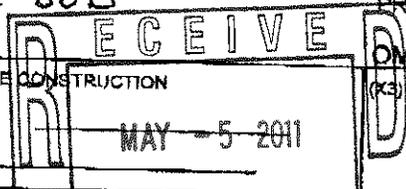


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 04/29/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  03/30/2011
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NAME OF PROVIDER OR SUPPLIER  LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE AND ZIP CODE 1033 NORTH HIGHWAY 10 MANCHESTER, KY 40962
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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)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was conducted on March 28-30, 2011. Deficient practice was identified with the highest scope and severity at "F" level.	F 000	<b>Disclaimer for Plan of Correction</b> Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicaid/Medicare Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction would not be taken as establishing any standard of care, and the facility submits that the actions by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal, or equitable, in administrative, civil or criminal proceeding.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of a cleaning schedule, the facility failed to provide necessary housekeeping and maintenance services to ensure equipment/supplies were clean and stored in a clean area, and failed to ensure the resident nutrition room was clean. Observation revealed the crash cart (cart that contains supplies needed to resuscitate a resident) was being stored in the East Wing shower room and was soiled. In addition, three drawers in the East Wing nutrition room were observed to be soiled.  The findings include:  1. Observation of the East Wing shower room on March 30, 2011, at 10:00 a.m., revealed the crash cart was being stored in the shower room. Further observation revealed the shower room was not being used during the observation; however, the floor was wet and a pair of shoes was observed on the floor.	F 253	1 Crash carts in the facility were cleaned, opened supplies were discarded, and the crash carts were restocked by the unit manager. The nourishment room drawers were cleaned on all units by the unit manager. Crash cart was moved from the shower room and will be stored in a small room on East Wing.  2 The cleaning duties for the crash cart and nourishment room was reviewed and revised by the DON/ADON. Crash carts will now be cleaned weekly on Friday and as needed. Cleaning schedules were updated to include cleaning of the drawers in the nourishment room. The nourishment room drawers will be cleaned daily and as need by the 3-11 C.N.A.s.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Clara E. Bevers* TITLE  
*Director* (X9) DATE  
*5/05/11*

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.

Received Time May. 5. 2011 3:11PM No. 8501



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F 253	Continued From page 2 included making sure "all shower rooms are clean, all cleaning supplies are put back in cabinets, and the cabinet is locked." The cleaning schedule did not include cleaning the crash cart. In addition, the cleaning schedule did include cleaning the nourishment room on the 3:00 to 11:00 shifts; however, three drawers were observed to be soiled.	F 253		
F 280 SS=D	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, the facility failed to periodically review and revise the comprehensive care plan for one of nineteen sampled residents (resident #9).	F 280	Resident #9's MD was notified on 3-29-11. New orders was obtained to continue the use of the indwelling F/C. Care plan was completed to reflect continued need for indwelling F/C and interventions.  100% audit of all residents with an indwelling catheter was completed by the DON/ADON on 3-31-11 to ensure all care plans were current and appropriate and interventions in place. All records were found to be in compliance.  All licensed nursing staff was inserviced on initiation and revision of care plans on 4-6-11 by the Staff Development Coordinator.  New admits, readmits with indwelling Foley Catheters will be audited to ensure all care plans are current, appropriate and interventions are in place, daily Monday – Friday x 4 weeks, weekly for 4 weeks, monthly x 4 months by the DON or designee. The results of the audits will be reviewed at the monthly Performance Improvement Meeting. Systems will be updated as indicated. Audits will be continued until committee determines compliance.	
		1		
		2		
		3		
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		5	Completion date.	4-29-11

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F 280	<p>Continued From page 3</p> <p>Resident #9 was readmitted to the facility on March 18, 2011, with an indwelling catheter; however, the facility failed to revise the comprehensive care plan to address the care required for the indwelling catheter.</p> <p>The findings include:</p> <p>Review of resident #9's medical record revealed the resident was admitted to the facility on January 16, 2009, with diagnoses of Alzheimer's Disease and history of colon cancer. Review of a significant change in status assessment (SCSA) dated December 28, 2010, revealed the facility assessed resident #9 as being moderately impaired in daily decision making and was dependent on staff for all activities of daily living.</p> <p>Further review of the record revealed resident #9 was admitted to a hospital on March 15, 2011, and was readmitted back to the facility on March 18, 2011. Review of the admission assessment revealed the admitting nurse had documented resident #9 entered the facility with an indwelling catheter.</p> <p>Review of the comprehensive care plan revealed the facility failed to revise the care plan to address the indwelling catheter and failed to initiate interventions related to the care required for resident #9's indwelling catheter.</p> <p>An observation conducted on March 28, 2011, at 9:50 a.m., 1:00 p.m., 3:00 p.m., and 5:50 p.m., revealed resident #9 had an indwelling catheter connected to a bedside drainage bag.</p> <p>Interview on March 29, 2011, at 1:40 p.m., with LPN #2 revealed the LPN was responsible for</p>	F 280		

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F 280	<p>Continued From page 4</p> <p>readmitting resident #9 to the facility on March 18, 2011. LPN #2 stated an indwelling catheter had been inserted during the hospital stay for resident #9 and the indwelling catheter was present when the resident returned to the facility. LPN #2 stated it was the responsibility of the nurse that admits a resident to complete a full head to toe assessment, write the physician orders, and update the comprehensive care plan to address any changes. LPN #2 stated the LPN had failed to update the care plan to address the indwelling catheter. LPN #2 reviewed resident #9's medical record and was unable to find documentation for the clinical reason resident #9 required an indwelling catheter.</p> <p>Interview on March 29, 2011, at 4:45 p.m., with the Unit Manager (UM) revealed when a resident was readmitted to the facility staff was required to review all medications, transcribe physician's orders, perform a complete physical assessment, and update the comprehensive care plan if necessary. The UM stated all orders were reviewed by the UM each morning and then the care plan was reviewed by the UM to ensure the care plan had been updated. The UM stated the physician's orders did not indicate an indwelling catheter; therefore, the comprehensive care plan was not revised to address the indwelling catheter.</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>Based on observation, interview, and record review, it was determined the facility failed to meet professional standards of quality for one of nineteen sampled residents. The facility failed to provide evidence that resident #2 received intravenous (IV) solution set tubing change every forty-eight hours as stated per the facility's policy.</p> <p>The findings include:</p> <p>Resident #2 was readmitted to the facility on March 7, 2011, with medical diagnoses of Osteomyelitis, Decubitus Ulcer of the right heel, and gangrene. The resident had a physician's order dated March 7, 2011, for Vancomycin (antibiotic) to be administered intravenously.</p> <p>Observation conducted on March 28, 2011, at 11:15 a.m., revealed resident #2 had Vancomycin infusing intravenously (IV). There was no date on the IV solution set tubing.</p> <p>An interview conducted on March 28, 2011, at 11:50 a.m., with Registered Nurse (RN) #1 revealed the nurse was responsible for changing the IV solution set tubing for resident #2 every three days when Vancomycin was administered. RN #1 further stated resident #2's IV tubing changes were tracked and recorded on the Medication Administration Record (MAR). After review of the MAR, RN #1 stated that according to the MAR resident #2's last IV solution set tubing change was performed on March 19, 2011. RN #1 stated he/she had administered IV Vancomycin for resident #2 on March 28, 2011. However, the nurse stated he/she had not reviewed the MAR to determine the date of the last tubing change and had not changed the IV solution set tubing for resident #2 on March 28,</p>	F 281	<p>1 Resident #2 IV tubing was changed and the date was recorded on the IV Flow Record on 3-28-11. Resident had no noted adverse effects from the IV tubing not being changed.</p> <p>2 100% audit was completed on all residents receiving IV therapy by the DON/ADON on 3-31-11 to ensure all IV tubing was dated and documented per facility policy.</p> <p>3 An inservice was conducted by the Staff Development Coordinator on 4-11-11 for all licensed staff related to IV tubing, being dated and changed every forty eight hours and documentation of the IV tubing changes.</p> <p>4 Audits will be completed to ensure all IV Tubing is dated and documented per facility policy by the DON/designee daily Monday – Friday x 4 weeks, weekly x 4 weeks, then monthly for 4 months.. The results of the audits will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until Performance Improvement Committee determines compliance.</p> <p>5 Completion date.</p>	4-29-11

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F 281	Continued From page 6 2011.  An interview conducted on March 29, 2011, at 4:10 p.m., with the Director of Nursing (DON) revealed the facility's policy for IV solution set tubing change is every 48 hours. The DON further revealed facility nurses were required to record and track the date the resident's solution set tubing was changed on the resident's IV flow sheet.  Record review of resident #2's care plan dated March 7, 2011, revealed the resident was assessed to receive IV medication with nursing intervention to change IV tubing per the facility's policy. Additional review of the facility's policy (no date) revealed IV solution set tubing is changed every 48 hours.	F 281			
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, and record review, it was determined the facility failed to provide appropriate treatment and services to restore as much normal bladder function as	F 315  1  2	Resident #9s MD was notified on 3-29-11. New orders was obtained to continue the use of the indwelling Foley Catheter. Care plan was completed to reflect continued need for the indwelling catheter and interventions.  100% audit of all residents with an indwelling catheter was completed by the DON/ADON on 3-31-11 to ensure all care plans were current and appropriate diagnosis and interventions in place. All records were found to be in compliance.		



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F 315	Continued From page 8 evidence the facility had evaluated resident #9 for retraining of bladder function.  Interview on March 29, 2011, at 1:40 p.m., with LPN #2 revealed the LPN was responsible for readmitting resident #9 to the facility on March 18, 2011. LPN #2 stated an indwelling catheter had been inserted during the hospital stay for resident #9 and the indwelling catheter was present when the resident returned to the facility. LPN #2 stated he/she charted the indwelling catheter was discontinued because staff was required to remove indwelling catheters when a resident returned to the facility. LPN #2 stated resident #9's family had requested the indwelling catheter remain in place due to skin irritation of the resident's buttock. LPN #2 was unable to provide documentation regarding the family's request. LPN #2 stated the physician was not contacted to obtain the clinical condition that required resident #9 to have the indwelling catheter or regarding the family's request to leave the indwelling catheter in place.  Interview on March 29, 2011, at 4:45 p.m., with the Unit Manager (UM) revealed residents that required an indwelling catheter were to have a pertinent diagnosis to support the use of the indwelling catheter. The UM stated the nurse that readmitted the resident should have contacted the physician for orders related to the indwelling catheter and obtained a diagnosis to continue the indwelling catheter.  The facility failed to provide a policy to address indwelling catheters.	F 315			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	Continued From page 9 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to provide supervision to prevent accidents. Observation of medication administration pass on March 30, 2011, at 4:30 p.m., revealed a Registered Nurse (RN) left an open bottle of Reglan (antiemetic) liquid medication on top of the medication cart in a hallway of the facility unattended.  The findings include:  A review of the facility's policy titled "LTC Facility's Pharmacy Services and Procedures Manual" with a revision date of May 1, 2010, revealed facility staff should not leave medications or chemicals unattended.  Observation of medication administration pass on March 30, 2011, at 4:30 p.m., revealed the RN who was administering medications removed a bottle of Reglan liquid medication from the medication cart. The nurse stated the lid for the medication was broken and stated he planned to dispose of the bottle of medication. The nurse placed the medication on top of the cart and entered a resident's room to administer medications, leaving the medication unattended in the hallway.	F 323  1  2  3  4  5	The DON immediately, upon being notified by the surveyor on March 30, 2011, went to the nurse responsible for the medication cart. Interview with the nurse revealed the bottle of Reglan had been discarded and a new bottle ordered.  100% audit of all medication carts was completed by the DON/ADON on 3-30-11 to ensure no medication was left unattended or unsupervised on top of the medication carts. The audit revealed no medications were left on top of medication carts.  Inservice was conducted on 3-31-11 by the Staff Development Coordinator with all licensed staff related to proper storage and supervision of all medications and medication carts.  DON/designee will audit medication carts daily Monday – Friday x 4 weeks, weekly x 4 weeks, then monthly x 3 months.  Completion date.	4-29-11

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F 323	Continued From page 10  Observation revealed at least one resident, one visitor, and one staff member passed by the unattended cart and Reglan medication in the hallway while the RN was behind a closed curtain in a resident's room.  An interview with the RN on March 29, 2011, at 5:00 p.m., revealed the facility had residents who wandered and/or had a diagnosis of dementia and leaving medication unattended may pose an accident hazard to residents.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free of medication error rates of five percent or greater. Observations of a medication pass on March 29, 2011, at 9:20 a.m., revealed medication for resident #3 was not administered per physician's orders. Further observation of a medication pass on March 30, 2011, at 11:20 a.m., revealed a medication for resident #19 was not administered in accordance with physician's orders. There were forty-one medication attempts observed, with three errors observed, resulting in the facility's medication error rate of seven percent.  The findings include:	F 332  1  2	Resident #3's physician was notified of medications being administered late, order received to continue Tamsulosin per MD orders. Resident #19's MD was notified of medication being administered at the wrong time and in the wrong form. Order was given to give the Carafate by mouth with water.  100% Medication Pass observations was conducted for licensed nurses by the DON/ADON/Pharmacy beginning 3-31-11 and completed 4-22-11 to ensure residents are free of medication errors. No medication errors noted during med pass observation.	

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F 332	Continued From page 11  1. Observation of medication pass on March 29, 2011, at 9:20 a.m., revealed nurse #1 administered Tamsulosin HCL 0.4 mg SR at 9:20 a.m., to resident #3.  Record review of resident #3's March 2011 physician's orders revealed an order for Tamsulosin HCL (Flomax) 0.4 mg SR by mouth to be administered one-half hour "after same meal."  Review of the facility's policy titled General Dose Preparation and Medication Administration with a policy revision date of May 1, 2010, revealed staff was to follow manufacturer medication administration guidelines. According to the manufacturer's guidelines for Flomax, the medication should be taken "½ hr after same meal of each day."  Interview with nurse #1 at 9:30 a.m. on March 29, 2011, revealed resident #3 went to the dining room for breakfast and had eaten at approximately 7:30 a.m. Interview with the Director of Nursing (DON) on March 30, 2011, at 12:00 p.m., also revealed resident #3 ate breakfast in the dining room and breakfast meals were served at approximately 7:00 a.m.  Based on observation and interviews, resident #3 received the Flomax medication approximately one hour and 20 minutes after the prescribed timeframe.  2. Observation on March 30, 2011, at 11:20 a.m., of medication pass revealed LPN #2 prepared Reglan (antiemetic) 5 milligrams (mg) and Sucraifate (anti-ulcer) 1 gram (g) and	F 332  3  4  5	Inservice was conducted on 4-8-11 by the Staff Development Coordinator with all licensed staff regarding medication administration.  Medication Pass observation will be conducted by the DON/ADON on 3 staff members and 5 residents daily Monday – Friday x 4 weeks , then 2 x weekly for 4 weeks, then monthly x 4 months to ensure compliance with orders, med pass regulations, manufacturer's medication administration guidelines, etc. All audits will be reviewed in the monthly Performance Improvement Meeting. Audits will continue until the Performance Improvement Committee determines compliance.  Completion date.	4-29-11	

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OMB NO. 0938-0391

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F 332	Continued From page 12 administered the medications with water to resident #19.  Review of the March 2011 monthly physician's orders and the Medication Administration Record (MAR) revealed the Sucralfate was ordered by the physician to be crushed, mixed with a liquid to make a "slurry," and administered every eight hours to resident #19. Further review of the MAR revealed the Sucralfate was scheduled for 8:00 a.m., 4:00 p.m., and 12:00 a.m. This was counted as two medication errors due to the medication being administered at the wrong time and failure to administer the medication as a slurry liquid.  Interview on March 30, 2011, at 11:30 a.m., with LPN #2 stated he/she thought the MAR directed the Sucralfate to be administered at 12 noon; however, LPN #2 stated he/she must have looked at the directions wrong because the medication should have been administered at 12 midnight. LPN #2 stated the medication was administered four hours after the morning dose and the resident should have received the medication eight hours apart. Further interview with LPN #2 revealed the physician had ordered that the Sucralfate tablet could be administered whole; however, LPN #2 was unable to find a physician's order that directed staff to administer the medication as a whole pill.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced	F 333		

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F 333	Continued From page 13 by: Based on observation, interview, and record review, it was determined the facility failed to ensure that one of nineteen sampled residents was free of a significant medication error. Resident #2 was administered an expired dose of intravenous (IV) antibiotic (ATB) Vancomycin.  The findings include:  Resident #2 was readmitted to the facility on March 3, 2011, with diagnoses of Osteomyelitis, Decubitus ulcer right heel, and gangrene. Record review of resident #2's physician's orders dated March 21, 2011, revealed an order for 1 gram of Vancomycin to be administered every 24 hours.  An observation conducted on March 28, 2011, at 11:15 a.m., revealed resident #2 had a bag of Vancomycin infusing intravenously. Further observation of the Vancomycin bag revealed an expiration date of March 23, 2011.  An interview conducted on March 28, 2011, at 11:50 a.m., with Registered Nurse (RN) #1 revealed he/she was responsible to check the expiration date on all medication that he/she administered. RN #1 revealed resident #2's Vancomycin was sent from the facility's pharmacy and was stored in the refrigerator. The RN further stated after checking the refrigerator he/she had accidentally administered Vancomycin to resident #2 on March 28, 2011, that had expired five days earlier on March 23, 2011. In addition, the RN stated resident #2 had two bags of Vancomycin remaining in the refrigerator with an expiration date of April 21, 2011.	F 333  1  2  3	Immediately upon identifying the expired IV medication had been given, the DON/ADON/Unit Manager inspected all IV medications for expiration. None was found. Pharmacy and resident's responsible party and resident #2's physician were notified of expired medication given and new orders were obtained. The RN Unit Manager completed a full physical assessment on resident #2 and no notations of adverse reaction were noted.  The DON/ADON & Unit Manager inspected all IV medication in facility for expiration. None were found.  The facility implemented an IV medication checklist to review expiration dates. The Staff Development Coordinator inserviced all licensed nursing staff on 3-31-11 related to the 5 R's of Medication Pass and checking for expiration along with the new checklist implemented.		

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F 333	Continued From page 14 An interview conducted on March 29, 2011, at 1:40 p.m., with RN #2 revealed the nurse is responsible to check the expiration date on all medications that he/she administered to residents. In addition, the RN stated expired medication could "lose potency" if used past the expiration date.  An interview conducted on March 29, 2011, at 2:55 p.m., with the Director of Nursing (DON) revealed the Vancomycin was dispensed to the facility by the facility's pharmacy, stored in the refrigerator, and expired 30 days after it was dispensed. The DON further revealed the medication nurse was responsible to dispose of all unused/expired medications.	F 333  4  5	The DON or designee will audit all IV medications in the facility weekly x 4, then monthly x 3 months to assure that all medications are disposed of properly when expired. All audits will be reviewed in the monthly Performance Improvement Meeting. Audits will continue until the Performance Improvement Committee determines compliance.  Completion date.	4-29-11	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide foods/liquids that were palatable and at the proper temperatures. Observations during the noon meal of the West Hall on March 28, 2011, and of the evening meal on the East Hall on March 28, 2011, revealed the facility served foods/liquids that were not palatable or at the proper temperatures.  The findings include:	F 364  1 2 3	No residents were found to be adversely affected by this practice.  All residents with oral diets have the potential to be affected.  An inservice was completed on 3-29-11 by the Registered Dietician for the Dietary Manager/dietary staff related to palatability and temperature of milk. An inservice was conducted on 4-6-11 by the Staff Development Coordinator for all nursing staff regarding timely serving of meal trays to residents that dine in their room and for restorative dining. Education was provided to all nursing staff if a meal tray is on the meal cart longer than 20 minutes a new tray is to be requested for that resident.		

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F 364	Continued From page 15  1. Observation of the noon meal on March 28, 2011, revealed a meal tray cart was delivered to the West Hall at 12:10 p.m. Two CNAs were observed to remove the meal trays from the cart and deliver the trays to the residents' rooms. Further observation at 12:30 p.m. (20 minutes after meal cart arrived to the floor), revealed the two CNAs were each in a resident's room feeding a resident. Observation of the meal cart revealed two resident meal trays remained on the cart.  At 12:45 p.m. (35 minutes after the cart arrived on the floor), the facility's Registered Dietitian (RD) was summoned to the meal cart to test the temperature of the food on one of the remaining resident trays. A substitute tray was ordered for the resident. The temperature of the pureed carrots was 116.4 degrees Fahrenheit and milk was 48.9 degrees Fahrenheit (normal 41 degrees Fahrenheit or below).  The individual foods on the tray were taste tested by the facility's RD and a surveyor. The RD and the surveyor revealed the turkey and dressing were warm and palatable. However, the taste test revealed the carrots were barely warm and not palatable.  2. Observation of the evening meal on March 28, 2011, from 5:35 p.m. until 6:08 p.m., revealed six meal trays were delivered to the East Hall for residents in the restorative dining area. The meal trays were delivered in an open delivery cart with only a plastic covering on the cart. Further observation revealed residents were not in the restorative dining room when the trays were delivered to the floor. The CNAs began to bring residents to the restorative dining room after the	F 364	4 Dietary Manager/designee will audit dietary staff food preparation for temperature and palatability of food daily. Coolers have been purchased by dietary department to place milk into for delivery to resident rooms and restorative dining during meal times.  5 DON/designee will audit tray carts for timely delivery of trays and temperature of milk 3 x daily x 4 weeks, randomly x 4 weeks and monthly x 3 months.  6 Completion date.	4-29-11	

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F 364	<p>Continued From page 16</p> <p>trays were delivered to the floor. The last resident tray was taken off the cart at 6:08 p.m., and was intercepted by the surveyor. A new tray was requested for the resident. The facility's RD took the following food temperatures from the intercepted tray: milk was 51 degrees Fahrenheit, and buttermilk was 51.4 degrees Fahrenheit (normal 41 degrees Fahrenheit or below).</p> <p>Interview with the facility's RD on March 28, 2011, at 6:18 p.m., revealed there was no policy that stated how long a meal tray should be left on the delivery cart prior to being served to a resident; however, the RD stated 20 minutes was an acceptable timeframe. The RD stated that the milk was at an improper temperature and should have been below 41 degrees Fahrenheit.</p> <p>An interview with CNA #5 on March 28, 2011, at 6:15 p.m., revealed meal trays should not be left on the delivery cart longer than 15 minutes. The CNA acknowledged the intercepted tray should not have been delivered to the resident and that a new tray should have been ordered for the resident.</p> <p>An interview with LPN #1 on March 28, 2011, at 6:12 p.m., revealed that resident trays should not be left on the delivery cart longer than five or ten minutes after the cart was delivered to the unit. LPN #1 stated a fresh tray should be ordered for the residents whose meal trays were undelivered for an unacceptable length of time.</p> <p>During a group interview on March 29, 2011, at 1:15 p.m., seven residents revealed food at the facility was served cold at times. The residents stated that food trays sometimes sat too long on</p>	F 364		



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F 372	Continued From page 18 gravel/mud surface rather than a smooth non-absorbent asphalt/concrete surface as required by the Kentucky Retail Food Establishment Act and State Retail Food Code, Section 24.  An interview was conducted with the facility Dietary Manager on March 28, 2011, at 1:00 p.m., and revealed the facility garbage and refuse was collected three times a week on Monday, Wednesday, and Friday.  A review of the facility Food Establishment Inspection Report revealed the Department for Public Health had cited the facility on November 11, 2010, for improperly contained garbage and refuse.  An interview was conducted with the Facility Administrator on March 29, 2011, at 9:30 a.m. The Facility Administrator stated the facility had unsuccessfully attempted to obtain a third dumpster after the Health Department inspection in November 2010.	F 372		
F 441 SS=D	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,	F 441  1	Resident #20 and #21 were assessed by the Unit Manager, no adverse effects was noted related to nurse #3 not wearing gloves or washing hands.	

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F 441	Continued From page 19 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 infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections for resident #20 and resident #21. During observation of a medication pass, nurse #3 failed to perform handwashing during medication administration, and failed to wear gloves while performing a blood glucose check for a resident.	F 441  2  3  4  5	100% observation was completed on 4-1-11 by the nurse management team on all residents receiving medications via g-tube and bedside glucose monitoring to assure compliance with hand washing and doning gloves when needed.  The Staff Development Coordinator inserviced all licensed nurses on Infection Control Guidelines on 4-8-11. Inservice included hand washing guidelines and wearing of gloves while performing blood glucose checks.  The DON or designee will perform audits on 3 staff members and 5 residents during med pass to assure hand washing and glove wearing compliance daily Monday through Friday x 3 weeks, weekly x 4 weeks, then monthly x 4 months. These audits will be reviewed in the Performance Improvement meetings monthly. Systems will be updated as indicated. Audits will continue until committee determines compliance.  Completion date.	4-29-11

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F 441	<p>Continued From page 20</p> <p>The findings include:</p> <p>Review of a facility policy titled Feeding Tube-Instilling Medication, not dated, revealed staff should wash their hands before and after administration of medications.</p> <p>During observation of a medication pass on March 29, 2011, at 4:30 p.m., nurse #3 was observed to administer medication tablets by mouth to one unsampled resident. The nurse then prepared resident #20's medications for administration, donned gloves, and administered the medication through the resident's gastrostomy tube (feeding tube). The nurse did not wash his hands before or after administering medications through the resident's feeding tube, and continued to administer medications to a third resident without washing his hands.</p> <p>Review of the Centers for Disease Control (CDC) and Prevention recommendations for Hand Hygiene and Glove Recommendations dated March 31, 2011, revealed staff was required to wear gloves during finger-stick glucose monitoring, administration of insulin, and any other procedure that involves potential exposure to blood or body fluids. On March 29, 2011, at 5:10 p.m., nurse #3 was observed performing a blood glucose check on resident #21. The nurse pierced the resident's finger with a lancet, squeezed the resident's finger to obtain a blood sample, and proceeded to check the resident's blood glucose level while not wearing gloves.</p> <p>During an interview with nurse #3 on March 29, 2011, at 5:15 p.m., the nurse stated he had difficulty performing blood glucose monitoring and initiating intravenous lines while wearing gloves</p>	F 441		

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F 441	Continued From page 21	F 441		
F 463 SS=D	<p>and acknowledged that he did not always wear gloves when performing these tasks.</p> <p><b>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</b></p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure calls could be communicated from toilet and bathing facilities to the nurses' station. Observation of three toilet areas in the facility shower rooms revealed the pull cord to activate the call light system was not accessible from the toilet.</p> <p>The findings include:</p> <p>Observation of two West Wing shower rooms and one East Wing shower room on March 30, 2011, at 9:40 a.m. and 10:00 a.m., revealed each shower room contained a stall with a toilet. Further observation revealed the switch that activated the call light system was on the outside of the toilet stall and not accessible to the resident. A string to activate the call light in the West Wing shower rooms was threaded between the bathroom stall and wall into the toilet area; however, the call light was not readily accessible to the toilet and one call light could not be activated due to the positioning of the string.</p> <p>Observation of the East Wing shower room</p>	F 463 1  2  3  4  5	<p>The Maintenance Director immediately went to East/West Wing shower rooms and modified the call light strings by placing a track to hold the call string in place to make the call light string level with the commode within reach of the residents.</p> <p>All residents had the potential to be affected.</p> <p>Executive Director and Maintenance Director inserviced staff 03-30-11 on proper placement of string through track and within reach of the residents. Problems identified will be reported to the immediate supervisor.</p> <p>Executive Director/Maintenance Director and/or designee will complete audits of the call light daily (Monday through Friday) x 2 wks, then 3 x per week x 1 month to ensure the string remains in the track and within reach of residents. Audits will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until Performance Improvement Committee determines compliance.</p> <p>Completion date.</p>	4-29-11

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F 463	<p>Continued From page 22</p> <p>revealed the switch that activated the call light system was on the outside of the toilet stall and not accessible to the resident. Further, the cord attached to the call switch was on the outside of the toilet stall and not accessible in the toilet area.</p> <p>Interview with a Certified Nursing Assistant (CNA) on March 30, 2011, at 1:50 p.m., revealed at least one unsampled resident utilized the East Wing shower room toilet unassisted.</p> <p>Interview with the Maintenance Supervisor on March 30, 2011, at 11:05 a.m., revealed the facility had walls put up around the toilets in the shower rooms a few years ago to provide more privacy for residents. The Maintenance Supervisor explained that the contractor who put up the walls should have put the call light switch on the inside of the toilet stall.</p>	F 463			

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PRINTED 04/13/2011  
EFORM APPROVED  
OMB NO. 0938-0391

**D E C E I V E D**

APR 26 2011

(X3) DATE SURVEY COMPLETED  
03/29/2011

Division of Health Care  
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	
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NAME OF PROVIDER OR SUPPLIER  LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP+4 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
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K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>TYPE OF STRUCTURE:</b> 1991 One-story unprotected frame Type V(200) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on March 29, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Laurel Creek Health Care Center was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p><i>Disclaimer for Plan of Correction</i></p> <p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Kentucky Medical Investors Ltd., d/b/a Laurel Creek Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicaid/Medicare Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction would not be taken as establishing any standard of care, and the facility submits that the actions by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal, or equitable, in administrative, civil or criminal proceeding.</p>	
K 038 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit doors were readily accessible at all times. This deficient practice affected one of five smoke compartments, staff, and approximately eighteen residents. The facility has the capacity for 106 beds with a census of 84 on the day of the survey.</p> <p>The findings include:</p>	K 038		

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

*Clara Benson* *Eric Director*

(X6) DATE  
4/25/11

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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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL CREEK HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962</b>		
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K 038	Continued From page 1  During the Life Safety Code tour on March 29, 2011, at 10:20 a.m., with the Director of Maintenance (DOM), an exit door with a magnetic lock releasing device located in the West Wing was observed not to release when tested. These types of locks are used for the safety of wandering residents and to control access to the building. The locks should release within 15-30 seconds to let people out of the building that are unfamiliar with the coded key pad adjacent to the doors in an emergency situation. An interview on March 29, 2011, at 10:20 a.m., with the DOM revealed the exit door magnetic locks were tested weekly. The DOM stated that the DOM was not aware the lock was not functional.  Reference: NFPA 101 (2000 Edition).  7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock	K 038	1 Maintenance Director immediately adjusted the lock on West Wing on 3-29-11.  2 Maintenance Director checked all other doors to assure there were no problems, none was identified.  3 On 3-29-11 the Executive Director inserviced the Maintenance Director and all staff related to the exit door magnetic releasing system problem identified with the West Wing door. Staff was instructed to report problems immediately to the Executive Director/Maintenance Director.  4 Executive Director/Maintenance Director/or designee will complete audits on all doors daily (Monday through Friday) x 2 weeks, then 3 times a week x 2 weeks, then 1 time per week ongoing. Audits will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until Performance Improvement Committee determines compliance.	4-29-11	

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K 038	Continued From page 2 within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.	K 038		
K 052 SS=F	d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052  1	The Director of Maintenance contacted Safe Care (contractor) to request in-house maintenance of system. They scheduled to come in as soon as possible.	

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K 052	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the building fire alarm system functioned as required by NFPA standards. This deficient practice affected five of five smoke compartments, staff, and all the residents. The facility has the capacity for 106 beds with a census of 84 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on March 29, 2011, at 10:45 a.m., with the Director of Maintenance (DOM), a test of the fire alarm system revealed that after the initial test the fire alarm system did reactivate, however, the fire alarm control panel did not indicate which area of the facility the second test occurred. This type of test ensures that the fire alarm will reactivate and show the location of a fire that spreads to other locations in the facility. An interview with the DOM on March 29, 2011, at 10:55 a.m., revealed the facility had to install a new fire alarm system recently and the DOM was not aware the fire alarm system was not functioning properly.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>1-5.4.8 Alarm Signal Deactivation. A means for turning off activated alarm notification appliances shall be permitted only where it is key-operated, located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. Such means shall be permitted only if a visible zone alarm indication or the equivalent has been provided as specified in 1-5.7.1, and subsequent actuation of initiating devices on other initiating</p>	K 052  2  3  4  5	<p>All residents have the potential to be affected.</p> <p>Inservice was started for all staff present and will be completed by 4/26/11. A directional chart was posted at the control panel.</p> <p>Maintenance Director will complete audits daily (Monday through Friday) for 4 weeks, then 3 x per week for 2 weeks, then 1 x per week for 1 week. Audits will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until Performance Improvement Committee determines compliance.</p> <p>Completion date.</p>	4-29-11
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K 147	Continued From page 5 resident and staff members in the Beauty Shop.  The findings include:  During the Life Safety Code tour on March 29, 2011, at 10:10 a.m., with the Director of Maintenance (DOM), an electrical outlet located near the sink in the Beauty Shop was tested and found not to be protected by a Ground Fault Circuit Interrupter (GFCI). GFCI receptacles and/or GFCI circuit breakers help prevent personnel from accidental shock by receptacles located near wet areas. An interview with the DOM on March 29, 2011, at 10:10 a.m., revealed the DOM thought the outlet was protected by a GFCI circuit breaker in the electrical panel box.  Reference: NFPA 70 (1999 Edition).  517-20. Wet Locations a. All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption of power under fault conditions can be tolerated, or be served by an isolated power system if such interruption cannot be tolerated. Exception: Branch circuits supplying only listed, fixed, therapeutic and diagnostic equipment shall be permitted to be supplied from a normal grounded service, single- or 3-phase system, provided that a. Wiring for grounded and isolated circuits does not occupy the same raceway, and b. All conductive surfaces of the equipment are grounded. b. Where an isolated power system is utilized, the equipment shall be listed for the purpose and installed so that it meets the provisions of and is in accordance with Section 517-160.	K 147  1  2  3  4  5	The GFCI was installed immediately in the Beauty Shop by the Maintenance Director.  All outlets were check by the Maintenance Director to assure they were GFCI and outlets were found compliant.  The Maintenance Director was inserviced by the Executive Director on 3-30-11 related to GFCI receptacles and/or GFCI Circuit Breakers and prevention of accidental shock by receptacles located near wet areas.  Audits will be completed by Maintenance Director daily (Monday through Friday) for 2 weeks then weekly for 2 weeks, then randomly for 1 month. Audits will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until Performance Improvement Committee determines compliance.  Compliance date.	4-29-11

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K 147	<p>Continued From page 6</p> <p>FPN: For requirements for installation of therapeutic pools and tubs, see Part F of Article 680.</p> <p>3-3.3.3 Receptacle Testing in Patient Care Areas.</p> <p>a. The physical integrity of each receptacle shall be confirmed by visual inspection.</p> <p>b. The continuity of the grounding circuit in each electrical receptacle shall be verified.</p> <p>c. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.</p> <p>d. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz)</p> <p>3-3.4.2.3 Maintenance and Testing of Electrical System.</p> <p>a. Testing Interval for Receptacles in Patient Care Areas.</p> <p>1. Testing shall be performed after initial installation, replacement, or servicing of the device.</p> <p>2. Additional testing shall be performed at intervals defined by documented performance data.</p> <p>Exception: Receptacles not listed as hospital-grade shall be tested at intervals not exceeding 12 months.</p>	K 147		