated he did not consider the incident "abuse", but should have documented the investigation.</p> <p>3. A record review revealed Resident #7 was admitted to the facility on 07/03/08, with diagnoses to include Cerebral Vascular Accident, Chronic Obstructive Pulmonary Disease, Depressive Disorder and Anxiety Disorder. A review of the Minimum Data Set (MDS), dated 04/24/11, revealed the facility identified the resident as cognitively intact and independent with transfer and ambulation.</p> <p>An interview with Resident #7, on 06/01/11 at 3:10 PM, revealed that on one occasion he/she had asked LPN #2 for two Tylenol related to leg pain. Resident #7 stated that the nurse said, "You are not sick." The resident stated the response of the nurse was upsetting. Later, another nurse approached him/her that same night and offered the pain medication and he/she took it. Resident #7 stated he/she reported the</p>	F 226		

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F 226	<p>Continued From page 5</p> <p>incident to the DON the next morning and told the DON he/she would not take any medications from LPN #2 again. The DON asked Resident #7 if LPN #2 didn't give the medications any more would that satisfy him/her. Resident #7 stated LPN #2 continued to work at the facility and never gave him/her medications again.</p> <p>An interview with the DON, on 06/03/11 at 9:25 AM, revealed that sometime during the fall of 2010 Resident #7 had reported he/she had requested Tylenol from LPN #2 and the nurse had refused to give him/her the medication. The DON asked LPN #2 about the incident, and LPN#2 stated it was unusual for Resident #7 to request Tylenol at that time of day and she was just trying to find out why he/she was hurting. The DON stated, "From the time I was aware of the incident until the time LPN #2 left employment, LPN #2 did not provide any further direct care to Resident #7." The DON stated she asked LPN #3 if she heard the incident between Resident #7 and LPN #2 and LPN #3 denied having any knowledge of the incident. The DON stated she filled out a form, if she considered it was abuse and abuse could be other types of abuse, not just physical. The DON did not provide documented evidence of the investigation and LPN #2 was not reassigned or suspended, pending completion of an investigation.</p> <p>An interview with LPN #3, on 06/03/11 at 10:00 AM, revealed the DON informed LPN #3, "When we work with LPN #2, we had to give the medications to Resident #7."</p> <p>An interview with the Administrator, on 06/03/11 at 11:30 AM, revealed that he was not aware of</p>	F 226		

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F 226	<p>Continued From page 6</p> <p>the incident involving Resident #7 and LPN #2. He stated if a resident asked for pain medication and a nurse refused to give it, it is the facility's responsibility to conduct an investigation.</p> <p>An interview with LPN #2, on 06/03/11 at 11:42 AM, revealed the DON was aware of allegation. "I was not allowed to provide direct care or pass medications to Resident #7." LPN #2 remained an employee of the facility until 03/21/11, working primarily 3-11 shift.</p> <p>A review of LPN #2's personnel record, revealed that on 08/18/10, the nurse had been written up related to disruption of the work place through ineffective communication with staff, residents and resident's families. The DON conducted a review with LPN #2 on 08/31/10 and documented that there had been no problems identified in the previous two weeks.</p>	F 226			

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K 000 K 018 SS=F	<p>INITIAL COMMENTS</p> <p>A Life Safety Code off hours survey was initiated and concluded on 05/31/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exlts, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 05/31/11, it was determined the facility failed to ensure the corridor doors were capable of closing to resist the passage of smoke. The deficient practice has</p>	K 000 K 018	<p>Chair blocking smoke barrier door next to TV room was removed on 5/31/11. All other smoke barrier doors were checked for obstruction and none were found on 5/31/11.</p> <p>Policy has been written not to have any impediment to closing of smoke doors on 6/20/11.</p> <p>All staff will be in- serviced by Maintenance Supervisor on 06/29/11 regarding no impediment to closing of smoke doors. New staff will be in- serviced by Maintenance Supervisor during new employee orientation.</p> <p>QA will be completed by Maintenance Supervisor on 6/30/11 to audit obstructions that prevent closing of smoke doors. QA will be completed by Maintenance Supervisor or designee monthly for three months then quarterly for one year.</p>
	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>William B. [Signature]</i>		TITLE <i>Administrator</i>
			(X6) DATE 6/24/11



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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K 018	Continued From page 1 the potential to affect two (2) smoke compartments, all residents, staff and visitors. The facility is licensed for forty six (46) beds with a census of forty four (44) the day of the survey. The findings include: An observation on 05/31/11 at 6:40 PM, revealed a smoke barrier door located in corridor Hall 1 next to the Television Room was blocked with a chair that prevented the door from closing to resist the passage of smoke. An interview on 05/31/11 at 7:30 PM, with the Maintenance Director revealed that he was unaware the door was blocked and he moved the chair immediately. Reference: NFPA 101 (2000 Edition) 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, lie-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. NFPA 101 LIFE SAFETY CODE STANDARD	K 018			
K 025 SS=F	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	K 025			

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K 025	<p>Continued From page 2</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility has the capacity for forty six (46) beds and the census was forty four (44) on the day of the survey. The deficiency has the potential to affect all three (3) smoke compartments, all residents, staff and visitors.</p> <p>The findings include:</p> <p>A tour of the facility conducted on 05/31/11 at 7:50 PM revealed that all the smoke barriers located above the drop ceiling throughout the facility, were noted to be penetrated by electrical wiring, piping, and miscellaneous openings.</p> <p>An interview with the Maintenance Director on 05/31/11 at 7:50 PM revealed he was aware of the penetrations, and confirmed that the penetrations needed to be sealed.</p> <p>Reference to: NFPA 101 Life Safety Code 2000 Edition</p>	K 025	<p>All smoke barriers above recessed ceiling that have been penetrated by pipes, wiring, and miscellaneous will be sealed by fire retardant product by 6/29/11.</p> <p>Policy has been written on 6/20/11, that smoke barriers that have been penetrated above recessed ceiling will be sealed.</p> <p>Maintenance staff will be in-serviced by Maintenance Supervisor on 06/29/11 regarding smoke barrier penetrations. New maintenance staff will be in-serviced by Maintenance Supervisor during employee orientation.</p> <p>QA will be completed by Maintenance Supervisor on 6/30/11 to audit penetration of all smoke barriers. QA will be completed by Maintenance Supervisor or designee monthly for three months then quarterly for one year.</p>	7/1/11

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K 025	<p>Continued From page 3</p> <p>8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective 's shall be as follows:</p> <p>(3) 1/2-hour fire barrier - 20-minute fire protection rating</p> <p>(1) 2-hour fire barrier - 1 1/2-hour fire protection rating</p> <p>(2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke</p>	K 025		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 K 064 SS=E	<p>Continued From page 4</p> <p>barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. This deficient practice affected each of the three (3) smoke compartments, staff, residents and visitors. The facility has the capacity for forty-six (46) beds and the census was forty-four (44) on the day of survey.</p> <p>Findings Include:</p> <p>Observations on 05/31/11 at 6:46 PM, revealed the wall mounted, portable fire extinguishers located in Resident Halls 1 and 2, were mounted above the maximum allowable height of five (5) feet above the finish floor. Further observations during the survey revealed that all portable fire extinguishers within the facility were mounted higher than the maximum allowable height.</p> <p>An interview on 05/31/11 at 6:50 PM, with the</p>	K 025 K 064	<p>Fire extinguishers located in Resident Halls 1 and 2 were lowered to maximum height of 5' on 6/8/11. All other fire extinguishers were checked. Any that were higher than maximum allowable height were lowered to 5' level.</p> <p>Policy has been written on 6/20/11, that all fire extinguishers not exceeding 40 lbs. will be mounted at maximum height of 5' and any greater than 40 lbs. will be mounted at maximum of 3.5'.</p> <p>Maintenance staff will be in- serviced by Maintenance Supervisor on 06/29/11 regarding fire extinguishers mounting height. All new staff will be in-serviced by Maintenance Supervisor during new employee orientations.</p> <p>QA will be completed by Maintenance Supervisor on 6/30/11 to audit fire extinguishers height. QA will be completed by Maintenance Supervisor or designee monthly for three months then quarterly for one year.</p>	7/1/11

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K 064	Continued From page 5 Maintenance Director, revealed that he was unaware of the height limitations for wall mounted, portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above the finish floor. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). NFPA 101 LIFE SAFETY CODE STANDARD	K 064		
K 072 SS=F	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, it was determined the facility failed to maintain exit access according to NFPA standards. The deficient practice has the potential to affect all	K 072	Trash carts, chairs, linen carts, wheelchairs, telephone stand, lifts and hand rub dispenser on a stand stored longer than thirty minutes were removed from resident halls 1 and 2 on 6/1/11. The balance of resident halls 1 and 2 corridors were checked for other items stored longer than thirty minutes and no other items were found. Policy has been written on 6/20/11, that trash carts, chairs, linen carts, wheelchairs, telephone with stand, lifts, hand rub dispenser on stand or other items will not be stored in resident halls 1 and 2 corridors for longer than 30 minutes.	

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K 147	<p>Continued From page 7</p> <p>wiring was maintained according to NFPA standards. The deficient practice has the potential to affect two (2) smoke compartments, including residents, staff, and visitors. The facility is licensed for forty six (46) beds with a census of forty four (44) the day of the survey.</p> <p>The findings include:</p> <p>An observation on 05/31/11 at 7:00 PM revealed an extension cord was plugged into a power strip located behind the television set, in the living room area, running a fan.</p> <p>An observation on 05/31/11 at 7:01 PM revealed an extension cord was plugged into a wall receptacle located behind the yellow couch in the living room area.</p> <p>An interview on 05/31/11 at 7:02 PM with the Maintenance Director revealed he was unaware of the use of extension cords and he removed them immediately.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>Multiple outlet adapter extension cords located behind TV set and behind yellow couch in living room area were removed on 5/31/11 by Maintenance Supervisor. All other areas were checked for multiple outlet adapter extension cords and none were found.</p> <p>Policy has been written on 6/20/11 that multiple outlet adapter extension cords will not be used in the facility.</p> <p>Staff will be in-serviced by Maintenance Supervisor on 06/29/11 that multiple outlet adapter extension cords cannot be used in this facility. All new staff will be in-serviced by Maintenance Supervisor during new employee orientation.</p> <p>QA will be completed by Maintenance Supervisor on 6/30/11 to audit use of any multiple outlet adapter extension cords. QA will be completed by Maintenance Supervisor or designee monthly for three months and then quarterly for one year.</p>	7/1/11	