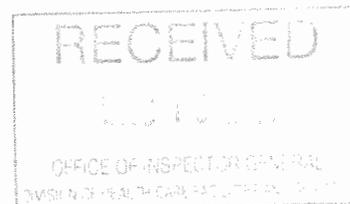


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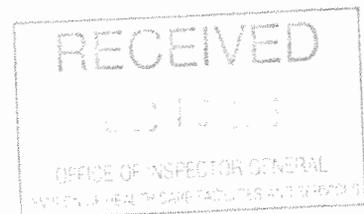
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
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F 514	<p>Continued From page 165</p> <p>event form or other documentation related to Resident #10's fall.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed the nursing staff involved in the incident would complete an event form in the computer. She stated she had no memory or documented evidence that she or the IDT informed the nurse of the need to complete a fall event form.</p> <p>5. Review of Resident #12's clinical record revealed the facility admitted the resident on 06/12/15 with diagnoses Difficulty Walking, Weakness, Pneumonia and Respiratory Failure.</p> <p>Review of Resident #12's FCEF, dated 08/04/15 at 11:37 PM, revealed the resident sustained an unwitnessed fall with injury of a nasal fracture. The form did not have seventy-two hours of reassessment documentation of the resident's response to treatments or the effectiveness of the interventions and the Interdisciplinary Team did not document a review regarding the established root cause, evaluation, thoroughness or effectiveness of the actions taken.</p> <p>On 10/15/15 at 2:45 AM, interview with Registered Nurse (RN) #4, revealed she was a new employee and felt uncomfortable with only having received five days of orientation and then was on her own. She stated the facility had just started the new Electronic Medical Record (EMR) and she was still learning how to navigate through the computerized medical record. She stated she had not looked at Resident #12's care plan and did not know where to locate it in the new EMR. She stated if the EMR was not complete she would not have the necessary information to meet the needs of the resident.</p>	F 514		



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F 514	Continued From page 166 On 10/27/15 at 11:30 AM, interview with the Assistant Director of Health Services (ADHS), revealed the Interdisciplinary Team reviewed events and determined what caused residents fall. He stated the team had not determined any other issues with the documentation or event investigation process in their review of Resident #12. He stated if the resident's medical record was not complete it would be difficult for staff that were unfamiliar with the resident to meet their needs. Interview with LPN #8, on 10/14/15 at 8:10 PM, revealed the new EMR system was difficult to navigate and she did not know where to locate certain resident information in the computer. She stated the new EMR system had been updated several times since going live in June of 2015; which made it more difficult to remember to document follow-up assessments after a resident event. She stated after an event occurred nursing must document on the resident for 72 hours. She stated the system used to prompt nursing to make follow up assessments and now it did not. She stated if you were unaware of an event then you would not know to perform a resident assessments. She stated a complete and up to date medical record was important for resident care. Interview with LPN #4 on, 10/08/15 at 2:25 PM, revealed the event forms had areas for her to click on, to add additional interventions for resident care; however, she did not know if the EMR automatically developed a plan of care or revised the resident's plan of care, when she clicked on additional interventions. She stated the Minimum Data Set nursing staff normally revised	F 514			



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F 514	<p>Continued From page 167</p> <p>care plans sometime after the event. She stated if she instituted interventions for resident care she verbally told staff, but if they did not continue to tell other staff about the new interventions the information would not get forwarded to ensure resident care needs were met. She stated if the medical record did not contain assessments or pertinent resident information resident needs could not be met.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed she did not know staff were not completing reassessment documentation or assessing for further injuries after an event according to facility policy. In addition, she stated the facility event forms had changed over time and used to have a section for documenting the root cause; however, that section was deleted. She stated if forms were not completed the medical record was not complete and the facility could not analyze data to determine if additional actions needed to be taken for the resident. She stated the Interdisciplinary Team (IDT) met every day, except on weekends and holidays, to discuss events that happened the previous day. She stated the IDT did not keep notes or documentation related to the discussion or decisions made during the review of the event. She stated it would be difficult to provide the necessary care and services to residents if the medical record did not contain all nursing assessments and pertinent documentation.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 and took the following actions to remove the Immediate Jeopardy on 10/23/15:</p> <p>1. The facility conducted a review of the</p>	F 514			

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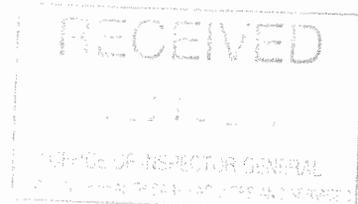
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F 514	<p>Continued From page 168</p> <p>sixty-three (63) current residents' care plans from October 12-20, 2015 by the Minimum Data Set (MDS) nurses to ensure care plan interventions were current. Eight (8) care plans required revision. Change in condition (including falls) will be reviewed with care plan revision as needed during the Clinical Care Meeting. The Director of Health Services will be responsible for overseeing the meetings with follow up on events that have occurred within the last twenty-four (24) hours. Education was provided for the Interdisciplinary Team (Administrative Nurses, Social Services, Activities, Therapy Director, and MDS Nurses on 10/19/15 by the Assessment Support Nurse and the External Audit Nurse.</p> <p>2. A Care Plan Audit tool was developed and will be used to ensure care plans are reviewed and revised during the Clinical Care Meeting (Monday-Friday) and weekend days by the Director of Health Services, Assistant Director of Health Services, or MDS Nurse.</p> <p>3. A Profile Binder with current safety interventions (based on the care plan) for each resident was placed on each unit, on 10/21/15, for the nursing aides. The binders will be updated daily after the Clinical Care Meeting by the MDS or Medical Records. Audits will be completed daily.</p> <p>4. Charge Nurses will round daily during the Medication Pass to observe for compliance with safety interventions according to the plan of care. Audits will be conducted on the first and second shift and Night Shift Nurses will conduct routine rounds that included observing for safety interventions for five (5) random residents.</p>	F 514			

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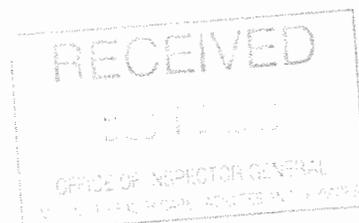
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F 514	Continued From page 169 5. Falls will be reviewed during the weekly Clinical at Risk meetings to ensure effective interventions are in place. Residents who sustained a fall will be followed in these meetings for four (4) weeks. 6. Safety Device Audits (five residents per day) will be conducted daily by department leaders, on random shifts, to ensure devices are in place and functioning.	F 514			
	7. An audit was conduct on 10/18/15 of each resident's medical record to ensure proper information related to Advance Directives were in the Soft file at each unit. Advance Directives information will be obtained at admission with appropriate papers signed and placed into the Soft File at each unit. This would include each resident's code status. 8. Education for the Executive Director, Medical Record Staff, Director of Health Services and her assistant, and Social Services were completed on 10/19/15, by the Clinical Director, of the importance of maintaining the integrity of medical record and Advance Directives information being available for Charge Nurses in the event of a resident was transferred to the hospital. 9. Scanning guidelines will be followed based on protocols for the Electronic Health Record. Daily audits will be conducted by the DHS, ADHS, MDS, and Medical Records to ensure completion of all admission records and Advance Directive information placed into the Soft Files. These audits will be reviewed during the daily Clinical Care Meeting. 10. A Quality Assurance (QA) Meeting was				



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F 514	<p>Continued From page 170</p> <p>conducted on 09/18/15 to review Falls Trending. Another QA meeting was held on 10/19/15 with the Medical Director in attendance to review the Guidelines and protocol for conducting Quality Assurance Meetings.</p> <p>11. Education was provided by the Clinical Director to the Executive Director, Director of Health Services and her assistant, and other department leaders that included issues of fall management, Advance Directives, and monitoring of care plans. Corrective plans were developed based on trends prevalent in a system not in compliance. Action plans developed with focus on goals and protocols for Clinical Care Meeting and its direct relationship to Quality Assurance activities.</p> <p>12. Audits implemented will be reviewed during the monthly QA meeting and during the Clinical Support Nurse's routine visits that occur once a week. Audits included Safety Device, Advance Directive, and Soft files, Clinical Care Meetings, Clinical at Risk Meetings, Care Plans, and QA.</p> <p>The State Survey Agency (SSA) validated the implementation of the facility's AOC as follows:</p> <p>1. Record review revealed Residents #5, #8, #10, #13, and #19 care plans were revised. Resident #20 was sampled during the extended survey due to being the only resident with a fall since the alleged Immediate Jeopardy abatement date of 10/23/15. The resident's care plan was reviewed during the Clinical Care Meeting and revised as needed.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed the</p>	F 514			



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F 514	<p>Continued From page 171</p> <p>Interdisciplinary team received training on care plan revision and implementation. She stated she was responsible for overseeing the Clinical Care Meetings and ensured the care plan was revised and all events received follow-up monitoring to ensure the event reports were completed. In addition, she randomly reviewed one-two care plans daily to ensure completion.</p> <p>2. Sampled Resident #20's fall (10/25/15) was discussed in the Clinical Care Meeting and revision of the care plan was completed. Review of the care plan audits revealed revision of the care plans were occurring after an event or change in the resident. Review of the sampled residents for the extended survey revealed the care plan had been revised after a change in the resident's status to include falls.</p> <p>3. Observation of the 400, 500, and Health Care Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for interview during the extended survey.</p> <p>4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement.</p>	F 514			

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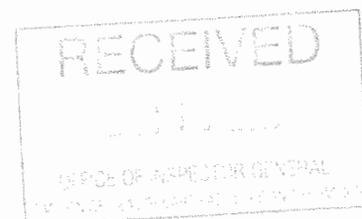
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F 514	Continued From page 172 Interviews with LPN #5, on 10/26/15 at 4:00 PM, LPN #12 on 10/27/15 at 11:15 AM, and LPN #6 on 10/28/15 at 9:00 AM, revealed the nurses conducted walking rounds to check for safety devices and call lights at the beginning of the work shift and again when they administered medications. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed she had randomly observed walking rounds between the nursing aides and nurses giving report. Review of the safety devices/call light audits revealed at least five (5) residents were observed daily for safety device and call light placement and proper functioning of the devices. 5. Review of the Fall Circumstance Event Report for Resident #20, revealed the fall was discussed in the Clinical Care Meeting. Audits revealed Resident #20 was included. Interview with LPN #5, on 10/26/15 at 4:00 PM, revealed the resident slid from the bed and experienced no injury. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, Executive Director, on 10/28/15 at 3:00 PM, and Clinical Director, on 10/29/15 at 12:00 PM, revealed all falls and any change in condition were discussed during the Clinical Care Meetings. Review of the audits revealed the meetings were held on October 21, 22, 23, 26, and 27. A meeting was held on 10/28/15 at 10:00 AM and validated by observation of the SSA. Review of the Changes in condition, including fall investigation and root cause analysis will be discussed during the Clinical Care Meetings. The Fall Circumstance Event Reports are reviewed for	F 514			

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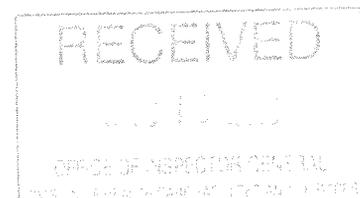
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F 514	<p>Continued From page 173 completion and ensure appropriate safety interventions had been implemented to reduce the risk of future falls.</p> <p>6. The facility reviewed all safety devices and conducted assessments with some safety devices discontinued. There were seven (7) residents with safety devices during the extended survey. Review of the audits revealed five (5) or more residents were audits to ensure safety devices were in place and functioning.</p> <p>7. Review of the Soft Files for the 500, 400, and Health Care Units revealed each resident had been offered Advance Directives and each resident had a code status. These forms were scanned into the electronic record and the original signed form was kept in the Soft File at each unit.</p> <p>Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she had received training on the Soft Files, scanning forms into the electronic record, and maintaining the medical record. She stated she was responsible for conducting audits of new admission paperwork to ensure the code status and Advance Directive forms are signed and placed into the Soft file on each unit.</p> <p>Observation of the new admission process revealed Advance Directive forms were signed and placed into the soft file. Resident #21, #22, and #23 were sampled during the extended survey to validate the admission paperwork was completed and Advance Directive forms signed and placed into the Soft file.</p> <p>8. Review of the training record revealed</p>	F 514			



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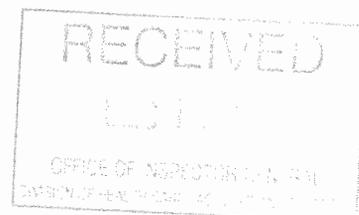
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F 514	<p>Continued From page 174</p> <p>education was provided on 10/19/15 as stated in the AOC. Interview with the Medical Records, on 10/28/15 at 2:40 PM, Director of Health Services, on 10/28/15 at 1:50 PM, and Social Services on 10/28/15 at 2:48 PM, revealed they had received the training.</p> <p>9. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she received training on the scanning guidelines. She stated she now had additional staff to help with the scanning of the medical record into the electronic record. She stated audits were conducted daily to ensure scanning guidelines are followed.</p> <p>Review of the Daily Careplan audit forms, Falls Interventions audit forms, Call Light audit forms, Fall Investigation audit forms, the Safety/Assistive Device audit forms, and the Admission audit forms revealed they were all completed.</p> <p>10. Review of the QA signature sheets revealed QA meetings were held on 10/19/15 and 10/29/15. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director on 10/29/15 at 12:00 PM validated the QA meetings were held on those dates.</p> <p>Interview with the Clinical Director and the Clinical Support Nurse, on 10/29/15 at 12:00 PM, revealed the QA meeting on 10/19/15 was to develop the Plan of Action to correct the Immediate Jeopardy, develop audits, and capture any trends of non-compliance. The Clinical Director stated staffing was reviewed to determine if it contributed to the non-compliance and she was looking at staffing as part of the solution. She stated the facility had been given extra hours for staffing and was in the process of</p>	F 514			



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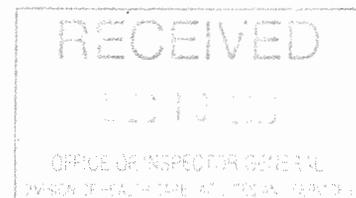
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F 514	Continued From page 175 determining where the hours would be best spent. The Clinical Director stated the QA meeting of 10/29/15 was to review audits, and evaluate the plans of actions. She stated the audits revealed no problems and the AOC was implemented and monitored as stated. She stated the facility would continue to meet monthly and she would be at the facility almost daily to assist the new Executive Director and ensure compliance. The Clinical Support Nurse stated she would visit the facility at least twice a week and as needed to ensure the Clinical Care and Clinical at Risk meetings were conducted according to the AOC. The Clinical Director stated she would attend the monthly QA meetings for at least six (6) consecutive months. 11. Interview with the Clinical Director, on 10/29/15 at 12:00 PM, revealed she provided the education to the Executive Director and Director of Health Services on 10/19/15. Review of the training records validated the training. Interview with the Executive Director and Director of Health Services on 10/29/15 at 12:15 PM, revealed they received training on Advanced Directives, revision of care plans, documentation, audits, monitoring, scanning guidelines, systems related to falls, and the protocols for Quality Assurance. 12. Review of the audits revealed the facility conducted the audits as stated in the AOC. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director, on 10/29/15 at 12:00 PM, revealed the audits were conducted and forwarded to them for review of compliance. The audits were brought to the 10/29/15 QA	F 514		



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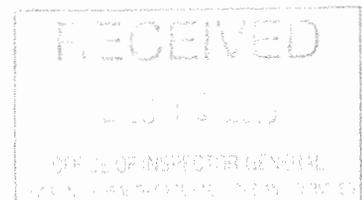
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
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F 514 F 520 SS=K	Continued From page 176 meeting to review and discuss trending. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. 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 have an effective system in place to ensure the Quality Assurance (QA) Committee investigated and developed	F 514 F 520	All residents have the potential to be affected by the alleged deficiency. Quality Assurance meetings were held on 9/18/15, 10/9/15, 10/29/15, 11/24/15, and 12/4/15. Discussion centered around survey results, protocols and implementation of systems related to falls or other deficiencies. Ongoing audit results were discussed and ongoing education. New ED and Administrator met with the Medical Director to review the QA process on 12/7/15. Medical Director in attendance on 9/18/15 and 11/24/15 and 12/4/15. Pharmacy Consultant attended meeting on 11/24/15.	



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F 520	<p>Continued From page 177</p> <p>plans of action in response to identified problems. The facility failed to provide the assessed needs of its residents and failed to maintain a safe environment. Interviews with the Management staff and QA members revealed they were aware of the facility's numerous falls with significant injures. However, they failed to develop a plan of action to meet residents fall risk needs to ensure their safety. This failure affected five (5) of twenty-five (25) sampled residents and had the potential to affect more residents of the facility relative to the system for ensuring that residents received the required supervision of care and services to maintain their safety and well-being. (Refer to F280, F282, F323 and F514)</p> <p>On 09/07/15, Resident #1 sustained an unwitnessed fall that resulted in injury and transfer to the hospital. Review of the Emergency Room record, dated 09/07/15, revealed the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two rib fractures and a Flailed Chest injury (a life threatening medical condition that occurs when a segment of the rib cage breaks under extreme stress and becomes detached from the rest of the chest wall, so a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure. Staff stated they were busy off the unit or tending to other residents on another hall when Resident #1 fell. Additional interview with staff revealed the bed alarm unit was not turned on and the resident's call light was not within reach at the time of Resident #1's fall.</p> <p>On 09/26/15 Resident #8 sustained an</p>	F 520	<p>Clinical Support in attendance at all QA Meetings.</p> <p>Inservice education was completed regarding guidelines and protocols for conducting QA meetings with ED, DHS, and QA leadership team. This inservice education was conducted on 12/7/15 by the Director of Compliance who is serving as the Interim ED and the VP of Continuing Education. This education included all areas cited in this survey, as well as the process for developing corrective action plans when non compliance is identified to ensure goals in a corrective action plans are measurable.</p>	



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F 520	<p>Continued From page 178</p> <p>unwitnessed fall with injury. The staff heard the resident yelling for help, went to investigate and found the resident on the floor. The resident sustained bruising and a skin tear to the right elbow, abrasion to mid-lower spinal bony prominence and complained of right lower rib pain. Review of the Radiology Report, dated 09/26/15, revealed Resident #8 had a right non-displaced lateral 8th rib fracture.</p> <p>On 09/30/15 Resident #10 sustained an unwitnessed fall. The staff found the resident on the floor complaining of back pain. The resident told the staff he/she had attempted to get to their walker; however, the walker tipped over and the resident fell. Emergency Medical Services was called and transferred the resident to the hospital. Hospital x-ray results revealed a thoracic compression fracture at T9 (9th vertebra). The resident continued to have severe pain and muscle spasms and a back brace was ordered.</p> <p>On 09/09/15 Resident #9 sustained an unwitnessed fall. The resident was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was noted on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation and the resident required ten (10) sutures to the right foot, underneath and between the fourth and fifth toes. The hospital X-ray results revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p> <p>On 08/04/15 Resident #12 sustained an unwitnessed fall with injury. The resident reported he/she tried to get up from the potty chair and fell.</p>	F 520	<p>Systemic change is the Chief Compliance Officer or the Clinical support nurses will be present for the next 6 consecutive monthly QA meetings then quarterly thereafter.</p> <p>The Chief Compliance Officer or Director of Compliance will review QA minutes and action plans weekly to assure effective results are being achieved through the QA process. Monitoring will occur monthly for the next 6 months then quarterly thereafter.</p> <p>Completion date 12/10/15</p>	

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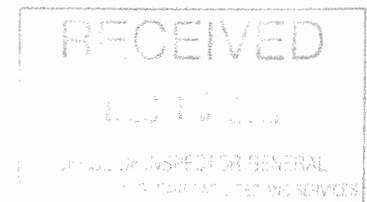
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F 520	<p>Continued From page 179</p> <p>The resident had swelling and an abrasion with bleeding to the nose. The Event Report revealed there were no possible contributing factors present at the time of the fall. The resident returned from the hospital with a diagnosis of a nasal fracture.</p> <p>The facility's failure to have an effective system in place, to ensure the facility implemented quality assurance activities that ensured resident needs were met, has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F520, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>Review of the facility's policy related to Guidelines for the Quality Assessment and Assurance Process, not dated, revealed the purpose was to provide continuous evaluation of campus systems to distinguish between isolated, pattern or system concerns, ensure systems were functioning appropriately, to prevent problems from arising to the extent possible, recognize incremental change that may be early signs of potential/future problems, and correct identified issues. The primary purposes of the Quality Assessment and Assurance Plan would be to establish and provide</p>	F 520		

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F 520	<p>Continued From page 180</p> <p>a system whereby a specific process, and the documentation relative to it, would be maintained to support evidence of an ongoing Quality Assessment and Assurance Program, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to campus residents. To develop a plan of correction and evaluate corrective actions taken to obtain the desired results. To provide a centralized, coordinated approach to quality assessment and assurance activities so as to bring about comprehensive program of quality assessment and assurance to meet the needs of the facility.</p> <p>Review, on 10/5/15 at 11:00 AM, of the QA signature sheets revealed the facility conducted QA meetings at least monthly with the required members.</p> <p>Interview with the Medical Director, on 10/16/15 at 12:40 PM, revealed the QA Committee had identified there were fifty-six resident falls from 07/01/15 to 10/01/15. The Medical Director stated the facility had resident's with higher than normal healthcare needs because of their need for rehabilitation after recent hospitalizations. He stated the facility needed to be more vigilant in providing resident care and safety, in order to meet these types of resident needs. He stated the QA Committee determined several residents had sustained significant injuries from their falls and the QA Committee determined the facility also had a staffing issue. He stated the only action plan put in place by the committee, to his knowledge, was to address the staffing issue; however, he did not know if the facility had increased staffing or not. He stated the new Electronic Medical Record also played a huge</p>	F 520			



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F 520	<p>Continued From page 181</p> <p>role in the problems the facility experienced. He stated the role of the QA committee was to improve identified quality issues.</p> <p>Interview with the Director of Health Services (DHS), on 10/16/15 at 11:30 AM, revealed she was aware some residents were missing fall event reports. The DHS stated the nursing management team was responsible for monitoring event reports for completion. The DHS stated when a nurse failed to complete an order the nurse was given a reminder paper to review the area of concern; the process was called the Continuous Quality Improvement (CQI) process. However, the facility did not keep a record of this process and she could not remember the staff that might have received these reminders. She stated she did not know of an action plan put in place by the QA Committee that addressed quality deficiencies related to falls or documentation issues. She stated the QA process was an important role in the facility to ensure resident's needs were met.</p> <p>Interview with the Director of Clinical Support and the Executive Director, on 10/16/15 at 10:45 AM, revealed the QA Committee met monthly to discuss QA issues. They stated no action plan was developed related to falls; however, a plan should have been developed to ensure resident safety. They stated the Interdisciplinary Team (IDT) should have been monitoring the electronic medical record documentation to determine if staff had not completed Event Reports and resident reassessments, in addition to determining the root cause of the events. They stated it was also the role of the DHS to monitor and address any identified concerns. They stated prior to the survey process beginning they had</p>	F 520			

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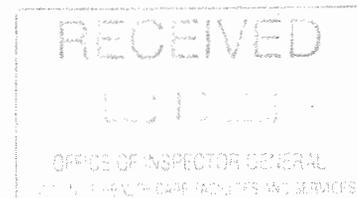
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F 520	Continued From page 182 not identified any issues with the QA system process conducted by the IDT or the DHS. They stated prior to the survey process neither had provided direction or guidance to the facility staff in regards to improving the quality processes, related to falls, care planning, or documentation. The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 and took the following actions to remove the Immediate Jeopardy on 10/23/15: 1. The facility conducted a review of the sixty-three (63) current residents' care plans from October 12-20, 2015 by the Minimum Data Set (MDS) nurses to ensure care plan interventions were current. Eight (8) care plans required revision. Change in condition (including falls) will be reviewed with care plan revision as needed during the Clinical Care Meeting. The Director of Health Services will be responsible for overseeing the meetings with follow up on events that have occurred within the last twenty-four (24) hours. Education was provided for the Interdisciplinary Team (Administrative Nurses, Social Services, Activities, Therapy Director, and MDS Nurses on 10/19/15 by the Assessment Support Nurse and the External Audit Nurse. 2. A Care Plan Audit tool was developed and will be used to ensure care plans are reviewed and revised during the Clinical Care Meeting (Monday-Friday) and weekend days by the Director of Health Services, Assistant Director of Health Services, or MDS Nurse. 3. A Profile binder with current safety interventions (based on the care plan) for each resident was placed on each unit, on 10/21/15,	F 520			

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F 520	<p>Continued From page 183</p> <p>for the nursing aides. The binders will be updated daily after the Clinical Care Meeting by the MDS or Medical Records. Audits will be completed daily.</p> <p>4. Charge Nurses will round daily during the Medication Pass to observe for compliance with safety interventions according to the plan of care. Audits will be conducted on the first and second shift and Night Shift Nurses will conduct routine rounds that included observing for safety interventions for five (5) random residents.</p> <p>5. Falls will be reviewed during the weekly Clinical at Risk meetings to ensure effective interventions are in place. Residents who sustained a fall will be followed in these meetings for four (4) weeks.</p> <p>6. Safety Device Audits (five residents per day) will be conducted daily by department leaders, on random shifts, to ensure devices are in place and functioning.</p> <p>7. An audit was conduct on 10/18/15 of each resident's medical record to ensure proper information related to Advance Directives were in the Soft file at each unit. Advance Directives information will be obtained at admission with appropriate papers signed and placed into the Soft File at each unit. This would include each resident's code status.</p> <p>8. Education for the Executive Director, Medical Record Staff, Director of Health Services and her assistant, and Social Services were completed on 10/19/15, by the Clinical Director, of the importance of maintaining the integrity of medical record and Advance Directives information being</p>	F 520			



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F 520	<p>Continued From page 184 available for Charge Nurses in the event of a resident was transferred to the hospital.</p> <p>9. Scanning guidelines will be followed based on protocols for the Electronic Health Record. Daily audits will be conducted by the DHS, ADHS, MDS, and Medical Records to ensure completion of all admission records and Advance Directive information placed into the Soft Files. These audits will be reviewed during the daily Clinical Care Meeting.</p> <p>10. A QA Meeting was conducted on 09/18/15 to review Falls Trending. Another QA meeting was held on 10/19/15 with the Medical Director in attendance to review the Guidelines and protocol for conducting Quality Assurance Meetings.</p> <p>11. Education was provided by the Clinical Director to the Executive Director, Director of Health Services and her assistant, and other department leaders that included issues of fall management, Advance Directives, and monitoring of care plans. Corrective plans were developed based on trends prevalent in a system not in compliance. Action plans developed with focus on goals and protocols for Clinical Care Meeting and its direct relationship to Quality Assurance activities.</p> <p>12. Audits implemented will be reviewed during the monthly QA meeting and during the Clinical Support Nurse's routine visits that occur once a week. Audits included Safety Device, Advance Directive, and Soft files, Clinical Care Meetings, Clinical at Risk Meetings, Care Plans, and QA.</p> <p>The State Survey Agency (SSA) validated the implementation of the facility's AOC as follows:</p>	F 520			

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F 520	<p>Continued From page 185</p> <p>1. Record review revealed Residents #5, #8, #10, #13, and #19 care plans were revised. Resident #20 was sampled during the extended survey due to being the only resident with a fall since the alleged Immediate Jeopardy abatement date of 10/23/15. The resident's care plan was reviewed during the Clinical Care Meeting and revised as needed.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed the Interdisciplinary team received training on care plan revision and implementation. She stated she was responsible for overseeing the Clinical Care Meetings and ensured the care plan was revised and all events received follow-up monitoring to ensure the event reports were completed. In addition, she randomly reviewed one-two care plans daily to ensure completion.</p> <p>2. Sampled Resident #20's fall (10/25/15) was discussed in the Clinical Care Meeting and revision of the care plan was completed. Review of the care plan audits revealed revision of the care plans were occurring after an event or change in the resident. Review of the sampled residents for the extended survey revealed the care plan had been revised after a change in the resident's status to include falls.</p> <p>3. Observation of the 400, 500, and Health Care Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the</p>	F 520			



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F 520	<p>Continued From page 186</p> <p>Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for interview during the extended survey.</p> <p>4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement.</p> <p>Interviews with LPN #5, on 10/26/15 at 4:00 PM, LPN #12 on 10/27/15 at 11:15 AM, and LPN #6 on 10/28/15 at 9:00 AM, revealed the nurses conducted walking rounds to check for safety devices and call lights at the beginning of the work shift and again when they administered medications. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed she had randomly observed walking rounds between the nursing aides and nurses giving report.</p> <p>Review of the safety devices/call light audits revealed at least five (5) residents were observed daily for safety device and call light placement and proper functioning of the devices.</p> <p>5. Review of the Fall Circumstance Event Report for Resident #20, revealed the fall was discussed in the Clinical Care Meeting. Audits revealed Resident #20 was included. Interview with LPN #5, on 10/26/15 at 4:00 PM, revealed the resident slid from the bed and experienced no injury.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, Executive Director, on 10/28/15 at 3:00 PM, and Clinical Director, on</p>	F 520			

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F 520	<p>Continued From page 187</p> <p>10/29/15 at 12:00 PM, revealed all falls and any change in condition were discussed during the Clinical Care Meetings. Review of the audits revealed the meetings were held on October 21, 22, 23, 26, and 27. A meeting was held on 10/28/15 at 10:00 AM and validated by observation of the SSA.</p> <p>Review of the changes in condition, including fall investigation and root cause analysis will be discussed during the Clinical Care Meetings. The Fall Circumstance Event Reports are reviewed for completion and ensure appropriate safety interventions had been implemented to reduce the risk of future falls.</p> <p>6. The facility reviewed all safety devices and conducted assessments with some safety devices discontinued. There were seven (7) residents with safety devices during the extended survey. Review of the audits revealed five (5) or more residents were audits to ensure safety devices were in place and functioning.</p> <p>7. Review of the Soft files for the 500, 400, and Health Care Units revealed each resident had been offered Advance Directives and each resident had a code status. These forms were scanned into the electronic record and the original signed form was kept in the Soft File at each unit.</p> <p>Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she had received training on the Soft Files, scanning forms into the electronic record, and maintaining the medical record. She stated she was responsible for conducting audits of new admission paperwork to ensure the code status and Advance Directive</p>	F 520			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
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F 520	<p>Continued From page 188</p> <p>forms are signed and placed into the Soft file on each unit.</p> <p>Observation of the new admission process revealed Advance Directive forms were signed and placed into the soft file. Resident #21, #22, and #23 were sampled during the extended survey to validate the admission paperwork was completed and Advance Directive forms signed and placed into the Soft file.</p> <p>8. Review of the training record revealed education was provided on 10/19/15 as stated in the AOC. Interview with the Medical Records, on 10/28/15 at 2:40 PM, Director of Health Services, on 10/28/15 at 1:50 PM, and Social Services on 10/28/15 at 2:48 PM, revealed they had received the training.</p> <p>9. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she received training on the scanning guidelines. She stated she now had additional staff to help with the scanning of the medical record into the electronic record. She stated audits were conducted daily to ensure scanning guidelines are followed.</p> <p>Review of the Daily Care Plan Audit forms, Falls Interventions audit forms, Call Light audit forms, Fall Investigation audit forms, the Safety/Assistive Device Audit forms, and the Admission audit forms revealed they were all completed.</p> <p>10. Review of the QA signature sheets revealed QA meetings were held on 10/19/15 and 10/29/15. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director on 10/29/15 at 12:00 PM validated the QA meetings were held on those dates.</p>	F 520			



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F 520	Continued From page 189 Interview with the Clinical Director and the Clinical Support Nurse, on 10/29/15 at 12:00 PM, revealed the QA meeting on 10/19/15 was to develop the Plan of Action to correct the Immediate Jeopardy, develop audits, and capture any trends of non-compliance. The Clinical Director stated staffing was reviewed to determine if it contributed to the non-compliance and she was looking at staffing as part of the solution. She stated the facility had been given extra hours for staffing and was in the process of determining where the hours would be best spent. The Clinical Director stated the QA meeting of 10/29/15 was to review audits, and evaluate the plans of actions. She stated the audits revealed no problems and the AOC was implemented and monitored as stated. She stated the facility would continue to meet monthly and she would be at the facility almost daily to assist the new Executive Director and ensure compliance. The Clinical Support Nurse stated she would visit the facility at least twice a week and as needed to ensure the Clinical Care and Clinical at Risk meetings were conducted according to the AOC. The Clinical Director stated she would attend the monthly QA meetings for at least six (6) consecutive months. 11. Interview with the Clinical Director, on 10/29/15 at 12:00 PM, revealed she provided the education to the Executive Director and Director of Health Services on 10/19/15. Review of the training records validated the training. Interview with the Executive Director and Director of Health Services on 10/29/15 at 12:15 PM, revealed they received training on Advanced Directives, revision of care plans, documentation,	F 520			

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F 520	Continued From page 190 audits, monitoring, scanning guidelines, systems related to falls, and the protocols for Quality Assurance. 12. Review of the audits revealed the facility conducted the audits as stated in the AOC. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director, on 10/29/15 at 12:00 PM, revealed the audits were conducted and forwarded to them for review of compliance. The audits were brought to the 10/29/15 QA meeting to review and discuss trending.	F 520			



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GLEN RIDGE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED R 12/10/2015
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/10/15 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185461	(Y2) Multiple Construction A. Building B. Wing 01 - GLEN RIDGE HEALTH CAMPUS	(Y3) Date of Revisit 12/10/2015
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Name of Facility GLEN RIDGE HEALTH CAMPUS	Street Address, City, State, Zip Code 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0050	Correction Completed 12/10/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>mg</i>	Reviewed By <i>kt</i>	Date: <i>12/23/15</i>	Signature of Surveyor: <i>Melanie Jordan</i>	Date: <i>12/23/15</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/15/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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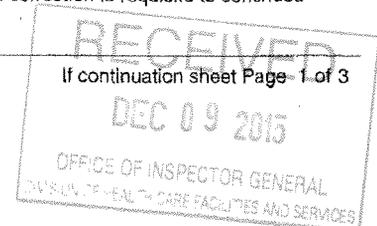
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/26/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GLEN RIDGE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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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: Original Building in 2006, Addition in 2012.</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II, 75 KW generator. Fuel source is Natural Gas with propane back-up.</p> <p>A Recertification Life Safety Code Survey was conducted on 10/15/15. The facility was found not in compliance with the Requirements for Participation in Medicare.</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>All residents have the potential to be affected by this alleged deficient practice. The deficient practice occurred in February and March 2015 by conducting the drills on the same shift for both months.</p> <p>Measures put in place to assure immediate and future compliance include review of fire drill schedule on 12/7/15 with Executive Director and Campus Support for Plant Operations. The schedule has been revised to</p>	12/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Remppford* TITLE: *X ED* (X6) DATE: *X 12-9-15*

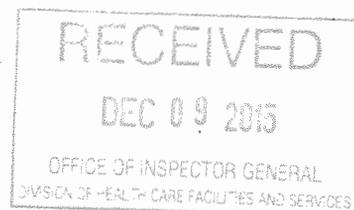
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K 000	Continued From page 1	K 000		
K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the nine (9) smoke compartments, residents, staff, and visitors. The facility has seventy (70) certified beds and the census was sixty-three (63) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the facility's fire drills, on 10/15/15 at 1:17 PM, with a Campus Support person revealed the facility had no evidence of fire drills being conducted during third shift in the first quarter of 2015. Fire drills are required to be conducted, at a minimum of one (1) per shift, per quarter of the year.</p>	K 050	<p>ensure the shift times are taken into consideration when conducting the random fire drills each month.</p> <p>The Executive Director will audit fire drill reports monthly for the next 6 months and report results to the QA Committee with recommendations to reduce the audits to quarterly thereafter.</p>	



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K 050	Continued From page 2 Interview, on 10/15/15 at 1:19 PM, with the Campus Support person revealed he was not aware of the facility did not have evidence of fire drills being conducted during the third shift in the first quarter of 2015. The census of sixty-three (63) was verified by the Executive Director on 10/15/15. The findings were acknowledged by the Executive Director and verified by the Campus Support person at the exit interview on 10/15/15. Reference: NFPA 101 Life Safety Code (2000 Edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		

