

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

RECEIVED

PRINTED: 09/30/2010
FORM APPROVED
OMB NO. 0938-0391

OCT 12 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <small>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</small>	(X3) DATE SURVEY COMPLETED 09/16/2010
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NAME OF PROVIDER OR SUPPLIER NORTHFIELD CENTRE FOR HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey and complaint investigation KY00014933 was conducted 09/14/10 through 09/16/10 and a Life Safety Code survey on 09/16/10. Deficiencies were cited for the standard health survey with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. There were no regulatory violations related to the complaint investigation.</p>	F 000	<p>This Plan of Correction is the Centers credible allegation of compliance. Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</p>	
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F 279	<p>F-279s/s E- Comprehensive Care Plan</p> <p>It is the practice of Northfield Centre to use the results of the assessment to develop, review and revise the residents' comprehensive plan of care.</p> <p>Corrective action for the 4 residents of Centre #13, #9, #19, #10 affected by the alleged deficient practice: MDS Coordinators and IDT Team re-assessed resident #13, #9, #19, and #10 and completed a comprehensive care plan based upon the assessment. Resident #13 a comprehensive care plan for respiratory care and isolation precautions were development on 09-17-10. Resident #9 and #19 had been revised on 09-17-10 to reflect current treatment residents were receiving. Resident #10 had revised care plan to reflection discontinuing of Foley catheter.</p>	10-31-10

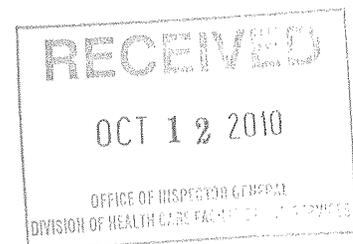
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paula Elm</i>	TITLE Executive Director	(X6) DATE 10-08-10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1</p> <p>review It was determined the facility failed to develop a Comprehensive Care Plan that included measurable objectives and timetables to address specific resident care needs and failed to revise the Care Plan for four (4) of twenty-two (22) sampled residents based on the results of the assessment. Resident #13 did not have a Comprehensive Care Plan developed for respiratory care and isolation precautions. Residents' #9 and #19 had care plan revisions that were not current with the treatment the resident was receiving. Resident #10 had a Foley Catheter on admission that had been discontinued, but the facility did not discontinue the care plan for Foley Catheter from Resident #10's Comprehensive Care Plan.</p> <p>The findings include:</p> <p>1) Review of the record for Resident #13 revealed the resident was admitted on 07/28/10 with Diagnoses including multiple spinal surgeries of the cervical spine and lumbar spine, Paraplegic, multiple decubitus, Gastronomy tube, feeding, Tracheostomy, and Colostomy.</p> <p>Observation of Resident #13 on 09/14/10 at 9:00am revealed an alert and oriented resident lying in a specialty bed with a tracheostomy, and gastronomy tube feedings infusing at 65cc per hour. The resident was on isolation precautions, but unsure of the reason. Resident #13's room was a private room and was equipped with oxygen and a suction canister with suction catheters available for use.</p> <p>Review of the Minimum Data Set (MDS) Admission Assessment completed 08/10/10 revealed Resident #13 was independent with</p>	F 279	<p>CONT. F-279</p> <p>To identify other residents who may be affected by the alleged deficient practice; IDT Team which include the MDSC, SS, AD, NSM and ADNS will review all resident's care plans and revise as necessary to ensure the care plan includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being as required. Education has been completed with the IDT team members who include the MSDC, SS, AD, NSM and ADNS to ensure comprehensive care plans are completed and revised as necessary on 09-21-10.</p> <p>Measures put into place to ensure the alleged deficient practice does not reoccur; Director of Nursing Services and /or designee will completed audit of 5 comprehensive care plans monthly for the next 90 days and then quarterly thereafter. This is to ensure that a comprehensive care plan is developed to meet all resident care needs and revised as necessary as well as observations of residents in comparison to physician orders to ensure accuracy. Director of Nursing Services and /or designee will validate that all residents have a comprehensive care plan upon admission</p>



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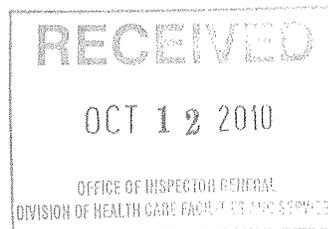
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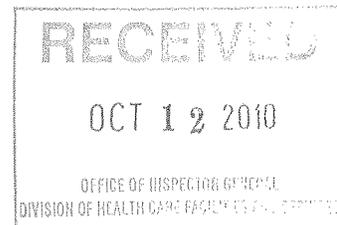
F 279	<p>Continued From page 2</p> <p>decision making, no difficulty with communication, bed mobility of total dependent with one person physical assist, and range of motion limited on both sides with partial loss of hands and legs. The (MDS) admission assessment revealed Resident #13 had five stage 2 and five stage 4 wounds. In addition, Resident #13 had special treatments and procedures including ostomy care, oxygen therapy, suctioning, and Tracheostomy care.</p> <p>An interview with the District Registered Nurse on 09/15/10 at 9:00am revealed that Resident #13 was placed in isolation on admission related to a history of respiratory infection including Multi Resistant Staph Aureus (MRSA). She stated they implement isolation procedures to protect other residents until they determine if cultures are negative.</p> <p>Review of the Comprehensive Care Plan revealed no Care Plan for Resident #13's care needs including tracheostomy care, suctioning of the residents trach, or isolation precautions. There was no indication on any of the Comprehensive Care Plans that this resident was in isolation or had any respiratory care needs related to the tracheostomy.</p> <p>Interview with Certified Nursing Assistant #7 on 09/14/10 at 2:30pm revealed she knew Resident #13 was in isolation but did not know what kind.</p> <p>Interview with Licensed Practical Nurse #6 on 09/15/10 at 08:15am revealed she thought Resident #13 was in wound isolation, not respiratory isolation.</p> <p>Interview with the Licensed Practical Nurse (LPN), MDS nurse, on 09/16/10 at 1:20pm</p>	F 279	<p>CONT - F. 279</p> <p>and are revised during care plan meetings. The Director of Nursing Services and/or designee will in-service all nurses related isolation precautions and definition of isolation on 10-11-10. District Director of Case Management will randomly audit completion and revisions of care plans monthly to ensure accuracy and completion.</p> <p>To monitor the solutions are sustained will be as follows: Director of Nursing Services and /or designee will audits 5 comprehensive care plans and revisions monthly. This will include a review of physician orders and resident observations to ensure that a comprehensive care plan is developed to meet all resident care needs and revised as necessary. All finding will be reported to Performance Improvement Committee monthly. Executive Director is responsible for overall compliance.</p>	10-31-10
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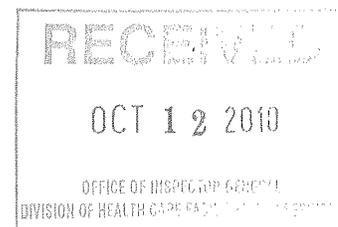
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F 279	<p>Continued From page 3</p> <p>revealed the nurse who admitted Resident #13 should have started a Care Plan for Resident #13's care needs including Isolation and respiratory care/trach care. She stated the resident should have these care plans to ensure the resident receives the care that is needed. The LPN, MDS nurse, continued to state they have started a new process for trying to improve care plans and resolve the issues they have.</p> <p>2) Record review on 09/16/10 of the care plan for Resident #9 admitted on 01/27/10, revealed an Interim Plan of Care dated 01/29/10, and no Individualized Comprehensive Plan of Care after the assessment was completed on 02/05/10.</p> <p>Record review found the care plan for the Potential for Infection R/T PICC line placement dated 01/29/10 not updated when Resident #9 had the PICC line removed.</p> <p>Record review found care plan to address the problem of the Resident has open area on right hand R/T cat bite dated 01/27/10 and was not updated. Observation on 09/14/10 revealed the resident had no wound on the right hand.</p> <p>Interview on 09/16/10 at 9:45am with the LPN MDS Coordinator revealed that a Comprehensive Care Plan was not entered for Resident #9. LPN MDS Coordinator stated care plans for Refuses PT/OT, Potential for Infection, Open area on Right hand, and ABT Treatment should have been updated as 'resolved' and removed from the chart and did not know why this was not done during the care plan meeting.</p> <p>Interview on 09/16/10 at 1:25pm with the LPN</p>	F 279		10-31-10



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F 279	<p>Continued From page 4</p> <p>MDS Coordinator revealed that the Interim Plan of Care was implemented upon admission, and is replaced with the Comprehensive Care Plan seven (7) days after the initial MDS is completed.</p> <p>3) Record review of Resident #19 revealed there was an interim plan on care on the chart dated 11/18/2009. The interim plan of care related to falls was updated on 07/17/2010. The interim plan of care on pressure was updated on 06/01/2010. There were no other updates to the interim plan of care since 11/18/2009. There was no comprehensive plan of care developed for Resident #19 after the comprehensive assessment had been completed on 12/01/09. The plan of care dated 11/18/2009 revealed the resident was on oxygen at two liters per nasal canula. Review of Resident #19's chart revealed a physician's order on admission 11/18/2009 for oxygen at two liters/mln per nasal canula, there was a subsequent physician's order on 12/04/2009 to discontinue oxygen during the day and to place resident on oxygen at two liters per nasal canula from 8pm to 8am. The current monthly MD orders did not have oxygen listed as a current order.</p> <p>Observation on 09/16/2010 at 9:25am revealed there was no oxygen concentrator in Resident #19's room.</p> <p>Interview with RN #2 on 09/16/2010 at 10:00am revealed Resident #19 was not currently receiving oxygen. She stated she thought it had been discontinued. RN #2 was unable to show that the plan of care had been updated. RN #2 could not find a doctor's order in the chart indicating that oxygen had been discontinued.</p>	F 279		10-31-10



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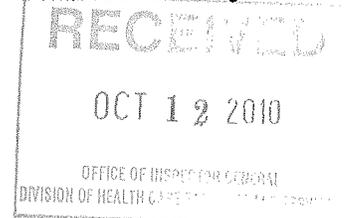
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F 279	<p>Continued From page 5</p> <p>Interview with LPN #4 on 09/16/2010 at 10:05am revealed there was not an order in the chart to discontinue oxygen therapy. He stated he would look through his stack of orders and check for original.</p> <p>Interview with LPN #4 on 09/16/2010 at 10:25am. revealed there was an original MD order which discontinued oxygen therapy on Resident #19 on 05/20/2010 due to non use and oxygen sats being above 95%. LPN #4 stated he could not produce an updated care plan to reflect the discontinuation of oxygen.</p> <p>4) A review of the record revealed Resident #10 was admitted on 02/18/10 with diagnoses including Left Below the Knee Amputation, Glaucoma, Blindness, Diabetes Mellitus Type 2, Benign Prostrate Hypertrophy, Chronic Kidney Disease and had a Foley Catheter.</p> <p>Continued review of the record revealed Resident #10 had a completed Comprehensive Care Plan based on the Comprehensive Assessment dated 02/22/10. A quarterly MDS Assessment was completed on 05/14/10 and 07/26/10 indicated the resident no longer had a Foley Catheter. Resident #10 continued to be care planned for the use of a Foley Catheter.</p> <p>An interview with the RN MDS Coordinator on 09/15/10 at 2:30pm revealed that the Care Plans are reviewed with the quarterly MDS Assessment and Care Plans that are no longer appropriate should be removed from the Comprehensive Care Plan. She stated they had a hard time setting up the Care Plan meeting for this resident because the resident's wife had been sick and the</p>	F 279		10-31-10
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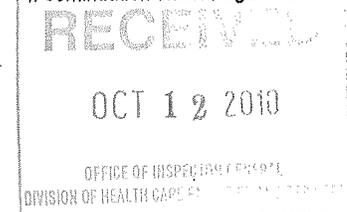
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F 279	Continued From page 6 family could not get the meeting scheduled. The RN MDS stated that if the family or the resident does not come to the care plan meeting, the facility does not have a care plan meeting per say, but that all disciplines will document an assessment. She stated that it is the responsibility of the MDS team to ensure Care Plans are current with the Residents needs.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop a Comprehensive Care Plan based on the Comprehensive Assessment and the	F 280	F-280 s/s-E Right to Participate Planning Care-Revised CP It is the practice of Northfield Centre to give the resident the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. Corrective action for the alleged deficient practice for residents #1, #9, #16, #19 care plans have been reviewed and revised as based on comprehensive assessments. Resident #1, #9, #16, and #19 comprehensive care plan was developed and completed according to resident care needs on 09-17-10. To identify other residents that may be affected by alleged deficient practice: IDT Care Plan Team including the MDSC, SS, AD, NSM and DNS has completed two audits of resident's medical records on 09-16-10 and 09-21-10. The IDT team will review, revise and complete all care plans to ensure it reflects the resident's highest practicable physical and psychosocial well-being.	10-31-10



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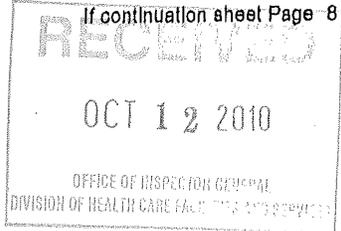
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F 280	<p>Continued From page 7</p> <p>Resident Assessment Protocol (RAP) triggers within seven (7) days after the completion of the comprehensive assessment for four (4) of twenty-two (22) sampled residents (Residents #1, 9, 16, and 19). Resident #1 admission Minimum Data Set (MDS) assessment was completed on 07/30/10 but no Comprehensive Plan of Care had been developed. Resident #9 did not have a Comprehensive Care Plan developed after an Admission MDS assessment on 02/05/10 and two quarterly MDS assessments, on 04/16/10 and 07/05/10. Resident #16 was admitted on 07/30/10 with the admission MDS completed on 08/10/10. There was no Comprehensive Care Plan on the medical record for Resident #16. Resident #19's admission MDS assessment was completed on 11/25/10. A Comprehensive Care Plan was not developed for Resident #19. The Resident had a Quarterly MDS assessment on 02/10/10 and 05/03/10, and an Annual MDS assessment with no Comprehensive Care Plan developed.</p> <p>The findings include:</p> <p>1) Review of the record for Resident #9 revealed only an Interim care plan was initiated upon admission. The facility staff were utilizing care plan update slips for new orders and new interventions. The facility did not have a comprehensive care plan related to care needs and RAPS that were triggered based on the comprehensive assessment dated 02/05/10 including: cognitive loss, psychotropic medication use, activities of daily living, nutritional status, and pressure ulcers.</p>	F 280	<p>CONT. F-280</p> <p>Measures put into place to assure the alleged deficient practice does not re-occur: Completion of in-service education regarding completion of comprehensive care plans and revision was conducted by Director of Nursing Services on 09-17-10.</p> <p>Monitoring to ensure that solutions are sustained: A daily review of all residents condition changes will be completed by Unit Manager and Weekend Manager to ensure comprehensive care plan is revised as necessary. Director of Nursing Services and Assistant Director of Nursing Services will completed random audit of 5 care plans monthly for 90 days and then quarterly thereafter to ensure care plans are accurate, reflect care provided and based on current assessment. The Director of Nursing Services and/or designee will validate that all residents have a comprehensive care plan developed upon admission and it will be reviewed and revised during care plan meetings. The IDT team members including the MDSC, AD, SS, NSM and ADNS will submit copies of comprehensive care plans and revisions weekly to ensure compliance. District Director of Clinical Operations and District Director of Case Management will audit monthly to ensure accuracy and compliance.</p> <p>Director of Nursing Services and/or designee is responsible for reporting all findings to Performance Improvement Committee for review. Executive Director is overall responsible for compliance.</p>	10-31-10
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F 280	<p>Continued From page 8</p> <p>An interview with the Minimum Data Set (MDS) LPN Coordinator on 09/16/10 at 9:45am and 1:25pm revealed that the Comprehensive Care Plan is intended to assist nurses to plan the resident's care to meet individual needs and to ensure that no concerns are overlooked. The LPN MDS coordinator stated the care plan slips were utilized by the nursing staff between assessments and that the updates were to be added to the Comprehensive Care Plan prior to Care Plan meetings. LPN MDS Coordinator stated the Comprehensive Care Plan should be completed within 7 days of the initial MDS assessment, and also stated there is no Comprehensive Care Plan entered for Resident #9, and added "we are doing that now." LPN MDS Coordinator stated care plans for Refuses PT/OT, Potential for Infection, Open area on Right hand, and ABT Treatment should have been updated as 'resolved' and removed from the chart and did not know why this was not done during the care plan meeting.</p> <p>Record Review of Resident #16 revealed an admission date of 07/30/10 and the admission MDS completed on 08/10/10. There was no Comprehensive Plan of Care on the medical record for Resident #16. In addition, there was an Interim Plan of Care with no date. Interview on 09/15/10 at 4:40pm with the RN MDS Coordinator revealed Resident #16 did not have a Comprehensive Care plan in the medical chart and a Comprehensive Care plan should have been done on 08/17/2010 but was not done. Interview on 09/16/10 at 1:25pm with LPN MDS Coordinator revealed upon admission, nurses pull an interim care plan which is placed in the medical chart and is replaced with a</p>	F 280		10-31-10

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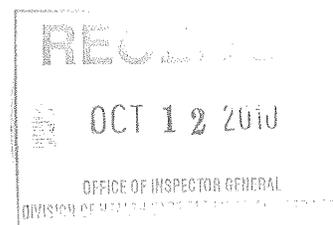
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 9</p> <p>Comprehensive Care plan within 7 days after the completion of the initial MDS.</p> <p>Record review of the care plan for Resident #1, admitted on 07/20/10, revealed an Interim Care Plan dated 07/22/10 with updates on 07/27/10, 08/06/10, and 08/13/10. No Comprehensive Plan of Care was on file for this resident. The Initial MDS was completed on 07/30/10.</p> <p>Interview with RN MDS Coordinator, on 09/15/10 at 12:00pm revealed that the computer generated Comprehensive Plan of Care should have been in the resident's chart by 08/06/10, however, it has not been placed there yet. The Comprehensive Care Plan should be in the resident's chart within seven (7) days of completion of the Initial MDS. No reasons were given for it being late other than it had not been done yet.</p> <p>Interview with LPN MDS Coordinator, on 09/16/10 at 1:20pm regarding the process for care planning, revealed that upon admission of the resident, the nurse pulls the Interim care plan and places it in the resident's chart. The triggers are obtained from the discharge summary from the hospital. The Interim care plan stays on file in the resident's chart until replaced with the Comprehensive Plan of Care, which is within seven (7) days of completion of the Initial MDS. The LPN MDS Coordinator stated that the purpose of the Comprehensive Care Plan is to help the nurses plan care for the residents. It is important because there may be items that were missed on the Interim Care Plan that were picked up later. She stated that the facility is currently conducting an audit of all care plans.</p>	F 280		10-31-10



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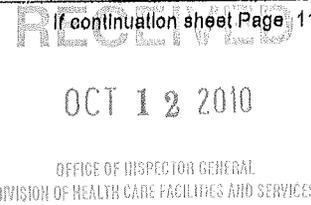
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F 280	Continued From page 10 Record review of Resident #19 revealed there was an Interim plan of care on the chart dated 11/18/2009. The Admission MDS assessment was completed on 11/25/10. There was no comprehensive plan of care on the resident's chart. Further review of the record for Resident #19 revealed a Quarterly MDS assessment completed on 02/09/10 and 05/03/10 and an Annual MDS assessment completed on 08/09/10 with no record of a Comprehensive Care Plan completed. Interview with LPN MDS Coordinator on 09/16/2010 at 1:25pm revealed that the computer generated comprehensive plan of care should be in the resident's chart within seven days of completion of Initial MDS and annual MDS assessment.	F 280		
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, interviews, and facility policies it was determined the facility failed to ensure food was served under sanitary conditions. The steam table was not maintained when a drainage problem had been identified and	F 371	F-371-s/s-F Food Procure, store/prepare/serve- sanitary It is the practice of Northfield Centre to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. Corrective action taken by Northfield Centre: Maintenance Supervisor on 09-16-10 removed steam table from Dietary Department and thoroughly cleaned and replaced piping for each well of steam table with new pipes. On 09-16-10 the Nutritional Service Supervisor immediately re-washed all bowls and cups to ensure no food particles remained. Also on 09-16-10	10-31-10



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F 371	<p>Continued From page 11</p> <p>had not been repaired. The facility left stagnant water with unidentified debris and reused the water to steam heat food prepared for residents meals without draining the water on a daily basis. In addition, multiple racks of bowls and cups stored for resident use had dried particles identified as food on the outer and inner surfaces. The food delivery carts were found with dried food inside the carts.</p> <p>The findings include:</p> <p>Review of facility policy on 09/16/10 identified "Kitchen Cleaning Reference" on page six (6) of seven (7) dated 04/28/06 revealed the steam table was to be cleaned with each use. The basic instructions provided was "1. Turn off heat and allow to cool. 2. Wash surfaces with warm soapy water, including top, back board, hoods (if any), front and sides. If baked on foods are stubborn, use a dull metal scraper to remove them. 3. Rinse with hot water. 4. Clean the top and underside of stainless steel trays/slide or serving shelf with stainless steel cleaner. Rinse with warm clear water. 5. If steam table has a wooden cook's ledge, wash, rinse, and sanitize. 6. Deline wells as needed". On page one (1) of seven (7) of the kitchen cleaning reference revealed the carts were to be cleaned after each use.</p> <p>Additional policy for Dishwasher/Dishmachine dated 04/28/10 revealed for clean dishes the diet aide, cook, or designee was to inspect the rack as it comes out of the machine for soiled items and items that were not thoroughly clean were to be sent through the dishmachine again.</p> <p>Observation on 09/16/10 at 9:10am during the</p>	F 371	<p>CONT. 371</p> <p>the Nutritional Service Supervisor immediately cleaned food delivery carts inside and out to ensure no dried food remained.</p> <p>To identify residents who may be affected by alleged deficient practice: all residents have potential to be affected-The Nutritional Service Supervisor and/or designee review daily the steam table to ensure repairs have been sustained and any additional repair items will be reported to Maintenance Supervisor and Executive Director immediately to ensure proper working order of steam table. Steam table, bowls and cups and food delivery carts will be monitored daily for the next 90 days by NSM or designee to ensure properly sanitary condition.</p> <p>Measure put into place to ensure alleged practice does not reoccur; The Nutritional Service Supervisor completed an in-service with all Nutritional Service employees on 09-17-10 to review policies/procedures regarding cleaning and maintenance procedures. Nutritional Service Supervisor and/or designee will audit daily for the next 90 days the steam table, all bowls and cups and food delivery carts to ensure proper sanitation and working order. All maintenance concerns will be immediately brought to the Maintenance Director and Executive Directors attention to ensure all equipment is in proper working condition. The Registered Dietitian and the Executive Director will monitor weekly to ensure compliance of sanitation policies.</p>	10-31-10
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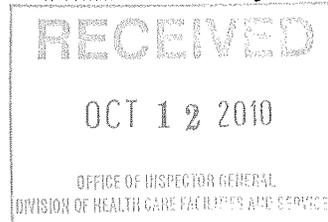
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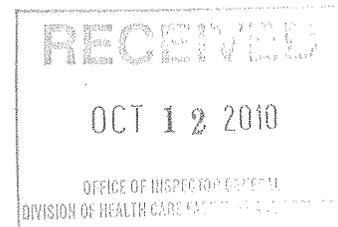
F 371	<p>Continued From page 12</p> <p>sanitation tour revealed the five (5) compartment steam table had standing water remaining in the wells. The water had excessive amounts of unidentified debris, food particles with some rust discoloration appearing in the wells.</p> <p>Interview on 09/16/10 at 9:10am with the Dietary Manager revealed the water was drained and the compartments were cleaned once to twice a week. She thought the sediment was possibly rust backing up in the wells causing the discoloration and identified some particles floating in the water as food. She stated the drainage system was not working and they had to have the shop-vac brought in to drain the water from the wells. She said she reported this to the maintenance department a couple of months ago and had mentioned the problem to the maintenance manager on passing.</p> <p>Interview on 09/16/10 at 2:15pm with the Maintenance Manager revealed he was made aware of the steam table not draining on 07/09/10 and he replaced the nipples on each drain hose. He stated he was not aware the problem had not been corrected. He stated he notified the dietary staff the steam table was to be drained and cleaned daily.</p> <p>Observations on 09/14/10 at 8:40am of the initial tour of the kitchen revealed a tray of cups ready for resident use had dried substance identified as food on the outer and inner surfaces.</p> <p>Observations on 09/16/10 at 9:15 am of the sanitation tour revealed several trays of bowls ready for resident use with dried substance identified as food on the outer and inner surfaces.</p> <p>Interview on 09/16/10 at 9:15am with the Dietary</p>	F 371	<p>CONT. F-371</p> <p>Monitoring performance to ensure actions are sustained; Nutritional Service Supervisor and /or designee is responsible to ensure steam table is in proper working condition and meets sanitary conditions, all bowls and cups are cleaned according to policy and procedure and no food particles remain and all food delivery carts are cleaned daily to ensure no dried food particles remain daily for the next 90 days. The Registered Dietitian and Executive Director will monitor steam table, bowls and cups and food delivery carts weekly to ensure compliance. All finding will be reported to Performance Improvement Committee monthly until compliance. Executive Director is overall responsible for compliance.</p>	10-31-10
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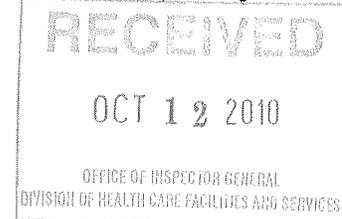
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F 371	Continued From page 13 Manager revealed the staff checked the dishes before serving food to the residents; however they should have been removed from possible use prior to serving the residents. Observations on 09/15/10 at 12:15pm revealed dried food matter, a pink residue, and what appeared to be applesauce on the inside of carts being filled with resident lunch trays. Interview on 09/15/10 at 12:15pm with the Dietary Manager revealed the carts were taken outside and pressure washed monthly and cleaned on a as needed basis between the pressure washing. She stated it should have been cleaned prior to use.	F 371		
F 441 SS=E	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	F 441	F-441-s-s-E Infection Control, prevent spread, linens It is the practice of Northfield Centre to establish 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. Corrective action for residents of Northfield Centre to be affected; on 09-16-10 and 09-27-10 in-servicing was completed with all nursing assistants and nurses regarding ready to eat food items and handling procedures.	10-31-10



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F 441	Continued From page 14 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain infection control to provide a sanitary environment related to handling of ready-to-eat foods with bare hands by multiple employees during the lunch meals served on 09/14/10 and 09/15/10. The findings include: Review of the facility policy on Infection Control revealed that all personnel are educated to follow standard and transmission-based precautions including managing food safety, including employee health and hygiene, and waste disposal. Observation of lunch tray pass on the North Hall on 09/14/10 at 11:45am revealed the staffing coordinator using bare hands to hold an	F 441	CONT. F-441 To identify other residents that have the potential to be affected by alleged deficient practice; immediate in-servicing of all nursing assistants and nurses on 09-16-10 and again on 09-27-10 to ensure compliance regarding food handling of ready to eat foods. Education included sanitizing hands prior to passing meals trays for each resident as well as wearing gloves, food handling with utensils and infection control procedures. Measures put into place to assure the alleged deficient practice is sustained: In-servicing completed with all nursing assistance and nurses regarding food handling on 09-16-10 and 09-27-10. Director of Nursing Services and /or designee to monitor weekly meal service to ensure compliance with infection control procedures and food handling policy. Director of Nursing Services and/or designee will report all finding to track and trend to Performance Improvement Committee monthly to ensure compliance. Executive Director is overall responsible.	10-31-10



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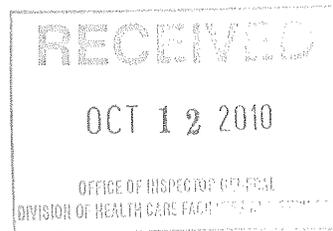
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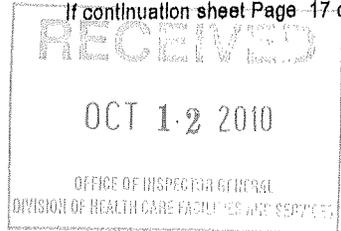
F 441	<p>Continued From page 15</p> <p>unsampled resident's grilled cheese sandwich while cutting it up for him. Staffing coordinator washed hands afterward and continued to pass trays.</p> <p>Interview on 09/16/10 at 11:25am with the staffing coordinator revealed that she was taught to sanitize hands before passing trays or serving a resident in the dining room and between each resident. When asked about handling ready-to-eat foods she stated she had just found out yesterday from dietary that she was not supposed to touch the resident's food with bare hands. Before that she thought it was okay as long as hands were sanitized. She stated that meal service training is provided once a year and inservices a few times a year. She stated that she must have missed that in her training as she does not pass trays and serve food on a regular basis. She further stated that touching resident's food with bare hands could lead to cross-contamination and the spread of bacteria.</p> <p>Observation on 09/15/10 at 12:10pm revealed CNA #7 touched un-sampled resident's sandwich with both bare hands while attempting to give the resident food from the resident's tray.</p> <p>Interview with CNA #7 revealed that it was wrong to touch the sandwich with bare hands and in doing so, posed an infection control problem. CNA #7 also stated there was a potential to transfer germs.</p> <p>Observation on 09/14/2010 at 12:15pm revealed both CNA #4 and CNA #5 touched bread with bare hands while buttering bread for un-sampled resident.</p>	F 441		10-31-10
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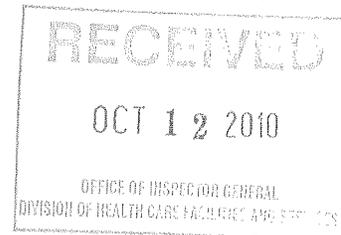
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F 441	Continued From page 16 Observation on 09/15/2010 at 12:05pm revealed CNA #6 touched a baked potato while cutting and buttering the potato for a resident. Without washing hands, CNA #6 was observed to pull up a chair and feed a different un-sampled resident. Interview with CNA #4 on 09/16/2010 at 9:50am revealed she was aware she should not touch residents' food with her bare hands. She stated it was an infection control issue and she should have used gloves. She reported that she knows if she uses gloves to assist resident with food preparation, she should remove gloves and wash her hands before assisting the next resident. Interview with CNA #5 on 09/16/2010 at 9:55am revealed she should not have touched the bread of a resident. She stated it could be an infection control problem for residents if she doesn't wash her hands. Interview with CNA #6 on 09/16/2010 at 9:30am revealed she had received training on serving food to residents and that she knew she should not have touched the baked potato for resident with her bare hand. She stated she might "pass something" from one resident to another.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determined the facility failed to	F 456	F- 456-s/s-F Essential Equipment, safe operating conditions It is the practice of Northfield Centre to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	10-31-10



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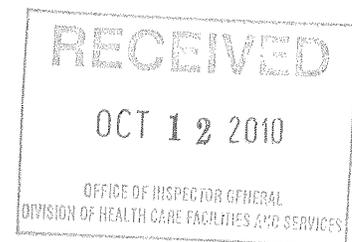
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F 456	<p>Continued From page 17</p> <p>maintain one of three (3) ice makers to ensure safe operating condition. In addition, the environment tour revealed an opened area in the drywall behind a commode in room #32. Numerous bathrooms sinks were observed to have open areas around the plumbing exposing the drywall and interior walls. The sink utilized by staff and residents in the South bathing room was not secured as it was pulling away from the wall which could cause potential harm.</p> <p>The findings include:</p> <p>Review of facility policy on 09/15/10 identified "Kitchen Cleaning Reference" on page four (4) of seven (7) dated 04/28/06 revealed the ice Machine was to be cleaned monthly and the staff were to disconnect or turn off the machine, allow machine to defrost, remove ice, scrub all ice machine surfaces and gaskets with warm soapy water, use a de-limer if needed, rinse with clear, hot water, sanitize inside with clean cloth that has been saturated with sanitizing solution allow inside to air dry, wash and rinse exterior and use stainless steel cleaner as needed.</p> <p>Observations on 09/16/10 at 11:30 am of the ice Machine located on the North Hall revealed the inside plate to have rust built up along the length of the bracket. The gasket seal had come loose on both corners. The ice machine was approximately 1/4 full with ice and a quarter sized unidentifiable black substance was observed on the ice. The exterior left side of the ice machine had an unidentified black substance built up and spread outward on the midline seam of the machine going down towards the floor. Beneath the black substance was also a whitish substance staff identified as possible calcium build-up.</p>	F 456	<p>CONT- F. 456</p> <p>Corrective action for the residents that were affected by alleged deficient practice; ice machine identified to be not in safe operating condition was immediately removed from usage until proper repairs were completed. Room #32 drywall behind a commode was repaired on 09-17-10 and the sink utilized by the staff and residents in the South bathing room was secured on 09-17-10.</p> <p>To identify residents that could be affected by the alleged deficient practice; review of all ice machines checked to ensure safe operation was completed on 09-17-10, an audit of all residents rooms was completed to ensure all drywall was intact on 09-18-10, and a review of all resident bathing areas and restrooms were reviewed and repaired if necessary to ensure all sinks were secured.</p> <p>Measure put into place to ensure that the alleged deficient practice does not re-occur: Weekly audit will be completed by the Maintenance Director and/or designee of all ice machines. resident rooms and bathing areas for the next 90 days. The Executive Director will also conduct a bi-weekly review to ensure compliance.</p> <p>The Maintenance Director will report all finding to the Performance Improvement Committee monthly for the next 90 days and then quarterly thereafter. Executive Director will audit weekly to ensure compliance and track and trend areas identified through Performance Improvement Committee. The Executive Director is overall responsible.</p>	10-31-10



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2010
NAME OF PROVIDER OR SUPPLIER NORTHFIELD CENTRE FOR HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD, LOUISVILLE, KY 40222	
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F 456	<p>Continued From page 18</p> <p>Interview on 09/16/10 at 2:32pm with CNA #11 revealed she had filled the cooler from the ice machine on the North Hall for residents use earlier that day. She stated she did not notice the rust or substance built up on the outside of the ice machine. CNA's #'s 9 and #10 revealed the ice machine on the North hall was used to obtain ice for the residents use and were not aware when it was cleaned or who was responsible to clean the ice machine.</p> <p>Interview on 09/16/10 at 1:45pm with the Maintenance Manager revealed the ice machine on the North Hall had not been cleaned for at least two months. He stated he was not aware of the rust build up and could not identify what the black substance on the left side of the ice machine was; however, it should not be there. He said he would have to check it more often.</p> <p>Observations on 09/16/10 during the environmental tour revealed the sink in the South shower room was loose and pulled away from the wall. Numerous resident bathrooms sinks were observed to have open areas around the plumbing exposing the drywall and interior walls. (rooms #'s 32, #33, #34, #39, and #'s 44-51) In addition room #32 had an open hole in the drywall behind the commode.</p> <p>Interview on 09/16/10 with the Maintenance Manager revealed he was not aware of the open areas and all surfaces were to be intact. He stated the shower room sink had been loosened by the stretchers and wheel chairs bumping into and had been repaired before. He stated staff would verbally tell him of needed repairs and there was a notebook/log on the units the staff</p>	F 456		10-31-10



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F 456	Continued From page 19 could use to write information. He stated he usually wrote down the needs identified by the staff on his personal notepad and was not sure if these things had been reported to him.	F 456		10-31-10
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OCT 12 2010

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY LICENSING

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

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on September 16, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000	K-038 -s/s -D Life Safety Code Standard It is the practice of Northfield Centre to ensure exit access is arranged so that exits are readily accessible at all times.	10/31/10
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey on 9/16/2010, it was determined the facility failed to maintain exit access according to NFPA standards. The findings include: Observation on 9/16/2010 at 10:15AM with the Maintenance Director, revealed the exit access doors to the laundry room were blocked by the laundry cart. This is a keyed access door. Interview with the Maintenance Director and Laundry Worker on 9/16/2010 at 10:15 AM, indicated that the laundry room doors are not to be blocked at any time. Reference NFPA 101 (2000 Edition)	K 038	Corrective action for alleged deficient practice: Laundry cart was removed immediately from access door and in-servicing conducted with all laundry staff members to ensure door remains accessible at all times on 09-16-10 and on 09-27-10. All residents have the potential to be affected by alleged deficient practice; The Maintenance Supervisor completed entire facility audit to ensure all doors were accessible according to Life Safety Code. Measures put into place to ensure alleged deficient practice will not re-occur; The Maintenance Supervisor conducted in-servicing with all members of the laundry staff on 09-16-10 and 09-27-10 on keeping laundry cart from blocking access door. Weekly monitoring will be completed by Maintenance Supervisor and/or designee daily for the next 90 days to ensure compliance of all access door ways Monitoring by the Maintenance Supervisor and /or designee will be completed daily for the next 90 day and then quarterly thereafter. All finding will be reported to Performance Improvement Committee monthly. Executive Director is overall responsible.	

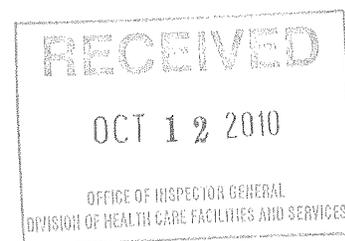
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paula Fern. J.</i>	TITLE <i>Executive Director</i>	(X8) DATE <i>10-08-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 038	Continued From page 1 19.2 Means of Egress Requirements 19.2.1 General Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with chapter 7.	K 038	<p>K-056 s/s F Life Safety Code Standard</p> <p>It is the practice of Northfield Centre to have automatic sprinklers, 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 Inspection, Testing and Maintenance of Water-Based fire Protection Systems. It is fully supervised, there is reliable, adequate water systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system.</p> <p>Corrective action for alleged deficient practice: The Centre contracted for sprinklers to be installed by Brown Sprinkler Company on 10-20-10.</p> <p>All residents have the potential to be affected by alleged deficient practice; The Centre is contracted with Brown Sprinkler Company to install sprinkler on 10-20-10.</p> <p>Measures put into place to ensure the alleged deficient practice is sustained is by installation of sprinklers in all canopies by Brown Sprinkler Company on 10-20-10.</p> <p>Monitoring by Maintenance Supervisor will be completed weekly for next 90 days. All findings will be reported to Performance Improvement Committee monthly. Executive Director is overall responsible.</p>	10/31/10
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, It is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey on 9/16/2010, it was determined that the facility failed to ensure the building had a complete sprinker system, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 9/16/2010 at 11:00 AM with the Maintenance Director, revealed five (5) canopies with combustible construction. The first canopy is located over the front entrance to the building. The second canopy is located over the north-wing exit. The third canopy is located over the</p>	K 056		



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K 056	Continued From page 2 south-wing day-room exit. The fourth canopy is located over the rehabilitation unit exit. And the fifth canopy is located off the breakroom exit. Interview with the Maintenance Director on 9/16/2010 at 11:00 AM, revealed that he was unaware of the canopies needing sprinklers. Reference NFPA 13/1999 (Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft. (1.2m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code survey on 9/16/2010, it was determined the facility failed to ensure no combustible decorations were used in the facility, according to NFPA standards. The findings include: Observation on 9/16/2010 at 1:10 PM with the Maintenance Director, revealed resident room #39 Bed-B on the north-wing with the bed covered with stuffed animals. Further observation also revealed no smoke detector in the room. Interview with Maintenance Director on 9/16/2010, indicated that he was aware of the stuffed animals. He stated that the facility policy is not to	K 073	K- 073 s/s -D Life Safety Code Standard It is the practice of Northfield Centre to have no furnishings or decorations that are highly flammable. Corrective action for the alleged deficient practice; Room #39 Bed B all decorations and furnishings that were highly flammable were immediately removed on 09-16-10. Education was provided to resident of Room #39 Bed B regarding Life Safety Code Standard. All residents have the potential to be affected by alleged deficient practice; The Maintenance Supervisor completed an entire Centre audit on 09-16-10 of all residents beds were not covered with stuffed animals that were not flame retardant.	10/31/10



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K 073	Continued From page 3 treat these items for flame retardant. NFPA Standard NFPA 101.2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	CONT. F. 073 Measures put into place to ensure that alleged deficient practice will not reoccur; Education completed with Resident of Room #39 Bed B on 09-16-10 regarding highly flammable decorations. Review of Life Safety Code Standard with Resident Council on 10-05-10 with highly flammable decorations conducted by Executive Director. Maintenance Supervisor and /or designee will conduct weekly audits daily for next 90 days of all residents' room to ensure highly flammable decorations and stuffed animals are not present. Monitoring to ensure corrective action is sustained: Maintenance Supervisor and /or designee will complete daily audits of all resident rooms/beds to ensure no presence of highly flammable decorations. Executive Director will conduct weekly rounds to monitor for compliance. All findings will be reported to Performance Improvement Committee monthly. Executive Director is overall responsible.	10/31/10	

