

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

PRINTED: 05/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey was conducted on 05/01/12 through 05/03/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope/severity of a "D," with the facility having an opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#22), not in the selected sample, received services in the facility with reasonable accommodation of individual needs and preferences related to the use of a refrigerator in his/her room. Approximately three months ago, Resident #22 requested to have a refrigerator placed in his/her room. The Administrator denied the resident's request due to the facility's electrical wiring, which could not handle the amps of a small refrigerator.	F 246	What corrective action will be accomplished for those residents found to have been affected? Resident #22 was assessed for and approved for a personal dormitory refrigerator. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents residing in private rooms were assessed for personal preferences regarding a personal dormitory size refrigerator in their room.	5/29/2012

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

Frances M Marko

TITLE

Administrator

(X8) DATE

5/24/12

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

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F 246	<p>Continued From page 1</p> <p>Findings include:</p> <p>A review of "Residents have the right to" provided by the activities staff for the resident, and from the Ombudsman, revealed the residents have a right to retain and use personal possessions, including clothing, as space permits. Additionally, the "Personal Items" information, revised 02/16/10, provided to the residents revealed all furniture additions needed to meet personal space limitations: a.) allow enough area for safe mobility of resident, b.) allow for safe transfer of resident by staff or emergency personnel and c.) allow space for needed medical equipment. Further review of the "Personal Items" sheet revealed no language stating a resident could not have a refrigerator.</p> <p>A record review revealed the facility admitted Resident #22 on 05/11/07 with diagnoses to include Cerebrovascular Accident (CVA), Hypothyroidism, Neuropathy of feet and Kidney Disease.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/21/12, revealed the resident had a Brief Interview for Mental Status (BIMS) score of "15," and was assessed as alert and oriented to person, place and time. The resident was independent in his/her decision-making skills. The resident required extensive of assistance of one staff for moving from the bed to his/her chair.</p> <p>Observation and interview with Resident #22, on 05/01/12 at 9:15 AM, revealed the resident was seated in his/her wheelchair in his/her private room, awake and alert. The resident reported he/she requested to have a refrigerator in his/her</p>	F 246	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <ol style="list-style-type: none"> 1. A Personal Refrigerator Policy (Exhibit 1) was put into effect 5/24/2012. 2. The Personal Items guideline which is reviewed and signed by new residents on admission was revised to include guidelines on use of a personal refrigerator in this facility. (Exhibit 2) 3. All staff in serviced by Director of Nursing and/or Assistant Director of Nursing on personal refrigerator policy. 	

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F 246	<p>Continued From page 2</p> <p>room numerous times since admission to the facility and was told he/she could not have one due to the facility's wiring. Resident #22 revealed he/she informed the Administrator that he/she would purchase the refrigerator for the room and the facility would not have to pay for it. The resident reported he/she did not eat meals in the facility. The resident revealed he/she went out for meals and sent out for meals to be brought into the facility at times. On 05/03/12 at 2:30 PM, Resident #22 revealed he/she spoke with the Administrator approximately three months ago related to the issue. Resident #22 revealed he/she was told by the Administrator that there were no refrigerators in the facility, and the facility was not wired to handle refrigerators in the residents' rooms.</p> <p>An interview with the Administrator, on 05/03/12 at 10:21 AM, revealed there were no refrigerators in the residents' rooms because the electrical system in the facility did not allow it. There was not enough ampage in the rooms for the residents to have a refrigerator in their rooms. Resident #22 had inquired about a refrigerator and it was explained to him/her that there was not enough ampage to run a refrigerator in the residents' rooms. There was a refrigerator available for the residents to store their food in and it was offered to the resident when he/she brought food back to the facility.</p> <p>Observation of the medication room for the 200 unit, 300 unit and Transition To Home (TTH) unit, on 05/03/12 at 10:55 AM, revealed there was a tall dormitory-size refrigerator plugged into a power strip. On 05/03/12 at 10:57 AM, in the 100 wing medication room, an observation revealed</p>	F 246	<p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Social Services coordinator will audit residents quarterly to ensure that those residents who request a refrigerator are assessed per policy. Results of the audit are submitted to QA quarterly for follow up and recommendations.</p>		

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F 246	<p>Continued From page 3</p> <p>there was a tall dormitory size refrigerator plugged into a power strip that was plugged into a red outlet (identified as an emergency outlet by the nurse working on the 100 wing).</p> <p>An interview with the Maintenance Supervisor, on 05/03/12 at 12:35 PM, revealed he had been employed by the facility for nine (9) years and no resident ever had a refrigerator. He stated the refrigerators had to be on a circuit by themselves and the facility was not equipped to carry it. He revealed Resident #22 recently asked for refrigerator, but was not allowed to have it. He revealed the medication room refrigerators may pull about 15 amps of electricity and the rooms were wired with 20 amp receptacles. A resident's room could possibly pull a dormitory-sized refrigerator in the regular outlets, if nothing else was used in the outlet. There had not been any issues with the two dormitory-sized refrigerators in the medication rooms that were plugged in power strips, and the circuit breakers had not been tripped to his knowledge.</p> <p>An interview with the Director of Nursing (DON), on 05/03/12 at 1:05 PM, revealed there were not any refrigerators in the residents' rooms. She was informed by her supervisor, that the electrical system within the facility would not accommodate them. She was informed the outlets in the rooms could carry 20 amps and the small refrigerators used as much electricity as a full sized one. The residents had access to a refrigerator; however, foods items could not stay in there long periods of time. Resident #22 had Parkinson's disease and she was unsure if a refrigerator in his/her room would be safe. The residents' rooms were measured and furniture had to be measured, and</p>	F 246		

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F 246	Continued From page 4 be within parameters, so that the residents could bring personal items to decorate their rooms.	F 246			
F 315 SS=D	An interview with Resident #22's Power of Attorney (POA), on 05/03/12 at 1:54 PM, revealed Resident #22 spoke about the issue many times with her, but she had not discussed the issue about the refrigerator with the facility. She stated Resident #22 had discussed it with the facility many times and was informed that it was against the rules to have a refrigerator in the room. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate care and services related to indwelling urinary catheter care for one resident (#5), in the selected sample of 21 residents. Resident #5 was observed with an indwelling urinary catheter tubing dragging on the floor while the resident was being propelled in a wheelchair from the dining room to his/her room.	F 315	What corrective action will be accomplished for those residents found to have been affected? Resident #5's catheter tubing is secured off the floor both in bed and in his wheelchair by the use of a catheter tubing clip. Certified Nursing Assistant Assignment sheet has been adjusted to include the use of a catheter tubing clip to keep tubing off floor.	5/25/2012	

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F 315	<p>Continued From page 5</p> <p>Additionally, the indwelling catheter tubing was observed on the floor while the resident was in bed.</p> <p>Findings include:</p> <p>A review of facility's policy/procedure, "Catheter, Emptying Drainage Bag", dated December 1998, revealed in the Key Procedural Points, (#9) "Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage." Review of the facility's policy/procedure, "Catheter Inserting, Indwelling" revealed (#26) "Attach catheter to the drainage tubing tape catheter to inner thigh or secure with a leg band. Secure drainage tubing to bottom bed sheet with clip from drainage set."</p> <p>A record review revealed the facility admitted Resident #5 on 12/21/09 with diagnoses to include Neuropathic Incontinence requiring an indwelling urinary catheter. Review of a care plan, "Risk for Infection" was implemented on 12/07/10 and included an Intervention to "keep the drainage bag off the floor and cover for dignity."</p> <p>On 05/02/12 at 8:30 AM, an observation revealed Resident #5 was transported in a wheelchair by the staff from the dining room through the administrative hall, and down the entire length of the 100 Hall to his/her room, which was located at the far end of the hall. Observation revealed the resident's urinary catheter tubing was dragging on the floor. Observation, on 05/02/12 at 10:50 AM, revealed the urinary catheter tubing and drainage bag (in a dignity bag) draped from the side of the resident's bed and was lying on the floor surface</p>	F 315	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents with indwelling catheters not attached to a leg bag will have tubing secured off the floor with a catheter tubing clip.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>1. Protocol for securing catheter tubing in bed and in wheelchair has been revised to include use of a catheter tubing clip. (Exhibit #3)</p>		

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F 315	<p>Continued From page 6 next to the bed.</p> <p>Further record review revealed the resident was on a prophylactic daily antibiotic (Macroclantin) regimen for recurrent urinary tract infections. The resident required additional antibiotic treatment (Levaquin) on 07/21/11, 09/26/11, 11/21/11, 01/07/12, and 03/15/12, for a urinary tract infection (UTI).</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 03/28/12, revealed the facility assessed the resident to have moderate cognitive impairment, required extensive assistance with transfers and activities of daily living.</p> <p>An interview with Registered Nurse (RN) #1, on 05/03/12 at 2:00 PM, revealed she was unaware the indwelling urinary catheter tubing was on the floor by the resident's bed, and she should have obtained a clip to secure the tubing and the bag to the bed to prevent it from being in contact with the floor's surface. RN #1 stated, during transport, the staff should ensure the indwelling catheter tubing was not allowed to drag on the floor.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 05/03/12 at 2:25 PM, revealed catheter tubing "does not belong on the floor" and there was a potential for infection.</p>	F 315	<p>2. Director of Nursing and/or Assistant Director of Nursing provided in service education regarding proper placement of the catheter tubing off the floor and the use of the catheter tubing clip for all nursing staff.</p> <p>3. CNAs Assignment sheet includes catheter tubing clip for use with the indwelling catheter if it is not attached to a leg bag.</p> <p>4. Catheter tubing clip is available in each catheter insertion kit and additional clips are available in Medical Supplies.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>1. Nurse responsible for resident will check placement of the tubing q shift and document on the treatment record.</p> <p>2. Random audits of 3 residents per week by Nurse Supervisor will be completed and compliance reported to the QA committee monthly for follow up and recommendations.</p>		

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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: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 5/01/12. Christian Health Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred fourteen (114) beds with a census of one-hundred seven (107) on the day of the survey.</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>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Francis M. Marko UNHA TITLE Administrator (X6) DATE 5/24/12

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

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K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114)</p>	K 018	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>All resident rooms in the facility were inspected to determine if when the bathroom door was open it blocked the closing of the resident room door. All resident rooms on 100 wing except 105 and rooms 212, 305 and 405 were identified.</p> <p>The center hinge on the bathroom door of all rooms identified was replaced with a spring loaded hinge which closes the bathroom door automatically. This does not allow the bathroom door to stay in the open position blocking the resident room door closure.</p>	5/10/2012

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K 018	<p>Continued From page 2 beds and the census was one-hundred seven (107) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 05/01/12 at 2:15 PM, with the Maintenance Technician revealed the corridor doors to all resident rooms located on the 100 wing could be blocked by the resident bathroom doors. Room 104 was one door where the bathroom door was blocking the resident room door.</p> <p>Interviews, on 05/01/12 at 2:15 PM, with the Maintenance Technician confirmed the observation of the doors not closing due to the bathroom doors in the path of the door swing of the resident door.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and</p>	K 018	<p>What measures will be put into place or systemic changes made to ensure deficient practice will not recur?</p> <ol style="list-style-type: none"> 1. Staff in serviced by Director of Nursing and/or Assistant Director of Nursing regarding the function of the spring loaded hinge and requirement that resident room doors not be blocked from closure. 2. Monthly check by maintenance technician to ensure that spring loaded hinge functioning properly. 	

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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustble materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A. 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	How facility plans to monitor performance to ensure solutions are sustained. All rooms will be audited monthly for compliance and reported to the QA committee for follow up and interventions. (Exhibit K1)	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may	K 025		

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K 025	<p>Continued From page 4</p> <p>terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/01/12 between 9:15 AM and 10:00 AM, with the Maintenance Technician revealed the smoke partitions, extending above the ceiling located throughout the facility, were not properly sealed. The barriers failed to be properly sealed from piping and wires.</p> <p>Interview, on 05/01/12 between 9:15 AM and 10:00 AM, with the Maintenance Technician revealed he was not aware of the penetrations in the smoke barriers.</p>	K 025	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>The smoke partitions extending above the ceiling located throughout the facility were inspected and penetrations sealed with mortar and/or fire barrier caulk.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Smoke barriers will be inspected for penetration after any installation or maintenance done in the attic. The inspection will be completed by maintenance technician and any penetrations sealed.</p>	5/25/2012

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K 025	Continued From page 5 Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	How does the facility plan to monitor its performance to ensure that solutions are sustained? Smoke barriers will be inspected with quarterly building inspection to monitor barriers. Compliance will be reported to QA committee quarterly for follow up and recommendations.		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	What corrective action will be accomplished for those residents found to have been affected? The exit lighting fixtures located outside 100 wing shower hall and at the exit at the end of the time clock hall have been replaced with fixtures containing 2 bulbs. All other exterior exit lights contain 2 bulbs.	5/25/2012	

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K 045	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/01/12 between 10:05 AM and 1:30 PM, with the Maintenance Technician revealed the exterior exits at the side exit located at the end of the 100 wing shower hall and the exit at the end of the time clock hall were equipped with a single bulb for illuminating egress path to the public way from the exit.</p> <p>Interview, on 05/01/12 between 10:05 AM and 1:30 PM, with the Maintenance Technician revealed was unaware the lighting fixtures serving the exterior exits must include more than one bulb.</p> <p>Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness.</p> <p>Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination</p>	K 045	<p>What measures will be put into place to ensure deficient practice will not recur.</p> <p>All egress path fixtures will have 2 bulbs. New fixtures or replacement fixtures for egress path will have a minimum of 2 bulbs.</p> <p>How does the facility plan to monitor performance to ensure solutions are maintained?</p> <p>1. Egress lights monitored daily by maintenance technician and bulbs replaced as indicated. 2. Egress fixtures audited quarterly with building inspection to ensure 2 bulb fixtures at egress and compliance reported to QA for recommendations.</p>	

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K 045	Continued From page 7 level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey. The findings include: Observation, on 05/01/12 at 2:15 PM, with the Maintenance Technician revealed that an emergency light with battery backup located at the generator transfer switch did not function properly leaving the potential for the generator transfer switch to be in complete darkness. Interview, on 05/01/12 at 2:15 PM, with the Maintenance Technician revealed he was unaware the light was not functioning properly. He stated that he tests the light weekly by unplugging it to ensure that it would work.	K 046	What corrective action will be accomplished for those residents found to have been affected? The battery backup located at the generator transfer switch was inspected and battery replaced with a new Rechargeable Lead Acid Battery with a useful life of 24 months. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Lead Acid Battery for the battery back up to the emergency light for the generator transfer switch will be replaced yearly in May. The battery has a useful life of at least 24 months and replacement in advance will ensure battery backup working when needed.	5/01/2012

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K 046	Continued From page 8 Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046	How does the facility plan to monitor performance to ensure solutions are maintained? Battery Back Up Light located at the transfer switch for the generator will be checked weekly and reported compliance to QA monthly.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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. 19.7.1.2 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 NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and	K 050	What corrective action will be accomplished for those residents found to have been affected? A fire drill will be completed for the 11-7 shift in May and again in June to provide 2 drills for the first 2 quarters of the year.	5/25/2012

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K 050	Continued From page 9 visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey. The findings include: Fire Drill review, on 05/01/12 at 10:15 AM, with the Maintenance Technician revealed the fire drills were not being conducted at unexpected times under varied conditions. Second shift fire drills were being conducted predictably between 3:25 PM and 4:30 PM, and third shift was between 11:45 PM and 12:20 AM. Furthermore, there was no fire drill conducted for third shift during the first quarter of 2012. Interview, on 05/01/12 at 10:15 AM, with the Maintenance Technician revealed he was unaware the fire drills were not being conducted as required and that the facility could not use a fire drill at shift change for 2 shifts. Reference: NFPA Standard NFPA 101 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	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A Fire Drill schedule will be completed for maintenance as a guide to provide fire drills at least quarterly for each shift and at varied times and locations. (Exhibit K2) How does the facility plan to monitor performance to ensure solutions are maintained? Maintenance Technician will report monthly status of Fire Drills reported to QA committee for compliance and recommendations.		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056	What corrective action will be accomplished for those residents found to have been affected? Overhangs outside the exit door at the end of 100, 200, 300 and TTH have new sprinkler heads installed.	6/15/2012	

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K 056	<p>Continued From page 10 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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/01/12 between 10:15 AM and 1:10 PM, with the Maintenance Technician revealed the overhangs were 48 inches or greater and did not have sprinkler coverage located at the end of the 100 wing, 200 wing, 300 wing and TTH.</p> <p>Interview, on 05/01/12 between 10:15 AM and 1:10 PM, with the Maintenance Technician revealed he was unaware of the requirement for the area to be sprinkler protected.</p> <p>Observation, on 05/01/12 at 12:15 PM, with the Maintenance Technician revealed the closet</p>	K 056	<p>continued from page 10</p> <p>Closet in the Administrator's office had new sprinkler head installed.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Any overhangs attached to the building of 48" or greater will be sprinkled.</p>	

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K 056	Continued From page 11 located in the Administrator 's office did not have sprinkler coverage. Interview, on 05/01/12 between 10:15 AM and 1:10 PM, with the Maintenance Technician revealed he was unaware the closet did not have 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	How does the facility plan to monitor performance to ensure solutions are maintained? Sprinklers will be monitored for cleanliness quarterly and cleaned as indicated. Compliance will be reported to QA Committee quarterly for recomendation.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey.	K 062	What corrective action will be accomplished for those residents found to have been affected? 1. All sprinkler heads throughout facility were inspected for dirt and lint. Sprinkler heads were cleaned from lint and dirt throughout the facility. 2. The shelf in the SNF supply closet on the 100 wing that was within 18" of the sprinkler head was removed. The shelf in the 100 wing linen closet that was within 18: of sprinkler head was removed.	5/3/2012

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K 062	<p>Continued From page 12</p> <p>The findings Include:</p> <p>Observation, on 05/01/12 between 10:30 AM and 2:30 PM, with the Maintenance Technician revealed sprinkler heads located throughout the facility to be loaded with lint and dirt.</p> <p>Interview, on 05/01/12 between 10:30 AM and 2:30 PM, with the Maintenance Technician revealed he was not aware the sprinkler heads were loaded with so much debris.</p> <p>Observation, on 05/01/12 between 10:30 AM and 11:30 AM, with the Maintenance Technician revealed the SNF supply closet and the clean linen closet on the 100 wing had a shelf built around the room that was within 18" of the sprinkler head.</p> <p>Interview, on 05/01/12 between 10:30 AM and 11:30 AM, with the Maintenance Technician revealed he was not aware the closet shelves were built to close to the sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be</p>	K 062	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Sprinkler heads will be monitored for lint and dirt on the monthly room audit. The sprinkler heads will be cleaned as indicated for lint and dirt.</p> <p>All sprinkler heads will be cleaned and dusted quarterly.</p> <p>No new shelving shall be built within 18" of the sprinkler heads.</p> <p>How does the facility plan to monitor performance to ensure solutions are maintained?</p> <p>Maintenance shall report monthly to QA cleanliness of sprinkler heads for compliance and recommendations.</p>	

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K 062	Continued From page 13 permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062			
K 070 SS=D	6-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 6-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2. NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in	K 070			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	<p>Continued From page 14 non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/01/12 at 10:47 AM, with the Maintenance Technician revealed a portable space heater located in the MDS Office.</p> <p>Interview, on 05/01/12 at 10:47 AM, with the Maintenance Technician revealed he was not aware the heater could not exceed 212°F in nonsleeping, staff, and employee areas.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used</p>	K 070	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Space heater in MDS office was removed from the facility.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>All staff in-serviced by Director of Nursing and/or Assistant Director of Nursing regarding policy of no space heaters allowed in building.</p> <p>How does the facility plan to monitor performance to ensure solutions are maintained?</p> <p>Rooms and offices will be monitored monthly for presence of space heaters and any found will be removed. Compliance will be reported to QA committee for recommendations and follow up.</p>	5/25/2012

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K 070	Continued From page 15 In nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect five (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey. The findings include: Observation, on 05/01/12 between 9:15 AM and 2:00 PM, with the Maintenance Technician revealed a lift stored in the corridor from 9:15 AM till 2:00 PM located in the corridor next to the classroom. Further observation showed storage of a scale in the 100 wing shower hall, and carts full of storage in the time clock hall. Interview, on 05/01/12 between 9:15 AM and 2:00 PM, with the Maintenance Technician revealed	K 072	What corrective action will be accomplished for those residents found to have been affected? 1. Wheel chair scale moved to permanent location in teaching classroom. 2. Carts with storage moved from time clock hall. 3. Lift scale stored in teaching classroom. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? 1. All staff in-serviced by Director of Nursing and/or Assistant Director of Nursing regarding new location of scales and need to maintain hall and egress free of obstruction. 2. Hallways will be monitored daily for obstructions by nurse on each wing and maintenance technician.	5/25/2012

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K 072	Continued From page 16 the facility routinely stored the scale in the shower hall and the carts in the time clock hall. Further interview with the Administrator revealed she realized the lift next to the classroom was in the corridor during the entire time of my survey. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Any obstruction will be removed. How does the facility plan to monitor performance to ensure solutions are maintained? Three random weekly audits will be conducted by Nursing Supervisors and compliance reported to QA monthly for recommendations.	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to secure the gas meter and piping in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey. The findings include: Observation, on 05/01/12 at 2:15 PM, with the Maintenance Technician revealed there was no protection against physical damage to the gas main located outside the laundry area. The gas main is located directly next to parking and	K 130	What corrective action will be accomplished for those residents found to have been affected? An iron post, 4in in diameter by 5 feet high painted yellow, was set in concrete and positioned in front of gas main just off asphalt parking area. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Protective pipe will be monitored quarterly for damage and/or deterioration.	5/11/2012

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K 130	Continued From page 17 unloading and the asphalt from the parking lot goes right up to the gas main. Interview, on 05/01/12 at 2:15 PM, with the Maintenance Technician revealed he was not aware the gas main needed to have protection in front of them due to its location. Reference: NFPA 101 (2000 Edition) Gas meters, regulators and piping must be protected against physical damage in an approved manner when exposed to equipment traffic. The barriers must be designed to the largest piece of equipment that would be typically parked or used in the immediate area. NFPA 54, National Fuel Gas Code NFPA 101 LIFE SAFETY CODE STANDARD	K 130	How does the facility plan to monitor performance to ensure solutions are maintained? Maintenance to report quarterly to QA committee compliance of post for recommendations.	
K 147 SS=F	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 five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred fourteen (114) beds and the census was one-hundred seven (107) on the day of the survey. The findings include:	K 147	What corrective action will be accomplished for those residents found to have been affected? 1) Two beds in Rm 114 were plugged into wall outlet . 2) Electric lift chair in Rm 109 was plugged into wall outlet. 3) Placed new quadplex receptacle and battery charger and refrigerator plugged directly into outlet in 100 wing med room. 4) Power strip plugged directly into wall outlet in 100 wing O2 room.. 5) Extension cord removed from wall outlet in Administrator office . 6) Extension cord removed from HR office . 7) Quadplex receptacle placed in patient accounts office and power strip plugged in to wall outlet.	5/20/2012

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K 147	Continued From page 18 Observations, on 05/01/12 between 9:00 AM and 2:30 PM, with the Maintenance Technician revealed: 1) Two beds were plugged into a power strip located in room #114. 2) An electric chair was plugged into a power strip located in room #109. 3) Battery chargers along with a refrigerator were plugged into a power strip located in the 100 wing med room. 4) A power strip was plugged into another power strip located in the 100 wing oxygen room. 5) An extension cord was plugged in the wall located in the Administrator ' s office. 6) An extension cord was plugged into a power strip going to a calculator located in the H.R. office. 7) A power strip was plugged into another power strip located in the resident accounts office. 8) A power strip was plugged into another power strip located in the TTH nurses ' station. 9) A refrigerator was plugged into a power strip located in the social services office. 10) A hydro collator was plugged into a standard receptacle located in the therapy area. 11) A power strip was plugged into a multi-plug adapter located in the business office. 12) A power strip was plugged into another power strip, which had battery chargers and a refrigerator plugged into them, located in the central core med room. 13) The electrical panel was blocked by storage within 3 ' located in the central core electric room. 14) An extension cord was plugged into a power strip located in room #213.	K 147	cont from page 18 8) On TTH quadplex receptacle placed and power strip plugged directly into wall outlet 9) Refrigerator plugged directly into wall outlet and power strip removed in SS. 10) GFI receptacle installed in the Therapy Gym and hydroclator plugged directly into GFI receptacle. 11) Multi plug adapter removed in business office and quadplex receptacle installed. 12) New quadplex receptacles installed and battery chargers and refrigerator plugged into outlet in the central core medication room. 13) All items within 3 feet of the electrical panel located in central core removed and relocated 5/2/12. 14) Extension cord removed from Room 213 on 5/1/12. 15) Power strip replaced with 8' power strip in Activity office and extra power strips removed. 16) Quad recacle placed in 300 wing nurses station for battery chargers and power strip removed. What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur? 1. All staff in-serviced by Assistant Director of Nursing and/or Department Leaders regarding: A. Use of power strips and for what things - non medical equipment. B. Extension cords are not allowed	

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K 147	<p>Continued From page 19</p> <p>15) A power strip was plugged into another power strip located in the activity office</p> <p>16) Battery chargers were plugged into a power strip located in the 300 wing nurses ' station.</p> <p>Interview, on 05/01/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused. He was also not aware of the storage in front of the electrical panels.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>continued from page 19</p> <p>C. No appliances especially refrigerators can be plugged into power strips.</p> <p>D. Maintain at least a 3" clearance from electrical service panels.</p> <p>E. Electrical receptacles in wet locations must be GFI.</p> <p>F. Where additional outlets are needed quadplex receptacles must be installed by maintenance - no multi plug adaptors.</p> <p>2. Monthly room and office audits to be completed by maintenance and items corrected as found.</p> <p>How does the facility plan to monitor performance to ensure solutions are maintained? Monthly Audits completed by maintenance and compliance reported to the QA committee for recommendation and follow up.</p>	