

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

PRINTED: 12/16/2011
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 241	Continued From page 1 #1 standing over Unsampld Resident A and Unsampld Resident B while assisting them to eat. Interview with Registered Nurse (RN) #1 at the nurse's station across the hall from the dining room, on 11/29/11 at 1:00 PM, stated she was not aware that CNA #1 was standing during the meal. Further interview revealed the CNA should not have stood during the meal and any staff member that saw the CNA standing should have intervened and made sure she was seated while providing assistance to the residents during the meal. Interview with CNA #1, on 11/29/11 at 1:25 PM, revealed she knew it was unacceptable to stand over residents during the meal while providing assistance but she was not used to sitting and sometimes just forgot.	F 241	severe cognitive impairment. Administrator interviewed on 12/2/11 other residents that eat scheduled meals in A/R dining room to determine if adverse effects present due to dignity issue. No counseling needed. Administrator will address dignity issue at next scheduled Resident Council Meeting to assure no residents were adversely affected by the dignity issue. Dignity policy was reviewed by Director of Nursing on 12/03/11 with no changes made.	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility	F 371	All employees were educated by the Staff Development Coordinator on 12/21/11 regarding facility policy on Dignity and Respect of the residents. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education by the Staff Development Coordinator prior to assuming any direct care assignment. Staff Development Coordinator (RN) and the RN Supervisor will monitor meal service three times a week for four weeks to ensure each resident's dignity and respect is maintained. The results of these audits will be forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records	

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102		
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F 241	Continued From page 1 #1 standing over Unsampled Resident A and Unsampled Resident B while assisting them to eat. Interview with Registered Nurse (RN) #1 at the nurse's station across the hall from the dining room, on 11/29/11 at 1:00 PM, stated she was not aware that CNA #1 was standing during the meal. Further interview revealed the CNA should not have stood during the meal and any staff member that saw the CNA standing should have intervened and made sure she was seated while providing assistance to the residents during the meal. Interview with CNA #1, on 11/29/11 at 1:25 PM, revealed she knew it was unacceptable to stand over residents during the meal while providing assistance but she was not used to sitting and sometimes just forgot.	F 241	F241 continued Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility	F 371	It is the policy of Boyd Nursing and Rehabilitation Center to store, prepare, distribute, and serve food under sanitary conditions Emergency Water was checked and outdated water was discarded and replaced by the Dietary Manager on 11/28/11. Dietary Staff properly disposed of all outdated, undated and uncovered items on 11/28/11. Labels on all prepared food was checked for proper labels by dietary staff on 11/28/11. No other outdated or undated items found.	12/15/11	

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F 371	<p>Continued From page 2</p> <p>failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure food was properly dated and labeled and failed to ensure expired food items were discarded. In addition, the facility failed to ensure proper hand washing and usage of gloves during food preparation and distribution.</p> <p>The findings include:</p> <p>Review of the facility's policy on Safety and Sanitation, undated, revealed in item number nine (9) that all supplies will be clearly labeled.</p> <p>During initial tour of the facility, on 11/28/11 at 7:15 PM, observations in the dietary department included: a cup of vinegar dated 10/04/11 was not completely covered in the free standing refrigerator, two (2) glasses of thickened juice were undated, two (2) glasses of thickened milk were undated, three (3) boiled eggs were left sitting on a counter uncovered and undated, one (1) pack of doughnuts in the walk-in refrigerator was undated, two (2) cups of orange juice in the walk-in refrigerator did not have lids on the glasses, and twenty (20) gallons of the ninety-five (95) gallons of the emergency water supply had expired dates.</p> <p>Interview with the Dietary Manager (DM), on 11/28/11 at 8:15 PM, confirmed food items should be covered, labeled and dated. Further interview revealed, the expiration dates of all food and liquids should be checked periodically to ensure food was within a usage date and had not expired.</p> <p>Observation of the tray line, on 11/29/11 at 11:45</p>	F 371	<p>Dietary Aide #1 and Cook #1 were educated on proper glove use and proper hand washing techniques by the Dietary Manager on 12/05/11. Dietary Aide #1 was educated on contact contamination regarding sanitary conditions by the Dietary Manager on 12/06/11.</p> <p>"Resident Food Only" refrigerator was checked and all items expired were discarded and items were labeled properly by the Housekeeping Supervisor and the Dietary Manager on 12/01/11.</p> <p>Medical Records/Central Supply Supervisor removed all expired items from Medical Supply Room on 12/01/11.</p> <p>PTA was educated by contracted Therapy Manager on 12/05/11 regarding proper procedure on serving food under sanitary conditions not limited to but including checking of expiration dates.</p> <p>Policies and procedures for storing, preparing, distributing and serving food under sanitary conditions were reviewed by the Regional Dietary Manager and the facility Dietary Manager on 12/05/11. No changes were made to these policies.</p> <p>Administrator and Director of Nursing reviewed infection control log on 12/5/11 for past ninety days to ensure that no food borne illnesses had been reported as a result of the deficient practice. No food borne illness were reported.</p>	

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F 371	<p>Continued From page 3</p> <p>AM, revealed Dietary Aide #1 opened a drawer to get supplies with her gloves on and did not change gloves after removing supplies from the drawer and continued to handle plates as they were served. Additional observations revealed, Dietary Aide #1 allowed a tray to touch her uniform before preparation of the plated food. Also, during tray line, Dietary Aide #1 was observed touching her glasses and face with her gloves and continued serving items on the trays without washing her hands or changing gloves. Continued observations revealed, Cook #1 left the line to warm ham in the microwave and upon her return did not change gloves or wash her hands.</p> <p>Interview with Dietary Aide #1, on 11/29/11 at 1:00 PM, revealed she should have changed her gloves and washed her hands after touching her face and glasses. Further interview revealed, when the tray touched her uniform she should have put the tray to the side as contaminated and not used that particular tray for serving.</p> <p>Interview with the Dietary Manager, on 11/29/11 at 1:15 PM, revealed dietary staff should change their gloves and wash their hands when going from preparing or serving food to another task and returning to the food service. Further interview revealed, anytime kitchen equipment comes in contact with an employee's clothing it would be considered contaminated.</p> <p>Observation of the "Resident Food Only" refrigerator on 12/01/11 at 8:30 AM, revealed six (6) cans of Glucerna 1.0/eight (8) ounces with the expiration date of 10/01/11. In addition a can of Glucerna 1.2 was dented. Continued</p>	F 371	<p>Education was provided to all dietary staff by the Dietary Manager on 12/14/11 regarding facility policy and procedures for storing, preparing, distributing and serving food under sanitary conditions. Education was provided by the Director of Nursing to the Medical Records/ Central Supply Supervisor on 12/01/11 in regards to facility policy for storage and discarding of expired medical supplies. Housekeeping Supervisor re-educated housekeeping staff on 12/05/11 on proper cleaning and discarding of expired items in the refrigerators.</p> <p>Regional Dietary Manager revised daily audit checklist and educated facility Dietary Manager on checklist on 12/06/11. The facility Dietary manager will utilize daily audit checklist Monday through Friday to ensure that dietary staff is compliant with the facility protocols regarding storage, preparation, distribution and service of food. Results of these audits will be submitted weekly to the Regional Dietary Manager for review and recommendations for compliance. Medical Records/Central Supply Supervisor will conduct daily audit of Medical Supply Room Monday through Friday for four weeks and then weekly thereafter to ensure that items are in compliance with facility protocols regarding storage of medical supplies. Housekeeping Supervisor re-educated housekeeping staff on 12/05/11 on proper cleaning and discarding of expired items in the refrigerators. The results of these audits will be forwarded to the weekly Focus</p>		

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F 371	<p>Continued From page 4</p> <p>observations revealed a bottle of Heinz Yellow Mustard approximately half full, labeled restaurant package, not for resale, was opened and not dated. Also two (2) items labeled with residents' names were opened but not dated - a two (2) liter bottle of Sprite and a eight (8) ounce bottle of water. The refrigerator also contained a half-pint container of Dean's Cultured Buttermilk with a "sell by" date of 11/26/11.</p> <p>Interview with Certified Medical Technician (CMT) #16, on 12/01/11 at 9:35 AM, revealed Dietary and/or Housekeeping were responsible to clean and check for expired dates in the "Resident Food Only" refrigerator. Interview with Housekeeping Supervisor, on 12/01/11 at 10:00 AM, revealed the "Resident Food Only" refrigerator was checked usually around 6:30 AM for any outdates.</p> <p>Observation of a Physical Therapy Aide (PTA) #18, on 12/01/11 at 10:10 AM revealed she removed the half pint of Buttermilk with the "sell by" date of 11/26/11, opened the carton and offered the drink to a resident. Interview with PTA #18, on 12/01/11 at 12:10 PM, revealed she failed to look at the expiration date before she offered the milk to the resident. She further stated she had only worked at the facility for two (2) days and assumed as busy as the facility was the milk was rotated out and would have been fresh.</p> <p>Interview with the Dietary Manager on 12/01/11 at 12:00 PM, revealed the serving guidelines for dairy products was not followed. The milk should have been removed from circulation and not offered to a resident after the "sell by" date.</p>	F 371	<p>Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>		

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F 371	Continued From page 5 Observation of the Medical Supply Room, on 12/01/11 at 9:45 AM, revealed six (6) bottles of Glucerna 1.0/1500 milliliter with the expiration date of April 2011. Interview with Clinical Records Coordinator revealed her responsibilities included checking the supply room for outdates and she had failed to identify and remove the items.	F 371		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit</p>	F 431	<p>It is the policy of Boyd Nursing and Rehabilitation Center to ensure drugs and biologicals used in the facility be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, Boyd Nursing and Rehabilitation Center stores all drugs and biologicals in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys.</p> <p>Expired Vancomycin was properly discarded by the Licensed Practical Nurse on 11/29/11. The expired Sunscreen was properly discarded by the Certified Medication Tech on 11/29/11.</p> <p>Medication room was audited by RN Supervisor on 11/29/11 to ensure all drugs and biologicals were stored properly and expiration date had not expired. No other expired drugs were found.</p> <p>All licensed nursing staff was education by the Director of Nursing on 11/30/11 and</p>	12/15/11

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F 431	<p>Continued From page 6</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the proper storage of drugs and biologicals. The facility failed to ensure expired products including a brown bottle of medicine labeled for a resident and two (2) over the counter sunscreen agents were removed from storage.</p> <p>The findings include:</p> <p>Observation of the contents located in the medication room refrigerator, on 11/29/11 at 12:30 PM, revealed a brown bottle, labeled Vancomycin (antibiotic) for a resident with an expiration of 11/22/11 at 0700. Continued observation of the sink area in the medication room revealed 2 bottles of sunscreen agents on the counter, Ultimate Sun block Lotion SPF 60 and Sport Sunscreen Lotion with expired effective dates.</p> <p>Interview, on 11/29/11 at 11:55 AM, with the Nursing Supervisor, Registered Nurse (RN) #1, revealed the Vancomycin should have been disposed of when the last dose was given. Also the refrigerator was checked daily and nursing should have removed the outdated bottle. The RN #1 further stated she was not sure where the sunscreen came from but it was probably used for residents who needed protection sun during</p>	F 431	<p>12/15/11 on proper storage of all drugs and biologicals. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education by the Staff Development Coordinator prior to assuming any direct care assignment.</p> <p>The RN Supervisor and Staff Development Nurse will conduct audits daily for two weeks then weekly thereafter for eight weeks to ensure drugs and biologicals are stored properly and items are disposed off properly based on expiration date. The results of these audits will be forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>		

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F 431	Continued From page 7 outdoor activities during the summer months and was not properly stored or labeled.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	It is the policy of Boyd Nursing and Rehabilitation Center to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Cleaning procedures were immediately instigated by the dietary staff on 11/28/11 which included but not limited to: crumbs from toastmaster, coffee maker thoroughly cleaned, stove hood cleaned. Dietary staff properly cleaned ice scoop and returned to covered bin on 11/28/11. Dietary staff washed trays and dried according to policy prior to stacking 11/28/11. Dietary Manager removed fan from kitchen on 11/29/11. Dietary Aide #1 and Cook #1 were educated on proper glove use and proper hand washing techniques by the Dietary Manager on 12/05/11. Dietary Aide #1 was educated on contact contamination regarding prevention of development and transmission of disease and infection by the Dietary Manager on 12/06/11. KMA #1 was educated on 12/02/11 by the	12/15/11

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F 441	<p>Continued From page 8 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This is evidenced by observations during tour of the kitchen which revealed crumbs on the toastmaster front ledge, dust on the coffee pot, trays and pans stored wet, ice scoop lying on the counter top and a dirty stove hood. Kitchen observations of staff revealed a dietary aide touching glasses without changing gloves or washing her hands. In addition observations of the facility nursing staff included a Certified Medication Technician (CMT) cleaning the AccuScan (blood glucose monitoring device) without wearing gloves. During meal service a State Registered Nurse Aide (SRNA) failed to properly disinfect her hands while assisting two (2) residents with their meals. Observations also revealed during medication pass nursing staff failed to wash her hands between administration of eye drops.</p> <p>The findings include:</p> <p>Review of the facility's policy on Dishwashing Procedures, (undated), validated the procedure as, "proper sanitation of dishware and dishware</p>	F 441	<p>Staff Development Coordinator on proper hand washing and glove usage when administering eye drops.</p> <p>SRNA #1 was educated on 12/02/11 by the Staff Development Coordinator on proper hand washing while assisting a resident with meals.</p> <p>CMT #7 received education by the Staff Development Coordinator on 12/02/11 on proper procedure for glucoscan use and cleaning.</p> <p>On 12/02/11, the Administrator and Director of Nursing reviewed the infection control policies contained in the facility Infection Control Manual. No changes were made to these policies.</p> <p>Director of Nursing has monitored meal service since 12/1/11 and no resident has been noted with adverse reactions due to deficiency practice related to infection control.</p> <p>Administrator and Director of Nursing reviewed infection control log on 12/5/11 to ensure that no trends were identified related to improper infection control procedures and to ensure no foodborne illnesses occurred as a result of deficient sanitation practices. No trends were identified.</p> <p>Dietary Staff were educated by the Dietary Manager on 12/05/11 and 12/06/11 in proper cleaning procedures to ensure prevention of</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 9</p> <p>equipment is essential to prevent the spread of illness from one resident to another. For dishes and storage equipment to be properly cleaned, dishes and equipment must be washed to remove visible dirt and sanitized to kill germs. Furthermore, it is essential that food service workers use proper technique to avoid re-contaminating sanitized dishes. Thus, it is essential to establish systems to avoid the improper handling of dishware." Further review of the policy confirmed, in item number four (4), "cleaned dishes must be allowed to air dry before storage."</p> <p>Review of the facility policy, "Handwashing/Hand Hygiene", revised June 2010, revealed the facility considers hand hygiene the primary means to prevent the spread of infections. Hand Hygiene procedures help prevent transmission of healthcare-associated infections, and prevent spread of infections to other personnel, residents and visitors. The policy revealed specific examples when employees must wash their hands such as: before and after direct resident contact or assisting a resident with meals. Examples also included after contact with a resident's intact skin, removing gloves and handling soiled equipment/utensils.</p> <p>Review of the facility's policy, "Specific medication Administration Procedures," undated, item number L etates, "wash your hands or use alcohol gel."</p> <p>1. During initial tour of the facility, on 11/28/11 at 7:15 PM, observations in the dietary department included: the toastmaster noted with crumbs of</p>	F 441	<p>development and transmission of disease and infection and dishwashing procedure policy.</p> <p>Staff Development Coordinator conducted one on one education with all licensed nursing staff in regards to proper procedures for glucoscan use and cleaning 12/1 to 12/12/11.</p> <p>All staff were re-educated by Staff Development Coordinator on 12/21/11 in regards to infection control to prevent the development and transmission of disease and infection. This included but not limited to, proper procedures for hand washing and glove usage, cross contamination and infection control during meal service. Licensed nursing staff received the above education plus proper procedures for hand washing and glove usage in administration of eye meds and regarding cross contamination and infection control during med pass by the Staff Development Coordinator on 12/23/11. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education by the Staff Development Coordinator prior to assuming any direct care assignment.</p> <p>The RN Supervisor and Staff Development Coordinator will conduct a monthly audit for four months consisting of observation of nurses on every shift utilizing and disinfecting the glucoscan machines.</p>	

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
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F 441	<p>Continued From page 10</p> <p>bread on the front ledge, the coffee maker had dust on the door above the spout, serving trays were stacked wet, the hood over the gas stove (in the far left strip) was noted with yellowish black substances coming from the top of the hood, and an ice scoop (uncovered) was lying on the counter top.</p> <p>Interview with the Dietary Manager (DM), on 11/28/11 at 8:15 PM, confirmed the above observations. Further interview revealed, staff should have cleaned the appliances and counter tops and ensured dishes were given ample time for the drying process before stacking them.</p> <p>2. Observation of a Medication Pass, on 11/28/11 at 8:30 PM, revealed Kentucky Medication Aide (KMA) #1 did not change her gloves or wash her hand when administering eye drops.</p> <p>Interview with KMA #1, on 11/28/11 at 8:40 PM, validated she should have removed her gloves between eye drops and washed her hands and then administered the eye drop into the other eye and then removed her gloves and wash her hands again.</p> <p>3. Observations of the Dietary Department, on 11/29/11 at 11:40 AM, revealed an ice scoop uncovered on the counter at the fountain drink dispenser and a fan sitting in the floor blowing air into the dishroom.</p> <p>Interview with the Dietary Manager, on 11/29/11 at 11:42 AM, revealed the fan blowing air into the dishroom was an infection control issue as the dishes needed to air dry and not have air blowing over them to prevent the growth of germs.</p>	F 441	<p>The Housekeeping Supervisor will conduct daily audit Monday through Friday for four weeks then weekly thereafter on proper cleaning and discarding of expired items in refrigerators.</p> <p>The RN Supervisor and Staff Development Coordinator will monitor staff compliance with facility infection control protocols daily for four weeks. Any staff member deviating from proper protocol will be educated at that time.</p> <p>The results of these audits will forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>	

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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F 441	Continued From page 11 4. Observation of the tray line, on 11/29/11 at 11:45 AM, revealed Dietary Aide #1 opened a drawer to get supplies with her gloves on and did not change gloves after removing supplies from the drawer and continued to handle plates as they were served. Additional observations revealed, the Dietary Aide #1 allowed a tray to touch her uniform before preparation of the plated food. Also, during tray line, Dietary Aide #1 was observed touching her glasses and face with her gloves and continued serving items on the trays without washing her hands or changing gloves. Continued observations revealed, Cook #1 left the line to warm ham in the microwave and upon her return did not change gloves or wash her hands. Interview with Dietary Aide #1, on 11/29/11 at 1:00 PM, validated she should have changed her gloves and washed her hands after touching her face and glasses. Further interview revealed, when the tray touched her uniform she should have put the tray to the side as contaminated and not used that particular tray for serving. Interview with the Dietary Manager, on 11/29/11 at 1:15 PM, revealed the dietary staff should have changed her gloves and washed her hands. Further interview revealed, anytime kitchen equipment comes in contact with an employee's clothing it should be considered contaminated. 4. Observation of State Registered Nurse Aide (SRNA) #1, on 11/29/11 from 12:40 PM to 12:50 PM, revealed she failed to wash her hands before and after assisting a resident with meals. She was observed holding unsampled Resident A's	F 441		

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
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F 441	<p>Continued From page 12</p> <p>hand with her right hand and then grasping the resident's utensils in the same hand. Then without performing hand hygiene she used her right hand to grasp unshared Resident B's utensils and speared food and then placed the utensil in Resident B's hand. Continued observations revealed contact with both residents throughout the meal without hand washing observed.</p> <p>Interview with SRNA #1, on 11/29/11 at 1:25 PM, revealed she had received training on proper hand washing/hand hygiene. She acknowledged she should have sanitized her hands between residents while assisting with their meals. She further stated she "just forgot".</p> <p>Interview with the Director of Nursing (DON), on 12/01/11 at 9:30 AM, revealed Quality Assurance monitors infection control by performing random audits of nursing and non-nursing personnel to ensure staff was performing appropriate hand washing. Training regarding hand washing was done in orientation with new-hires, at least annually and any other time when a need was identified. She further stated the SRNA failed to follow the facility policies regarding hand washing when she did not wash her hands between residents.</p> <p>6. Review of manufactures recommendation for cleaning the blood glucose monitor, revealed you should wear personal protective equipment while using the product.</p> <p>Observation, on 11/30/11 at 3:00 PM, revealed Certified Medication Technician (CMT) #7 removed her gloves prior to cleaning the blood</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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F 441	Continued From page 13 glucose monitor after completing the blood sugar check for Resident #1. Interview, on 12/1/11 at 10:55 AM, with Licensed Practical Nurse (LPN) #4, revealed she should have cleaned the blood glucose monitor with a bleach wipe, removed gloves and washed hands. Interview, on 12/1/11 at 11:10 AM, with CMT #7, revealed she should have removed her gloves after cleaning machine with a bleach wipe.	F 441		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide or obtain laboratory services only when ordered by the attending physician for one (1) of thirteen (13) sampled residents (Resident #10). Resident #10 had a Physician's Order to discontinue all routine labs and weights, dated 10/18/11; however, record review revealed a routine lab had been performed on 11/17/11. The findings include: Record review revealed the facility admitted Resident #10 with diagnoses which included Chronic Kidney Disease, Joint Contractures, Type Two Diabetes, and Congestive Heart Failure.	F 504	It is the policy of Boyd Nursing and Rehabilitation Center to provide or obtain laboratory services only when ordered by the attending physician. No adverse reactions occurred to Resident #10 due to lab being conducted when no order was present as of 12/01/11. Physician notified by RN Supervisor of occurrence on 12/01/11. No additional orders received. All lab orders were reviewed by two licensed practical nurses by 12/15/11 to ensure that all labs reflected current orders of physician for all residents. No other discrepancies were found reflecting current orders for residents. All nursing staff received additional education by the Staff Development on 12/23/11 regarding facility lab procedures. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education by the Staff Development	12/15/11

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F 504	<p>Continued From page 14</p> <p>Review of Physician's Progress Notes, dated 10/18/11, revealed an order, "Change to Palliative Care/Comfort Care - No Routine Labs..." for Resident #10.</p> <p>Review of the November 2011 Physician's Orders revealed the order, dated 10/18/11, change to palliative care/comfort care with "NO ROUTINE LABS". However, further medical record review revealed laboratory results for a "Routine Lab", Basic Metabolic Panel (BMP) that was obtained on 11/17/11.</p> <p>Interview with Director of Nursing (DON), on 12/1/11 at 10:30 AM, revealed the facility failed to remove the laboratory requisition, requesting the BMP on Resident #10 from the routine lab orders file.</p>	F 504	<p>Coordinator prior to assuming any direct care assignment.</p> <p>Facility Charge Nurse on day shift will audit labs on Monday, Thursday and Friday. The RN supervisor will audit labs at random at least once a week for four weeks and then two times per week thereafter to ensure that lab orders are processed as ordered. The results of these audits will be forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>	

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Full fire alarm (upgrade completed in 2009)</p> <p>Sprinkler System: Full sprinkler system</p> <p>Generator: Type II. Diesel installed 1995</p> <p>A standard Life Safety Code survey was conducted on 11/30/11. Boyd County Nursing and Rehabilitation was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was fifty two (52). The facility is licensed for sixty (60) beds.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000	<p>To the best of my knowledge and belief, as an agent of Boyd Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>	K 062	<p>It is the policy of Boyd Nursing and Rehabilitation Center to ensure the automatic sprinkler system is continuously maintained in reliable operating condition and are inspected and tested periodically.</p>	12/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/23/2011
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has taken appropriate steps to ensure that the institution's policies and procedures 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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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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K 062	<p>Continued From page 1</p> <p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was maintained according to National Fire Protection Association (NFPA) standards. Sprinklers must be maintained to ensure their reliability during a fire. The deficiency had the potential to affect one (1) of three (3) smoke compartments.</p> <p>The findings include</p> <p>Observation, on 11/30/11 at 12:25 PM, revealed one (1) sprinkler head in the attic was covered with blown insulation. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 11/30/11 at 12:25 PM, with the Maintenance Director, revealed he was unaware the sprinkler head had been covered with blown insulation.</p> <p>Reference: NFPA 25 (1998) 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,</p>	K 062	<p>The sprinkler head in the attic was cleared of all insulation by the Maintenance Supervisor on 12/6/11.</p> <p>Administrator educated facility Maintenance Supervisor on 12/05/11 the importance of maintaining clearance of sprinkler heads for proper operation of the automatic sprinkler system.</p> <p>Maintenance Supervisor will conduct monthly audit of sprinkler heads to ensure compliance with sprinkler system. The results of these audits will forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>	

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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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K 062	Continued From page 2. loaded, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected.	K 062		
K 076 SS=E	NFPA-101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to	K 076	It is the policy of Boyd Nursing and Rehabilitation Center to ensure medical gas storage and administration areas are protected in accordance NFPA 99 with oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation and locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. Oxygen tanks were moved by Maintenance Supervisor on 11/30/11 to area that did not contain combustible items. Signs were remounted and staff was educated by Maintenance Supervisor for proper placement of tanks on 11/30/11. The Administrator educated the Maintenance Supervisor on 12/5/11 the importance of proper oxygen storage per NFPA guidelines.	12/15/11

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NAME OF PROVIDER OR SUPPLIER HOVD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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K 076	<p>Continued From page 3</p> <p>affect one (1) of three (3) smoke compartments, thirty four (34) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 11/30/11 at 12:56 PM, revealed in the oxygen storage room, the oxygen tanks were being stored within five (5) feet of combustible items. Combustibles cannot be stored within five (5) feet of oxygen storage due to fire spread. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 11/30/2011 at 12:56 PM, with the Maintenance Director, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials.</p> <p>Reference: NFPA 99 (1999 edition) Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in</p>	K 076	<p>Proper storage of oxygen tanks will be audited daily by the Maintenance Supervisor and RN Supervisor for a period of four weeks then weekly thereafter. The results of these audits will be forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2011
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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 076	Continued From page 4 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure single station smoke detectors installed in the facility were installed according to National Fire Protection Association (NFPA) standards. Smoke detectors must be installed properly to ensure their reliability to detect smoke during a fire. The deficiency had the potential to affect one (1) of three (3) smoke compartments, fourteen (14) residents, staff and visitors. The findings include: Observation, on 11/30/11 at 2:33 PM, revealed a single station smoke detector installed by the facility was improperly installed. The single station smoke detector was installed 16 inches down the wall from the ceiling. Single station smoke detectors must be installed no more than 12 inches down a wall and no closer than 4 inches from the ceiling. Further observation revealed the same for resident rooms 101, 102,	K 130	It is the policy of Boyd Nursing and Rehabilitation Center to ensure single station smoke detectors are installed in the facility according to NFPA standards. On 12/5/11 the Maintenance Supervisor removed smoke detector identified and remounted it per NFPA standards. All other smoke detectors were checked by the Maintenance Supervisor on 12/06/11 for proper placement per NFPA standards. The Administrator educated Maintenance Supervisor on 12/05/11 the importance on following NFPA standards when mounting smoke detectors. The Maintenance Supervisor will check smoke detector placement each month for a period of four months then bi-annually thereafter. The results of these audits will be forwarded to the weekly Focus Committee whose members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, and Social Service Director. Results will also be reviewed monthly by the CQI Committee	12/15/11

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

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K 130	<p>Continued From page 5</p> <p>103, 109, 110, 111 and 112. The observations were confirmed with Maintenance Director.</p> <p>Interview, on 11/30/11 at 2:33 PM, with the Maintenance Director, revealed he was not aware of the requirements for the proper installation of the single station smoke detectors.</p> <p>Reference: NFPA 72 (1999 edition) 2-3.4.3.1 Spot-type smoke detectors shall be located on the ceiling not less than 4 in. (100 mm) from a sidewall to the near edge or, if on a sidewall, between 4 in. and 12 in. (100 mm and 300 mm) down from the ceiling to the top of the detector. (Refer to Figure A-2-2.2.1.)</p>	K 130	<p>for further monitoring and continued compliance. CQI members consist of Administrator, Director of Nursing, Staff Development Coordinator, RN Supervisor, Dietary Manager, MDS Coordinator, Activities Director, Medical Records Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Pharmacy Consultant, Medical Director and Social Service Director. The committee will determine, based on the results of audits received, how long monitoring should continue.</p>	