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

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RECEIVED
FEB 2015
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185291	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS COLONIAL TERRACE	142 ROGER POWELL RD SEBREE, KY 42455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted on 01/06/15 through 01/08/15. The facility failed to meet minimum requirements for recertification with deficiencies at a highest scope and severity of a "D".	F 000	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedures it was determined the facility failed to provide the appropriate care and services for indwelling urinary catheters for one (1) of sixteen (16) sampled residents (Resident #3) and one (1) unsampled resident (Unsampled Resident A). Registered Nurse (RN) #1 changed Resident #3's suprapubic indwelling urinary catheter and was observed to put sterile gloves on over other gloves, and not to wash her hands before applying the sterile gloves. In addition, staff failed to ensure Unsampled Resident #A indwelling catheter bag was not touching the floor when the resident was in his/her wheelchair.	F 315	**F 315** Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **Criteria 1** Licensed Nursing staff members (RN's & LPN's) are using proper technique when changing the indwelling catheter and/or providing cath site care of Resident #3 as observed by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rick Edgerlinckson	Ct Administrator	2-4-15

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 315	Continued From page 1 The findings include: Review of facility policy and procedure titled, "Care of Indwelling Catheter", last revised 03/2012, revealed staff should provide care to residents with indwelling catheters while maintaining proper infection control practices. 1. Review of Clinical Nursing Skills manual, eighth (8th) edition of Smith, Duel, Martin, revealed for licensed staff to perform hand hygiene and open sterile supplies, open cleansing solution and pour over sterile gauze, then don sterile gloves". Record review revealed the facility admitted Resident #3 on 02/14/14 with diagnoses which included Paraplegia, Thoracic Spinal Cord Infraction, Neurogenic Bladder and Obstructive Uropathy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/26/14, revealed the facility assessed the resident's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of "15" indicating the resident was interviewable. The resident was dependent on staff for all care. Observation, on 01/06/15 at 3.10 PM, revealed RN #1 removed Resident #3's indwelling suprapubic urinary catheter due to leaking from the insertion site and there was no urinary output in the drainage bag. A large amount of urine gushed from the insertion site when the tube was removed soaking the bed linens. RN #1 washed her hands, donned clean gloves and opened the sterile urinary catheter kit; however, she failed to remove the clean gloves and wash hands prior to donning the sterile gloves. She opened the	F 315	SDC/ADON/QAPI Nurse on 01/14/15. The catheter drainage for Resident #A is kept up off of the floor as observed by the SDC/ADON/QAPI Nurse on 01/14/15. **Criteria 2** Facility currently has 3 residents with indwelling catheters. Licensed Nursing staff members (RN's & LPN's) are using proper technique when changing the indwelling catheter of each resident as observed by the SDC/ADON/QAPI Nurse on 01/14/15. The catheter drainage for each Resident with an indwelling catheter is kept up off of the floor as observed by the SDC/ADON/QAPI Nurse on 01/14/15. **Criteria 3** All licensed nurses (RN's & LPN's) received hands on training of changing/inserting indwelling catheters in accordance with Standards of Nursing Practices as provided by the SDC and QAPI nurse on 01/06/15. Orientation check off list for all new licensed nurses (RN's & LPN's) will include skills review for inserting indwelling catheter. All nursing staff members received education training on keeping catheter drainage bag/tubing off of the floor using secure straps and dignity bags as	

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F 315	Continued From page 2 sterile gloves in the kit and attempted to put them on the top of the gloves she was already wearing. The gloves broke apart and an assistant Certified Nurse Aide (CNA) obtained another pair of sterile gloves for RN #1 who placed them on over the existing clean gloves she was wearing with difficulty. The resident asked the RN if she was supposed to put gloves on over other gloves and the RN responded she always double gloved in this manner. RN #1 completed insertion of the indwelling suprapubic catheter. Interview with RN #1 at the time of the procedure revealed she always double gloved, placing sterile gloves over gloves she was already wearing. 2. Review of the procedure; "Suprapubic Catheter Care" from facility manual titled, Pearson Nursing Student Resources utilized by the facility revealed "Do not let the drainage bag rest on the floor. This can contaminate the system". Record review revealed the facility admitted Unsampled Resident A on 07/03/13 with diagnoses which included Other Symbolic Dysfunction and Abnormal Gait and Chronic Airway Obstruction. Observation, on 01/07/15 at 3:25 PM, revealed Unsampled Resident A was self propelling in a wheel chair on Wing #1. The resident had propelled his/herself from Wing 2 across the building to Wing 1 and his/her urinary catheter drainage bag was anchored to the wheelchair and dragging on the floor. There was a large build up of dust on the bottom of the urinary drainage bag from the floor.	F 315	indicated on 01/14/15 as provided by the DON, SDC and QAPI Nurse. **Criteria 4** The QA tool for monitoring of catheter insertion and care of the resident with an indwelling catheter will be utilized monthly X 3, then every 6 months as per established QA calendar under the supervision of the DON. The tool allows for up to 5 residents to be listed on it. Results of the audits will be reported to the QA Committee by the DON or Unit Managers each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Unit Managers shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Members of the QA committee include: DON, Adm, Medical Director, ADON, QAPI Nurse, SDC, Dty Manager, Maintenance Director, Social Services. **Criteria 5** Target Date	01/16/15

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F 315	Continued From page 3 Interview with RN #2 on 01/07/15 at 3:26 PM, who witnessed the urinary drainage bag dragging along the floor as Resident #A propelled from one side of the building to the other, revealed the urinary drainage bag dragging on the floor was an increased risk for infection. She stated the CNAs should ensure the drainage bag was not touching the floor. Interview with the Director of Nursing (DON), on 01/07/15 at 4:00 PM revealed she expected the nurse to wash her hands and don sterile gloves as was the facility policy, and not double glove. She additionally stated urinary drainage bags should "absolutely be off the floor".	F 315		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, sanitary and comfortable environment for residents related to multiple resident wheel chairs observed in disrepair and an unsanitary shower bed available for use observed in the men's shower room. The findings include: Interview with the Maintenance Supervisor, on	F 465	**F 465** The facility shall provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **Criteria 1** Wheel chair arms/backs/seats noted to have tears have been repaired/replaced for Residents # 6, 11, C, D, E & G on 01/12/15 by the maintenance department. The noted shower bed, not is use, was cleaned and inspected for compliance on 01/08/15 by the DON. **Criteria 2** Inspection of all resident wheelchairs was completed on 01/12/15 by the maintenance department.. Necessary repairs were completed on 01/12/15 by the maintenance department.	

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F 465	Continued From page 4 01/08/15 at 2:30 PM, revealed he was not aware of any written policy related to resident equipment. 1. Observation on 01/05/15 at 10:00 AM, revealed the wheel chair utilized by Resident #6 had multiple worn and torn areas to the wheel chair he/she was utilizing. Observation on 01/05/15 at 10:30 AM revealed Resident #11's wheelchair was in disrepair with worn and torn areas on the left arm pad. Observation on 01/08/15 at 2:00 PM revealed Unsampled Resident C's wheelchair's upper back section had a worn and torn area. Observation on 01/08/15 at 2:05 PM revealed Unsampled Resident D's wheelchair arms had splits and cracks visible. Observation on 01/08/15 at 2:08 PM revealed Unsampled Resident E's wheelchair upper back section had splits and cracks visible. Observation on 01/08/15 at 2:10 PM of Unsampled Resident G's wheelchair had worn and torn areas to the right and left arm pads. Interview with the Maintenance Supervisor, on 01/08/15 at 2:30 PM, revealed residents bump wheelchairs on the tables and tear the fabric on the arm rests. He stated the torn arm pads could cause skin tears. The Maintenance Supervisor revealed Nursing should fill out a work order when resident equipment was found in disrepair and he would be responsible to make the repairs. He stated the facility had a supply of arm pads for wheelchairs and he expected nursing to put in a	F 465	There are no other shower beds. **Criteria 3** A maintenance log is kept at each nurses' station. Maintenance staff check it daily (M-F) and are available on-call as needed on weekends. As part of the monthly deep cleaning schedule, housekeeping staff will take all equipment from the resident room to maintenance staff for inspection. Maintenance staff will sign off on the deep cleaning book to indicate that the equipment has been inspected. All facility staff received in-service education on of the above mentioned and reporting equipment repair needs (including, but not limited to wheelchair arms) to promote a safe/comfortable environment on 01/14/15 as provided by the DON, SDC and QAPI Nurse **Criteria 4** The QA tool for monitoring of safe resident equipment will be utilized monthly X 3, then every 6 months as per established QA calendar under the supervision of the Administrator. This tool includes, but is not limited to the monitoring of resident equipment (such as wheelchairs and shower beds) for cleanliness and safe repair. Results of the audits will be reported to the QA Committee by the Administrator or	

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F 465	Continued From page 5 work order. He gave no explanation as to why so many wheelchairs being utilized by the residents were in disrepair. 2. Observation of the men's shower room on 01/08/15 at 2:50 PM revealed a shower bed stored and ready for use to have a large area of pooled brown substance on the water funnel surface area. Interview with the Housekeeping Supervisor at the time of the observation revealed nursing was responsible to ensure the cleanliness of the shower beds and chairs.	F 465	Maintenance Director each month it is completed. If an accepted threshold of compliance is not achieved, the Administrator or Maintenance Director shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Members of the QA committee include: DON, Adm, Medical Director, ADON, QAPI Nurse, SDC, Dty Manager, Maintenance Director, Social Services. **Criteria 5** Target Date	01/16/15

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K 000	INITIAL COMMENTS CFR 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1973. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (211). SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1973 and upgraded in 2008, with 31 smoke detectors and 4 heat detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1973. GENERATOR: Type II generator installed in 2008. Fuel source is Diesel. A standard Life Safety Code survey was conducted on 01/06/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for eighty-seven (87) beds with a census of seventy-seven (77) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	RECEIVED FEB 2015 OFFICE OF INSPECTOR GENERAL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-4-15

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

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K 000	Continued From page 1 Fire). Deficiencies were cited with the highest deficiency identified at a scope and severity of an "D" .	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for eighty-seven (87) beds and the census was seventy-seven (77) on the day of the survey. The findings include: Observation, on 01/06/15 at 2:15 PM, with the	K 029	The Maintenance Director removed the door wedge which was in violation of Code, on 1/6/15. The Maintenance Director and maintenance assistant conducted a thorough inspection of the facility and off-site laundry on 1/7/15, finding no other violations. Two wedge type materials were found the facility, but not in use. They were discarded. The Staff Training Coordinator and Administrator conducted an inservice with the Maintenance Director, maintenance assistant, Activities Director and activities assistant, as well as department heads, on the morning of 1/7/15, specifically educating on the Life Safety Code violations. Additionally, the Maintenance Director and Staff Training Coordinator inserviced shift supervisors and therapy staff, and support service staff in housekeeping, laundry and dietary, on 1/7/15, regarding the Life Safety Code violations. Additionally, information was placed in the staff lounge by the Staff Training Coordinator on 1/8/15, regarding Life Safety Code. On 1/12/15, the Staffing Training Coordinator added a document to facility orientation packet pertaining to not wedging or propping doors and maintenance of a fire barrier as mandated by LSC Code.	

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K 029	Continued From page 2 Maintenance Director revealed a door wedge was in use preventing the self-closing door to the Activities Office hazardous storage room to close as required. Interview, on 01/06/15 at 2:16 PM, with the Maintenance Director revealed he was aware of the hazardous storage room, however; he was not aware the hold open device had to be of an approved type. The census of seventy-seven (77) was verified by the Administrator on 01/06/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 01/06/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards. Reference: NFPA 101 (2000 Edition) 9.3 2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following. (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9 3 m2)	K 029	The Administrator placed a sign on the door between the Activity Office and room where activities and events occur, that denotes the violation of the Life Safety Code, reminding staff that the door should not be propped or wedged opened, as it violates the need for a fire barrier. This sign was placed on 1/8/15. The Maintenance Director will do general inservices to all staff quarterly as well, on paydays, which occur on the 5th and 20th of each month, to refresh all staff on Life Safety Code issues. These will be provided in February/May/August/November. The Maintenance Director will conduct a monthly QA study for violations of Life Safety Code, with emphasis on the issue found, to ensure proper fire safety, and no compromising of Code. The Maintenance Director will present his monthly findings to the QA Committee, on a monthly basis, times 12 months. Members of the QA committee include: DON, Adm, Medical Director, ADON, QAPI Nurse, SDC, Dietary Mgr, Maintenance Director, Social Services Director. Others may be present based on presentations.	1/16/15

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K 029	Continued From page 3 (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices. Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing.	K 029		

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K 029	Continued From page 4 (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for eighty-seven (87) beds and at the time of the survey, the census was seventy-seven (77). The findings include:	K 147	On 1/6/15, the Administrator of the facility, in the presence of the Maintenance Director of the facility, removed the plug of a coffee maker from a power strip, and correctly plugged the coffee maker into a wall outlet, eliminating the violation of the Code. On the same day, 1/6/15, the facility Maintenance Director removed the plug of a coffee maker from a power strip in the noted Unit Manager office, and correctly plugged the coffee maker into a wall outlet. Both power strips were taken out of service and discarded by the Maintenance Director at those respective times, on 1/6/15. Additional outlets have been added by the Maintenance Director in both areas. The Maintenance Director, maintenance assistant and Supervisor of Housekeeping jointly conducted an inspection of the facility, and off-site laundry, on 1/7/15, for the purpose of inspecting for violations of the Life Safety Code, primarily for power strips and door wedge materials. Several power strips were removed from resident room use, and discarded, or returned to resident families,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185291		01/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS COLONIAL TERRACE	142 ROGER POWELL RD SEBREE, KY 42455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 5 1. Observation, on 01/06/15 at 2:17 PM, with the Maintenance Director revealed a coffee maker was plugged into a power strip located in the Administrator's Office. Interview, on 01/06/15 at 2:18 PM, with the Maintenance Director revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the power strip was being misused. 2. Observation, on 01/06/15 at 3:50 PM, with the Maintenance Director revealed a coffee maker was plugged into a power strip located in the Unit Manager's Office. Interview, on 01/06/15 at 3:51 PM, with the Maintenance Director revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the power strip was being misused. The census of seventy-seven (77) was verified by the Administrator on 01/06/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 01/06/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to	K 147	upon notification on 1/7/15 and 1/8/15. Residents were again informed that power strip use was not allowed in rooms. The Maintenance Director has engaged in adding more wall outlets in several resident rooms, where appropriate. This process began on 1/9/15. The Maintenance Director on 1/6/15 and 1/16/15 provided inservice education to administrative staff, department heads, and unit manager staff regarding power strip use, and inappropriate use. On 1/12/15, the Staffing Training Coordinator added a document to facility orientation packet regarding allowable use in health care facilities for power strips as provided by LSC. Maintenance and housekeeping staff are daily checking office areas and resident rooms, kitchen and laundry for compliance with Codes. The Maintenance Director will do general Inservices to all staff quarterly as well, on paydays, which occur on the 5th and 20th of each month, to refresh all staff on Life Safety Code issues. These will be provided in February/May/August/November. Additionally, the Social Services Coordinator informing/reminding new residents and families of residents, of Life Safety Code compliance, and potential violations. This process began on 1/7/15.	

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K 147	Continued From page 6 approval by the authority having jurisdiction. Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	A monthly CQI tool pertaining to the proper use of power strips, and potential violations, was initiated on 1/9/15. This tool will be utilized monthly times three (3) consecutive months, and then quarterly thereafter. The CQI tool/document will be used by the Maintenance Director. Information gathered will consist of proper use of office power strips;approved equipment; non-allowable equipment; additional emphasis on not using power strips as a substitute for wall outlets. This CQI document will be brought to monthly CQI, then to quarterly meetings, for review of compliance. The Maintenance Director is responsible for reporting the information. Members of the QA committee include: DON, Adm, Medical Director, ADON, QAPI Nurse, Staff Dev. Coord., Dietary Mgr., Maintenance Director, Social Serv. Director. Others may be present based on presentations. The monthly newsletter will provide information beginning with the first quarter of 2015, regarding both power strip use and door wedge violations. This document is compiled and completed by the facility office assistant with input from department heads. The Activities Director, who has charge over monthly Resident Council, will provide information to the Resident Council regarding the noted Life Safety Issues, beginning in February (the 24th).	1/16/15