

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

PRINTED: 11/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 000	INITIAL COMMENTS A standard health survey was conducted on 10/27/13 through 10/31/13 and a Life Safety Code survey was conducted on 10/29/13. Deficiencies were cited with the highest scope and severity an "F".	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to review and revise the plan of care in regards to the development of a pressure ulcer for one (1) of nineteen (19) sampled residents. Resident #4. The facility identified Resident #4 as a high risk for development of pressure ulcer related to incontinence of bowel and bladder, totally dependent with mobility, and Activity of Daily Living (ADL) care. The facility developed a comprehensive care plan; however, the facility staff failed to follow the current skin care plan. On 09/06/13 the facility identified Resident #4 had a stage 2 pressure area. The findings include: Review of the facility's policy titled Comprehensive Care Plan, revised date 09/13, revealed the purpose was to provide an ongoing	F 282	Resident #4's care plan has been reviewed and updated as of 10/31/13 to reflect current pressure ulcer. New care plan interventions include, referral to therapy to evaluate and treat. She was placed on Therapy case load on 11/19/13. Therapy provided a new wheelchair on 11/22/13, and placed a ROHO cushion in the chair at that time. Other interventions include pillow placed behind back and between legs while in bed, lay resident down in bed after meals and turn side to side every 3 hours to promote healing of coccyx wound by keeping resident off back. On 12/3/13 a positioning data collection tool was completed by the nursing staff which is designed to assist nursing in implementing an individualized turning and repositioning program. A Positioning assessment and evaluation tool was completed on 12/5/13 and a turning and repositioning schedule was established on the care plan on 12/5/13 to reflect resident #4's individual needs for repositioning every 3 hours. (Positioning data collection tool and positioning assessment and evaluation are attached to this plan of correction).	12/14/2013	

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

TITLE

(X6) DATE

X *Claude Mapp*

X Administrator

X 12/17/13

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.

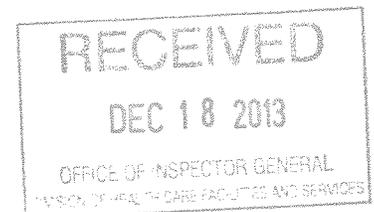
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OFFICE OF THE ASSISTANT ATTORNEY GENERAL
DIVISION OF HEALTH CARE FACILITIES SERVICES

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F 282	<p>Continued From page 1</p> <p>method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest level of functioning.</p> <p>Review of Resident #4's clinical record revealed the resident was admitted to the facility on 01/08/07. Review of the most recent comprehensive Reentry Minimum Data Set (MDS), dated 12/06/12, revealed the facility assessed the resident as having severe cognition impairment, was always incontinent of bowel and bladder, and required extensive assistance from the staff with bed mobility, transfers and toilet use. The facility assessed the resident as a high risk for pressure ulcer development related to laying flaccid in the bed or the wheelchair; unable to make needs known; incontinent; and decreased mobility. Review of the Quarterly MDS, dated 08/27/13, revealed the facility assessed the resident as a high risk for pressure ulcer development. Continued review of the comprehensive care plan for potential skin breakdown, dated 06/05/13, detailed approaches that included turning and repositioning, check positioning every hour and lay down between meals with a pillow between legs. On 09/06/13, a Stage II was noted on the resident's sacrum area.</p> <p>Observation of Resident #4, during initial tour, on 10/29/13 at 8:40 AM, revealed the resident was located in the common area, sitting in a high back wheelchair (w/c) with calf pads and elevated foot rests. Observations at 10:30 AM, 11:05 AM, 11:25 AM, 11:50 AM, and 12:05 PM thru 12:20 PM, revealed the resident's feet were contracted, and dangling off the foot rests. The resident's buttocks were in a forward position and the lower back was slanted down in the wheelchair.</p>	F 282	<p>Continued From page 1</p> <p>To identify residents at risk for skin breakdown the Braden Scale score was utilized in which 18 or below is the risk threshold for skin impairment. On 11/22/13 the DNS, Staff Development Coordinator and MDS/Care Coordinators reviewed all residents' Braden Scale Assessments that had been completed from 08/22/13 to 11/22/13. 68 residents were found with a Braden score of 18 or below. All care plans were reviewed for appropriate interventions to prevent skin breakdown. 4 out of 68 care plans were revised with new interventions. All residents received a head to toe skin check by a licensed nurse by 12/5/2013. No new facility acquired pressure ulcers and no new alteration in skin integrity were identified as evidenced by no new wound assessment documentation forms were initiated. The care plan interventions for all residents with wounds were adequate and appropriate.</p> <p>The CNAs are responsible for looking at residents' skin when providing daily care and to document any findings on the residents' skin tab in the point of care. CNAs will also notify the floor nurse of any abnormal findings; the floor nurse will assess and obtain treatment orders from physician. Any new areas of concern will be reported to the wound nurse. The floor nurses perform skin assessments on all residents weekly.</p>		



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F 282	<p>Continued From page 2</p> <p>Observations at 1:45 PM, 2:10 PM, 2:45 PM, 3:00 PM and 3:25 PM, revealed the resident laying in bed in a supine position. Observations at 4:00 PM, 4:20 PM and 4:50 PM, revealed the resident was sitting in a w/c with the right foot off of the foot rest, the buttocks were slanted forward and the resident's was back down in the w/c.</p> <p>Interview with CNA #2, on 10/31/13 at 3:00 PM, revealed Resident #4 was totally dependent on the staff for care needs. The CNA was responsible for the resident's care needs on 10/29/13 during the day shift hours. She revealed knowledge of the resident's pressure ulcer and risk for skin breakdown intervention. She stated no new interventions were implemented after the facility identified the resident's pressure. She stated if the resident did not get the required care this would increase the resident's potential for development of additional pressure ulcers.</p> <p>Observations of Resident #4, on 10/30/13 at 8:00 AM, 8:20 AM, 9:05 AM, 9:35 AM, 9:50 AM, revealed the resident was up in the w/c in the common area. Observations at 10:05 AM, 10:25 AM and 11:05 AM, revealed the resident was in their room in the w/c. Observations of the resident, at 1:35 PM, 2:00 PM, 2:40 PM, 3:10 PM, 3:45 PM and 4:05 PM, revealed the resident laying in bed in a supine position.</p> <p>Interview with CNA #1, on 10/31/13 at 10:35 AM, revealed the Point and Click kiosk provided instructions for Resident #4's care needs. She was responsible on 10/30/13 for the resident's care and the care plan interventions were incontinent care, turning and repositioning every two (2) to three (3) hours. She further revealed the kiosk did not provide information of the</p>	F 282	<p>Continued From page 2</p> <p>If alteration in skin integrity is identified, documentation will be completed on a Wound Assessment form and / or progress note. This is evidenced by: on 12/11/13 a wound assessment form was initiated for a resident with an open area identified on heel. The wound nurse completes weekly rounds and measures all wounds and notifies MD if wound is not improving. The wound nurse updates the care plans accordingly. The floor nurses will also notify the wound nurse of a change in condition regarding an existing wound. The Staff Development Coordinator completed staff education on following the plan of care, Turning Support & Positioning and Pressure Ulcer Prevention by 12/13/13.</p> <p>Focus audits that require the observation of care being provided and the interview of staff to determine the assistance given to residents will be completed by the floor nurses. These audits will be cross referenced with the care plans to ensure care is being delivered as care planned. 5 audits will be completed on each shift daily for 1 week, weekly for 3 weeks and monthly thereafter up to one year. MDS/Care Coordinators will audit all care plans of residents who are at risk for skin breakdown to ensure appropriate interventions are in place. These audits will be performed monthly for 3 months and then quarterly thereafter up to one year.</p>		

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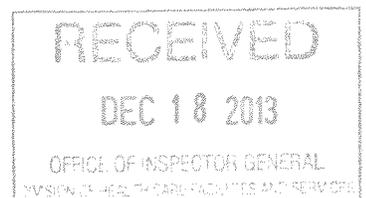
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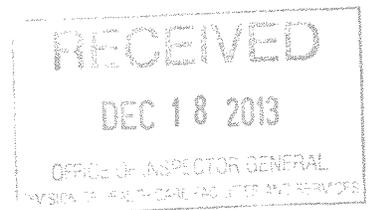
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F 282	<p>Continued From page 3</p> <p>resident's need to have a pillow placed between legs while in bed. She was aware of the resident's pressure; however, due to other morning facility obligation the resident did not always get checked for incontent care or turned and repositioned.</p> <p>Interview with LPN #1, on 10/31/13 at 11:00 AM, revealed she was responsible for the resident on 10/29/13. LPN #1 was aware of the resident's sacral pressure, interventions to promote healing and the facility's pressure guidelines. However, on 10/29/13 during the day shift hours, she was unaware of the amount of time the resident was up in the chair. She stated the resident should have had checked and changed and reposition increased to prevent further pressure and promote healing. She continued to state no new interventions were implemented since the Stage 2 was identified.</p> <p>Observation of Resident #4 during a skin assessment with RN #1, on 10/30/13 at 4:40 PM, revealed the resident was in a supine position without any positioning or off-loading devices noted. Observation of the resident's brief revealed the brief was wet. Continued observation during the skin assessment revealed the resident's sacral pressure tissue pink with wound bed edges intact.</p> <p>Interview with CNA #3, on 10/31/13 at 2:50 PM, revealed she was the person who identified and notified the nurse of the resident's skin breakdown. She stated the kiosk provided information regarding the resident's care needs. She stated the nurse would inform her if a new care need was added. She was unaware of the resident's need for a pillow between the legs</p>	F 282	<p>Continued From page 3</p> <p>All audits completed by floor nurses and MDS/Care Coordinators will be given to the DNS upon completion who will summarize and report the audit findings to the QA committee monthly not to exceed one year. One-on-one education and counseling, up to and including corrective action, will be provided to staff by the DNS where issues are found,</p>		



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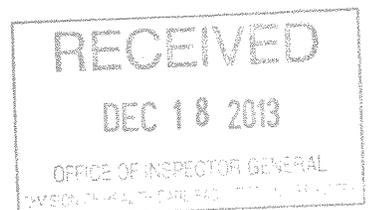
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F 282	Continued From page 4 while in bed. CNA #3 continue to state the resident's care needs did not increase after the skin breakdown was observed. Interview with RN #1, on 10/31/13 at 3:15 PM, revealed she was aware of the resident's sacral pressure and interventions. She stated she was unaware of the resident laying in a supine position for an extended period of time. She stated a resident with a sacral ulcer would have the pillow to offload pressure. She revealed visual rounds were made often to ensure the care was being followed. However, she failed to identify that the resident was not positioned with a pillow between the legs while in bed. Interview with the Director of Nursing, on 10/31/13 at 3:50 PM, revealed she was aware the resident had a facility acquired pressure area. She stated the CNAs were trained on skin care, turning and positioning and to report any changes in a resident's skin condition to the nurse. She stated the staff nurse was responsible for ensuring care was being implemented as care planned. She stated that she made rounds throughout the day to monitor resident care. However, she was unaware the resident's care plan was not implemented. She continued to state the MDS Coordinator was responsible for updating and ensuring accuracy of the care plan. She continued to state the MDS/wound nurse terminated the position without notice and some care plans may not have been reviewed or revised. She stated a resident with a pressure should have care plan interventions followed.	F 282			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314			



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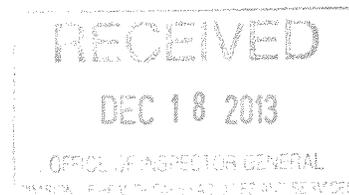
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F 314	<p>Continued From page 5</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide necessary treatment and services to promote healing of existing pressure ulcers and development of new pressure ulcers for one (1) of nineteen (19) sampled residents. The facility identified Resident #4 as a high risk for development of pressure sores related to incontinence of bowel and bladder, totally dependence on staff for bed mobility, transfers and toileting. The resident had a history of pressure ulcer development. The facility developed a care plan with nursing interventions to turn and reposition the resident every two (2) to three (3) hours and the resident was to lay down between meals with a pillow between the resident's legs. However, the facility staff failed to lay the resident in bed with a pillow between the legs to off load the pressure and failed to ensure the resident did not spend prolonged periods of time sitting in the wheelchair.</p> <p>The findings include: Review of the facility's policy titled Pressure</p>	F 314	<p>Resident #4's care plan has been reviewed and updated as of 10/31/13 to reflect current pressure ulcer. New care plan interventions include, referral to therapy to evaluate and treat. She was placed on Therapy case load on 11/19/13. Therapy provided a new wheelchair on 11/22/13, and placed a ROHO cushion in the chair at that time. Other interventions include pillow placed behind back and between legs while in bed, lay resident down in bed after meals and turn side to side every 3 hours to promote healing of coccyx wound by keeping resident off back. On 12/3/13 a positioning data collection tool was completed by the nursing staff which is designed to assist nursing in implementing an individualized turning and repositioning program. A Positioning assessment and evaluation tool was completed on 12/5/13 and a turning and repositioning schedule was established on the care plan on 12/5/13 to reflect resident # 4's individual needs for repositioning every 3 hours. (Positioning data collection tool and positioning assessment and evaluation are attached to this plan of correction).</p> <p>To identify residents at risk for skin breakdown the Braden Scale score was utilized in which 18 or below is the risk threshold for skin impairment. On 11/22/13 the DNS, Staff Development Coordinator and MDS/Care Coordinators reviewed all residents' Braden Scale Assessments that had been completed from 08/22/13 to 11/22/13. 68 residents were found with a Braden score of 18 or below.</p>	12/14/2013	



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F 314	<p>Continued From page 6</p> <p>Ulcers, Skin Assessment and Prevention, dated September 2012, revealed the purpose was to appropriately use prevention techniques and pressure redistribution surfaces on residents at risk for pressure ulcers. Continued review of the policy revealed a resident who was unable to reposition themselves independently would have an individualized repositioning schedule developed.</p> <p>Review of Resident #4's clinical record revealed the facility admitted the resident on 01/08/07 with a diagnosis of Alzheimer Disease. Review of the most recent comprehensive Minimum Data Set (MDS), dated 12/08/12, revealed the facility assessed the resident as having a severe cognition impairment, always incontinent of bowel and bladder, and required extensive assistance from the staff with bed mobility, transfers and toilet use. The facility assessed the resident as a high risk for pressure ulcer development related to laying flaccid in the bed or sitting in the wheelchair; unable to make needs known; incontinent; and decreased mobility. Review of the Quarterly MDS, dated 08/27/13, revealed the facility assessed the resident as a high risk for pressure with no existing pressure. Review of the Care Plan, dated 06/05/13, revealed the facility developed interventions to place the resident on a check and change toileting program. Continued review of the comprehensive care plan for potential skin breakdown revealed approaches that included turning and repositioning; check positioning every hour; and lay the resident down between meals with a pillow between legs. On 09/06/13, a Stage 2 pressure ulcer was noted on the resident's sacrum area. On 10/27/13, the record revealed the sacral pressure ulcer measurement 1 x 1 cm and the ulcer was noted</p>	F 314	<p>Continued From page 6</p> <p>All care plans were reviewed for appropriate interventions to prevent skin breakdown. 4 out of 68 care plans were revised with new interventions. All residents received a head to toe skin check by a licensed nurse by 12/5/2013. No new facility acquired pressure ulcers and no new alteration in skin integrity were identified as evidenced by no new wound assessment documentation forms were initiated. The care plan interventions for all residents with wounds were adequate and appropriate.</p> <p>The CNAs are responsible for looking at residents' skin when providing daily care and to document any findings on the residents' skin tab in the point of care. CNAs will also notify the floor nurse of any abnormal findings; the floor nurse will assess and obtain treatment orders from physician. Any new areas of concern will be reported to the wound nurse. The floor nurses perform skin assessments on all residents weekly. If alteration in skin integrity is identified, documentation will be completed on a Wound Assessment form and / or progress note. This is evidenced by: on 12/11/13 a wound assessment form was initiated for a resident with an open area identified on heel. The wound nurse completes weekly rounds and measures all wounds and notifies MD if wound is not improving. The wound nurse updates the care plans accordingly.</p>		



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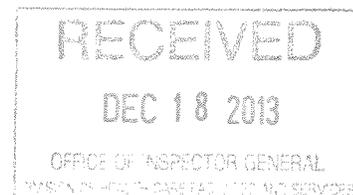
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F 314	Continued From page 7 to be healing. Observation of Resident #4, during initial tour, on 10/29/13 at 8:40 AM, revealed the resident sitting in a high back wheelchair (w/c) with calf pads and elevated foot rests. Observations 10:30 AM, 11:05 AM, 11:25 AM, 11:50 AM, and 12:05 PM thru 12:20 PM, revealed the resident's feet were contracted and off the foot rest, the resident's buttocks were slid forward and the lower back was slanted down in the w/c. Observation at 12:20 PM, revealed a staff member transferred the resident to the restorative dining area. Two (2) staff members positioned Resident #4 up in the w/c and had to reposition the resident's feet back onto the foot pads. Observations at 1:45 PM, 2:10 PM, 2:45 PM, 3:00 PM and 3:25 PM, revealed the resident was laying in bed in a supine position. Observation at 4:00 PM, 4:20 PM and 4:50 PM, revealed the resident was back in the w/c with the resident's right foot dangling off the foot rest, their buttocks was slanted forward and the lower back was down in the w/c. Interview with CNA #2, on 10/31/13 at 3:00 PM, revealed Resident #4 was totally dependent on the staff for care needs. The CNA was responsible for the resident's care needs on 10/29/13 during the day shift hours. The CNA indicated the resident had been placed in the w/c by the night shift staff. She revealed knowledge of the resident's pressure ulcer and interventions to prevent further skin breakdown. However, she stated the other job responsibilities had prevented her from providing care to the resident such as turning and repositioning and incontinent care. She stated when the resident did not get the required care, this would increase the resident's risk for further pressure ulcers.	F 314	Continued From page 7 The floor nurses will also notify the wound nurse of a change in condition regarding an existing wound. The Staff Development Coordinator, completed staff education on following the plan of care, Turning Support & Positioning and Pressure Ulcer Prevention by 12/13/13. Focus audits that require the observation of care being provided and the interview of staff to determine the assistance given to residents will be completed by the floor nurses. These audits will be cross referenced with the care plans to ensure care is being delivered as care planned. 5 audits will be completed on each shift daily for 1 week, weekly for 3 weeks and monthly thereafter up to one year. MDS/Care Coordinators will audit all care plans of residents who are at risk for skin breakdown to ensure appropriate interventions are in place. These audits will be performed monthly for 3 months and then quarterly thereafter up to one year. All audits completed by floor nurses and MDS/Care Coordinators will be given to the DNS upon completion who will summarize and report the audit findings to the QA committee monthly not to exceed one year. One-on-one education and counseling, up to and including corrective action, will be provided to staff by the DNS where issues are found.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
(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 314	Continued From page 8 Observations of Resident #4, on 10/30/13 at 8:00 AM, 8:20 AM, 9:05 AM, 9:35 AM, and 9:50 AM, revealed the resident was up in the w/c in the common area. Observations at 10:05 AM, 10:25 AM and 11:05 AM, revealed the resident was in their room sitting up in the w/c. The resident was taken to the dining room for lunch. Observation of the resident at 1:35 PM, 2:00 PM, 2:40 PM, 3:10 PM, 3:45 PM and 4:05 PM revealed the resident was laying in bed in a supine position without a pillow between the legs. Interview with CNA #2, on 10/31/13 at 10:35 AM, revealed she was responsible for the resident's care on 10/30/13. She revealed the resident was dependent with Activity of Daily Living (ADLs) care and was high risk for skin breakdown. The CNA interventions were to provide incontinent care, turning and repositioning every two (2) to three (3) hours. She continued to state the facility had no turning and repositioning system. She was aware of the resident's pressure ulcer and what interventions were to be provided. She stated if those interventions were not provided the resident could get another pressure ulcer. She stated the resident did not always get checked and changed or repositioned as scheduled due to getting busy. Observation during a skin assessment, with RN #1, for Resident #4, on 10/30/13 at 4:40 PM, revealed the resident was in a supine position without any positioning or off-loading devices noted. Observation of the resident's brief revealed the brief was wet. Interview with RN #1, on 10/31/13 at 3:15 PM, revealed she was responsible and preformed the	F 314			

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F 314	<p>Continued From page 9</p> <p>skin assessment for the resident on 10/30/13. The RN was aware of the sacral pressure, interventions and pressure guidelines pertinent to this resident. She stated she was unaware of the resident laying in a supine position in bed with no pillow placed between the resident's legs. She stated a resident with a sacral ulcer would have the pillow to offload pressure. She did not say how she would monitor implementation of the care plan interventions to promote healing.</p> <p>Interview with LPN #1, on 10/31/13 at 11:00 AM, revealed she was responsible for the resident care on 10/29/13. The nurse stated she was aware of the resident's sacral pressure; interventions to promote healing; and the facility's pressure guidelines. She stated she was responsible for monitoring the staff to ensure the interventions were provided. However, she was unaware of the amount of time the resident had been sitting in the w/c. She stated the resident should be checked and changed and repositioned according to the care plan to prevent further pressure and promote healing.</p> <p>Interview with the Director of Nursing, on 10/31/13 at 3:50 PM, revealed she was aware the resident had a reoccurring pressure. She stated the CNAs were trained on skin care, turning and positioning and to report any changes in a resident's skin condition to the nurse. She stated the staff nurse was responsible for ensuring care was being implemented as ordered. She stated that she made rounds throughout the day to monitor resident care. However, she was not aware the resident had sat up in the w/c for an extended period of time. She continued to state a resident with a pressure should be positioned off of the pressure area until it was healed.</p>	F 314			

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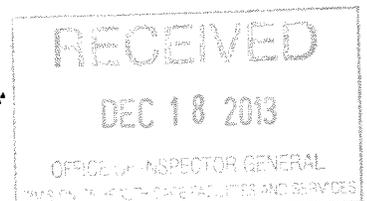
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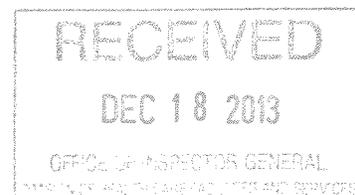
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F 431 SS=F	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in 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, interview, and review of</p>	F 431	<p>The two refrigerators were inspected on 10/31/13 to ensure all medications were dated and that any non-dated or expired medication was removed.</p> <p>All other areas where medications are stored were inspected on 10/31/13 and no expired or non-dated medication was found.</p> <p>Checking the medication refrigerators was added to the 3rd Shift Nurse Duty Log on 11/01/13. This duty will ensure that all medication storage areas are inspected daily. On 11/22/13 a memo created by the DNS was communicated to all nurses that specifies, the new duty added to the 3rd Shift Nurse Duty Log. Every nurse will sign an acknowledgement that they have read and understand the new duty added to the log by 12/9/13. The Staff Development Coordinator will review by 12/10/13 all signed acknowledgements sheets to ensure that all nurses have read the memo on new duties. After 12/9/13 any nurse who has not signed the acknowledgement will not be scheduled until education completed.</p>	12/14/2013



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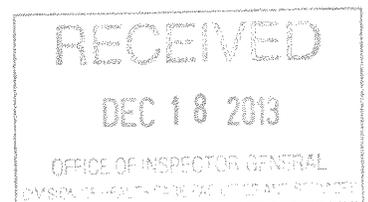
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F 431	<p>Continued From page 11</p> <p>the facility's policy, it was determined the facility failed to ensure medications ready for use were not expired. The facility maintained multidose vials of medication that were expired in two (2) of two (2) medication refrigerators.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure Acquisition, Receiving, Dispensing and Storage of Medications, issued September 2012, revealed the center would have a process in place to check for expired medications in accordance with state and pharmacy regulations.</p> <p>Review of the Night Shift Duties, revised July 2010, revealed the staff was to check medication carts to ensure appropriate medications had been dated and expired medications removed.</p> <p>Review of the Centers for Disease Control and Prevention Medication Storage and Handling revealed multidose vials that had been opened or accessed (e.g., needle-punctured), should be dated and discarded within 28 days unless the manufacturer specified a different (shorter or longer) date for that opened vial.</p> <p>Observation, on 10/31/13 at 7:45 AM, of the medication refrigerator on the C/D corridor revealed one (1) vial of Purified Protein Derivative (PPD) was opened and undated. The dispense date was 09/16/13.</p> <p>Interview with Registered Nurse (RN) #1, on 10/31/13 at 7:50 AM, revealed the vial should have been dated and initialed when it was opened as multidose vials were only good for thirty (30) days.</p>	F 431	<p>Continued From page 11</p> <p>The MDS/Care Coordinators will check the medication refrigerators and will audit the 3rd Shift Nurse Duty Log daily until all floor nurses have completed the training, then weekly for 3 weeks and monthly thereafter not to exceed one year. This will be completed to ensure proper use of the log and that medication areas are being inspected. One-on-one education and counseling, up to and including corrective action, will be provided to staff by the DNS where issues are found. The DNS will report the audit findings to the QA committee which will monitor to ensure medications are stored appropriately.</p>		



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F 431	<p>Continued From page 12</p> <p>Observation, on 10/31/13 at 9:30 AM, of the medication refrigerator on the A/B corridor revealed two (2) vials of Flu vaccine with the manufacture's expiration date of 06/30/13. One (1) vial was opened and undated.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/31/13 at 9:35 AM, revealed the night shift staff was responsible to check medication carts and refrigerators for expired medications. She stated a multidose vial was only good for thirty (30) days once it was opened.</p> <p>Interview with LPN #2, on 10/31/13 at 9:45 AM, revealed she was responsible for Staff Development and had administered the Flu vaccine to the residents the first week of October. She stated she had ordered some Flu vaccine and it was stored in the Staff Development office refrigerator. She stated she had not administered the flu vaccine that was expired. She stated there had not been any recent training on checking medications for expiration dates.</p> <p>Observation, on 10/31/13 at 9:55 AM, revealed the Flu vaccine stored in the Staff Development office was not expired.</p> <p>Interview with the Director of Nursing, on 10/31/13 at 2:00 PM, revealed the 11-7 nurses were responsible to ensure medications were checked for expiration dates in the medication carts and refrigerators. She stated the break in the system was miscommunication of the third shift duties list and the nurses had not dated the vials when they were opened. She stated the potential complications if the medication was expired was the efficacy of the drug and potential</p>	F 431		



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F 431	Continued From page 13 bacterial growth for multidose vials.	F 431			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1980</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet / dry) sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/29/13. The Good Samaritan Society - Jeffersontown was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>		

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

TITLE

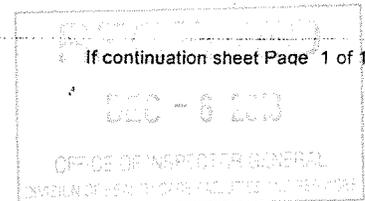
(X6) DATE

X Claude Mapp

X Administrator

X 12/6/13

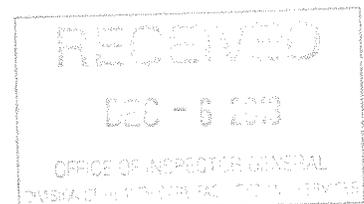
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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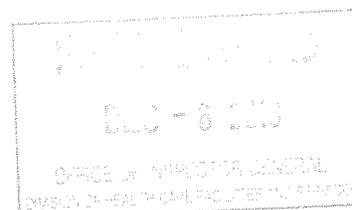
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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at F level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was ninety-one (91) on the day of the survey. The findings include: Observations, on 10/29/13 between 9:16 AM and 9:38 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed the doors to the Human Resources Record Room and the Janitor's Closet located in	K 029	The doors to the Human Resources Record Room and the Janitor's Closet located in the Administrative Area have had self-closing hinges installed on 11/05/13. All hazardous areas were checked by the Maintenance Supervisor on 11/06/13 to ensure self-closing or automatic-closing doors are used, where appropriate, to separate areas from other spaces. There were no other deficient practices identified. The Environmental Services Director and the Maintenance Supervisor will receive and review OIG Life Safety Code training by 12/10/13 that is presented by Robert G. Andrew II, Regional Program Manager for OIG – Division of Health to ensure compliance with all Life Safety Codes. The Maintenance Technician will check all doors requiring self-closing or automatic closing devices monthly on an ongoing basis to ensure said devices remain in all appropriate areas. These checks will be documented on an audit form. The Environmental Services Director will report the findings of the audit to the QA Committee monthly, not to exceed one year, to ensure self-closing or automatic-closing doors are used, where appropriate, to separate areas from other spaces.	12/11/2013



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K 029	<p>Continued From page 2</p> <p>the Administrative Area, did not have self-closing devices installed on the doors.</p> <p>Interview, on 10/29/13 between 9:16 AM and 9:38 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed they were not aware of the doors to the Records Storage Room and Janitor 's Closet not being equipped with self-closing devices. The Records Storage Room had been converted from a Staff Restroom, which did not require a self-closing device on the door.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 	K 029		



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K 029	Continued From page 3 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029			
K 056 SS=F	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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete automatic sprinkler system, in accordance with NFPA standards. The deficiency had the potential to affect six (6) of eight (8) smoke compartments, residents, staff,	K 056	The roof overhangs at the Courtyard entrance canopy and the exits from Resident Halls A, B, C and D will have automatic sprinkler coverage installed the week of 12/02/13. Landmark Sprinkler Incorporated will complete the work within all applicable standards by 12/10/13. The entire building will be inspected by Landmark Sprinkler Incorporated on 12/10/13 to ensure that complete sprinkler coverage is provided within all applicable standards. The Environmental Services Director and the Maintenance Supervisor will receive and review OIG Life Safety Code training by 12/10/13 that is presented by Robert G. Andrew II, Regional Program Manager for OIG – Division of Health to ensure compliance with all Life Safety Codes.	12/11/2013	



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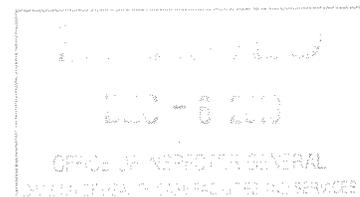
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K 056	Continued From page 4 and visitors. The facility has ninety-eight (98) certified beds and the census was ninety-one (91) on the day of the survey. The findings include: Observations, on 10/29/13 between 9:23 AM and 10:48 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed the roof overhangs at the Courtyard entrance canopy and the exits from Resident Halls A, B, C and D were not protected by automatic sprinkler coverage. The roof overhangs exceeded the maximum four (4) foot projection and were constructed with combustible materials. Interviews, on 10/29/13 between 9:23 AM and 10:48 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed they were not aware the roof overhangs were not being protected by automatic sprinkler coverage. 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	Continued From page 4 Landmark Sprinkler Incorporated will perform quarterly inspections on an ongoing basis to ensure that the automatic sprinkler system is operational within all applicable standards. The Environmental Services Director will report the findings to QA quarterly not to exceed one year.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066		



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K 066	<p>Continued From page 5</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for Staff, was properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect the Staff using the smoking area. The facility has ninety-eight (98) certified beds and the census was ninety-one (91) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/29/13 at 9:31 AM, with the Director of Environmental Services and</p>	K 066	<p>A 5# ABC fire extinguisher and an 18 1/4" x 14" terne plated (lead/tin coated steel) can constructed with a foot pedal and a ventilated base has been ordered from Pro Fire Extinguishment and will be made available by 11/29/13 to ensure the designated outdoor smoking area for Staff is equipped for safe smoking in accordance with NFPA standards. Until then, smoking has been prohibited.</p> <p>There are no other smoking areas on the premises.</p> <p>The Maintenance Technician will inspect the staff smoking area during his facility rounds on an ongoing basis. The Environmental Services Director and the Maintenance Supervisor will receive and review OIG Life Safety Code training by 12/10/13 that is presented by Robert G. Andrew II, Regional Program Manager for OIG – Division of Health to ensure compliance with all Life Safety Codes.</p> <p>The Environmental Services Director will report the findings of the Maintenance Technician's inspection to QA monthly, not to exceed one year, to ensure that the staff smoking area is safe in accordance with NFPA standards.</p>	12/11/2013	



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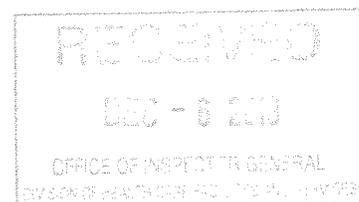
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K 066	<p>Continued From page 6</p> <p>Maintenance Supervisor revealed the designated outdoor smoking area for Staff did not have an approved metal container with a self-closing lid to empty ashtrays into and a fire extinguisher available for use.</p> <p>Interview, on 10/29/13 at 9:31 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed they were not aware of the requirements for the designated, outdoor smoking area for Staff to be equipped with an approved metal container with a self-closing lid to empty ash trays into and a fire extinguisher available for use.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited.</p>	K 066			



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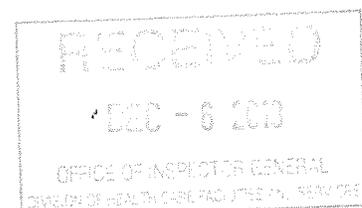
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K 066	Continued From page 7 Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments and Staff. The facility has ninety-eight (98) certified beds and the census was ninety-one (91) on the day of the survey. The findings include: Observations, on 10/29/13 at 9:13 AM, with the Director of Environmental Services and the	K 130	The unapproved locks [slide bolt types] were removed from the Human Resource's Restroom door as well as from the adjacent Human Resource's Records Room door on 10/29/13. The Maintenance Supervisor also checked all other doors within a required means of egress on 10/29/13 to ensure that they are not equipped with a latch or lock that requires the use of a tool or key from the egress side. There were no other deficient practices found.	12/11/2013



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K 130	Continued From page 8 Maintenance Supervisor revealed unapproved locks [slide bolt types] were installed on the egress side of the doors exiting from the Human Resources Restroom and the adjacent Human Resources Record Room to the exit access corridor. Interview, on 10/29/13 at 9:13 AM, with the Director of Environmental Services and Maintenance Supervisor revealed they were unaware of the slide bolt locks being prohibited and agreed that slide bolt locks could be a deterrent to exiting the rooms in the event of an emergency. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	Continued From page 8 The Maintenance Technician will inspect all doors within a required means of egress monthly on an ongoing basis to ensure that they are not equipped with a latch or lock that requires the use of a tool or key from the egress side. The Environmental Services Director and the Maintenance Supervisor will receive and review OIG Life Safety Code training by 12/10/13 that is presented by Robert G. Andrew II, Regional Program Manager for OIG – Division of Health to ensure compliance with all Life Safety Codes. The Environmental Services Director will report the findings of the inspections to the QA Committee monthly, not to exceed one year, to ensure that said doors are not equipped with a latch or lock that requires the use of a tool or key from the egress side.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, approximately twenty (20) residents, staff, and visitors. The facility has ninety-eight (98) certified	K 147	The hydrocollator located within the Physical Therapy Room was unplugged from the power strip that was plugged into a standard electrical wall outlet. The hydrocollator was relocated to a different area within the same Physical Therapy Room and was plugged into a ground fault circuit interrupter (GFCI) wall outlet on 10/29/2013. On 10/31/2013 the Maintenance Supervisor checked all medical equipment in use that contains water to ensure the devices are plugged into GFCI wall outlets.	12/11/2013



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K 147	<p>Continued From page 9 beds and the census was ninety-one (91) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/29/13 at 9:45 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed the hydrocollator (therapy equipment containing hot water) located within the Physical Therapy Room, was plugged into a power strip that was plugged into a standard electrical wall outlet and not plugged into a ground fault circuit interrupter (GFCI) wall outlet as required in wet areas.</p> <p>Interview, on 10/29/13 at 9:45 AM, with the Director of Environmental Services and the Maintenance Supervisor revealed they were not aware of the hydrocollator being plugged into a power strip that was plugged into a standard electrical wall outlet and acknowledged the requirement of medical equipment containing water to be plugged in a GFCI outlet. The equipment used within the Physical Therapy Room had recently been rearranged by the new Physical Therapy Staff.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D 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>Continued From page 9</p> <p>An additional GFCI wall outlet was installed in the Physical Therapy Room on 11/01/13 to provide better accessibility for equipment needing it. The Environmental Services Director will provide training by 12/10/13 to all restorative aides, MDS/Care Coordinators, and therapy staff who utilize medical equipment containing water in order to ensure equipment is plugged into appropriate wall outlets when in use.</p> <p>The Maintenance Supervisor will inspect areas, where medical equipment containing water is in use, daily for 1 week, weekly for 3 weeks and monthly thereafter not to exceed one year. The inspections will be reported to the QA Committee by the Environmental Services Director to ensure medical equipment containing water is plugged into GFCI wall outlets when in use.</p>		

