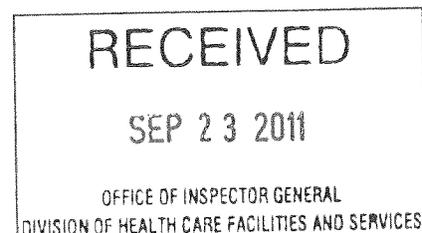


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
(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 160	Continued From page 1 specific regulations, it is HCR ManorCare policy to dispose of the funds within 30 days of discharge or expiration. Record Review of Resident #A's personal account, on 08/25/11 at 10:30 AM, revealed Resident #A expired on 02/21/11. Record review of his/her account revealed the Final Balance was Paid/Closed 04/04/11. Interview with the Accountant, on 08/25/11 at 10:40 AM, revealed sometimes the facility holds the account to make sure all the insurance money has gone through. Interview with the Business Office Coordinator, on 08/25/11 at 2:10 PM, revealed audits for accounts were completed monthly and could not understand why the account was not closed timely for Resident #A. Interview with the Administrator, on 08/25/11 at 4:00 PM, revealed she was to sign and review the resident trust fund monthly. A final report was to go to the corporate office after her review. The Administrator further stated she was not aware the account was not closed timely.	F 160	How will you identify other residents having the potential to be affected by the same deficient practice? - Residents that have a resident trust fund have the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Residents that have a resident trust fund will be monitored monthly by the Business Office Coordinator, after the reconciliation process has been completed. Any balances remaining in the resident trust fund for a discharged resident will be refunded to the appropriate payee within 30 days of the patient's discharge by the Business Office Coordinator, or Accounts Payable Manager. After the monthly reconciliation has been completed the Business Office Coordinator will identify residents that need to be refunded. The facility Administrator will then verify proposed refunds as accurate. The facility Administrator will then sign off on the resident trust fund summary report. Business Office Coordinator and Accounts Payable Manager reeducated on Resident Trust Fund Procedures by Assistant Administrator on 09/15/11.	
F 253 SS=E	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	F 253		



How does the facility plan to monitor its performance to ensure that solutions are sustained? - The facility Administrator will audit compliance with returning resident funds monthly for three months. Findings will be reported to the Quality Assurance Committee for review until the issue is deemed resolved.

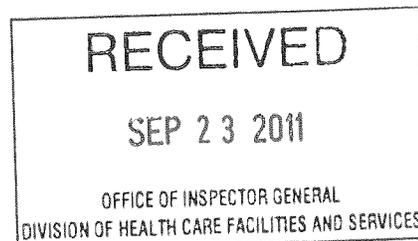
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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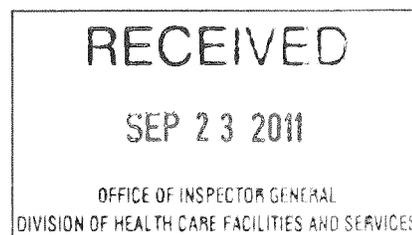
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F 253	Continued From page 2 by: Based on observation and interview it was determined the facility failed to maintain the environment in an orderly, sanitary and comfortable manner. Air conditioner unit covers in resident rooms, 213, 302, and the 100 unit shower room were loose. Resident room 213 had a dirty/dusty window shade. Resident rooms 213, 224, and 221 had torn wall paper. The call light strings for shower unit 100 was dirty and wrapped around the grab bar. Holes were found in the wall of resident room 302, and the facility chapel. Resident room 213 had scuff marks to the wall, air conditioner unit was loose, the toilet was displaced, and the call light was dirty and wrapped around the grab bar. The molding was coming away from the wall in resident room 309. The Finding includes: The facility did not have a written policy and procedure for facility maintenance and work orders. Observation, on 08/23/11 at 8:30 AM, revealed the shower room on unit 100 had nine (9) screw holes in the wall. The air conditioner unit was found to have a loose cover. Observation, on 08/25/11 at 10:10 AM, revealed the facility chapel had two (2) screw holes in the wall by the door. At 10:35 AM the resident room 302 had screw holes in the wall as well as a loose air conditioner cover. Observation, on 08/25/11 at 10:20 AM, revealed in room 213 the air condition unit cover was loose and sitting on the floor. The bathroom was found	F 253	F253 It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? – Air conditioner units in resident rooms 213 and 302, and 100 shower room were secured by the Maintenance Department on 08/25/11. Window shade and walls in room 213 were cleaned by the Director of Housekeeping on 09/12/11. Wall paper repairs were made by the Maintenance Department in rooms 213, 221 and 224 on 09/19/11. Holes in walls located in facility chapel, 100 shower room, and room 302 were filled by the Maintenance Department on 09/14/11. The toilet in room 213 has been secured to the wall by the Maintenance Department on 09/12/11. The call light strings for the 100 unit shower room and room 213 were replaced by the Maintenance Department on 08/26/11. The molding in room 309 was been secured to the wall by the Maintenance Department on 08/26/11. The toilet seat in the bathroom of room 213 as well as the wallpaper was cleaned by the Director of Housekeeping on 09/12/11.	10/05/11



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F 253	Continued From page 3 to have a dirty call light string wrapped around the grab bar. The bathroom also revealed a displaced toilet with a brown substance on the seat and the wallpaper was scuffed. Room 221 and 224 had torn wallpaper. Observation, on 08/25/11 at 10:52 AM, revealed in room 309 the wall molding was coming away from the wall under the television. Interview with the Director of Maintenance, on 08/25/11 at 2:00 PM, revealed the facility had a preventative maintenance program but does not keep work orders after the work had been done. Director of maintenance also revealed the air conditioners were a concern because they are dated and need to be replaced. He does no routine or daily inspections of air conditioner covers. The air conditioners were not part of his maintenance program. He further stated he keeps no records for the repairs that have been done.	F 253	How will you identify other residents having the potential to be affected by the same deficient practice? – Residents have the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – Audit of all toilets for cleanliness and ensuring they are secured to be made by Director of Maintenance and Director of Housekeeping no later than 09/30/11. Audit of patient rooms and patient areas for the condition of call cords, wallpaper, wall moldings, and air conditioner units, including checking for holes in walls to be completed by Director of Maintenance and Director of Housekeeping no later than 09/30/11. Preventative maintenance process changed where completed work orders are kept by the Director of Maintenance and Maintenance Assistant to allow record keeping of previous repairs beginning 09/19/11. Inspection of air conditioner covers by Maintenance Assistant to occur monthly when air filters are changed in the units.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	How does the facility plan to monitor its performance to ensure that solutions are sustained? – Ongoing monitoring of patient rooms by Housekeeping, Maintenance and Safety	



Committee will continue. Random audit of work orders to be completed weekly for one month and then monthly for two months by Assistant Administrator. Findings will be reported to the Quality Assurance Committee for review until the issue is deemed resolved.

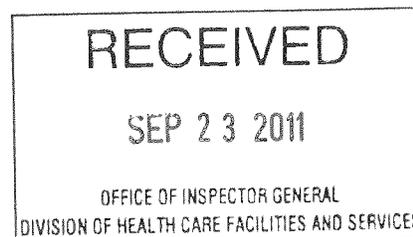
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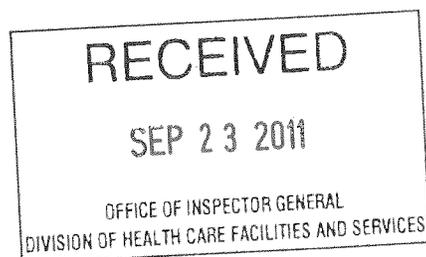
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F 279	<p>Continued From page 4</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to 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, resident record review and facility policy, the facility failed to use the results of the Resident Assessment Instrument (RAI) to develop the comprehensive care plan as it related to activities for one (1) of twenty-four (24) residents, Resident #21.</p> <p>The findings include:</p> <p>Review of the facility policy on Care Plans 08/2009 revealed a comprehensive care plan is developed after the completion of the comprehensive assessment. However, it is not stated within the policy that the assessment is to be utilized for the development of the care plan. It notes a care conference is held with members of the interdisciplinary team (IDT). The team determines the care plan based on the resident's needs. The care plan includes "measurable</p>	F 279	<p>F279</p> <p>It is the practice of this facility to 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>It is also the practice of this facility for the care plan to 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(4).</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – A new care plan has been written by Pathways Recreational Therapist on 09/16/11 for resident #21 with realistic goals that correlate with patient's present condition.</p>	10/05/11



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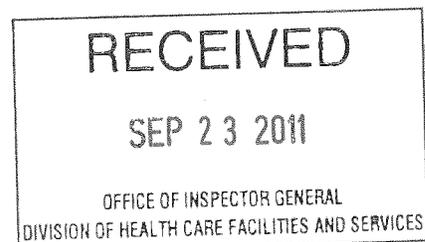
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F 279	<p>Continued From page 5 objectives and realistic target dates".</p> <p>Resident #21 was admitted to the facility on 08/02/11 with a diagnosis of traumatic brain injury following a motor vehicle accident. The facility assessed Resident #21 using the RAI as rarely or never understood, rarely or never understands others, severely impaired in decision making and with no speech.</p> <p>Record review of the Care Plan for Resident #21 revealed the goals: Will express satisfaction with leisure choices and participation when asked by activity staff; Will involve self in independent activities of choice and attend group activities as chooses. Will participate 5x/wk (five times a week) in independent leisure activities of choice; Will adjust positively to the facility by participating in either independent or group activities of interest 5 (five) days each week.</p> <p>Observation, on 08/24/11 at 3:15 PM, revealed Resident #21 sitting in a wheelchair at the nurses station. He/she wore a head protector helmet, pads to both sides of the head, the right arm in a cast from the shoulder to his/her fingers, a splint on the left hand, a pad to the left elbow, a pad between the knees and padded booties to both feet. The head of Resident #21 was turned to the left with his/her eyes fixed in that direction. There was no response from Resident #21 when spoken to and he/she did not move his/her head to sound.</p> <p>Observation, on 08/25/11 at 11:25 AM, revealed Resident #21 sitting at the nurses station for "free time". Observation was the same as the previous entry.</p>	F 279	<p>How will you identify other residents having the potential to be affected by the same deficient practice? – Residents have the potential to be effected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur – Recreational Therapists trained on individualizing patient care plans by MDS Nurse on 09/16/11. Each activities care plan on Pathways was reviewed by Recreational Therapist on 09/23/11 for realistic goals and interventions for each individual resident with focus on setting goals that could be achieved in a realistic period of time. Activities care plans for the Pathways Unit will be reviewed and updated in team conference by the Interdisciplinary Team quarterly and as needed.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained – MDS Nurse and Directors of Care Delivery to monitor to ensure activities care plans are updated and accurate monthly for three months. Findings will be reported to the Quality Assurance Committee for review until the issue is deemed resolved.</p>	



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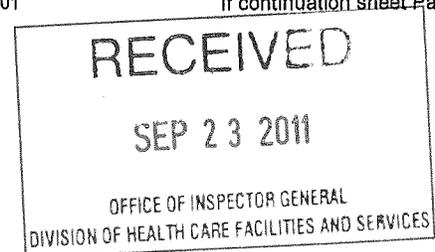
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F 279	Continued From page 6 Interview, on 08/25/11 at 9:52 AM, with the Pathways Director of Clinical Delivery revealed Resident #21 is unable to function independently and the activities on the care plan are not individualized for the resident. Interview, on 08/25/11 at 10:05 AM, with Recreational Therapist #1 revealed the goals listed on the care plan for Resident #21 were not realistic. She further revealed goals were to be realistic and attainable. Interview, on 08/25/11 at 10:45 AM, with Recreational Therapist #2 revealed she thought the goals were realistic at the time the care plan was written. She further revealed, her contribution to the care plan was not done together with the IDT; when she wrote her care plan, she was alone. Interview, on 08/25/11 at 2:45 PM, with the Administrative Director of Nursing Services (ADNS), revealed the IDT is to have general knowledge of each resident's care plan. She stated the different departments discuss, as a team, the care plan. The care plans are monitored by the ADNS for individualization by spot checking them "whenever necessary".	F 279			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 It is the practice of this facility that services provided or arranged by the facility meet professional standards of quality.	10/05/11	



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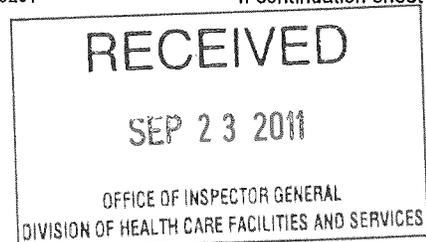
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F 281	<p>Continued From page 7</p> <p>Based on observation, interview, resident record review, facility policy and the Clinical Nursing Skills and Techniques Second Edition, the facility failed to follow accepted professional practice during medication administration by not checking the placement of the gastric tube (G-tube) on two (2) of three (3) unsampled residents, Resident B and Resident C.</p> <p>The findings include:</p> <p>Review of the facility policy on Enteral Tubes: Residual Checks and Irrigations/Flushes 12/2009 revealed the gastrostomy tube was to have placement verified by aspirating contents with a syringe.</p> <p>Review of the reference book Clinical Nursing Skills and Techniques Second Edition revealed tube placement was to be checked by auscultation while injecting air.</p> <p>Observation, on 08/24/11 of Registered Nurse (RN) #1, during the 8:00 AM medication pass revealed unsampled Resident's B and C both received medication per physician order through their G-tube. Placement was not checked on either resident to verify the G-tube was in the stomach.</p> <p>Interview, on 08/24/11 at 9:30 AM, with the Pathways Director of Clinical Delivery revealed prior to medication administration, G-tube placement is to be confirmed. She stated to verify placement, aspirate gastric contents and visualize that, then give a small flush prior to the administration of the medication.</p>	F 281	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - Residents B and C were reassessed on 8/25/11 for verification of enteral tube placement by Pathways Nurse Supervisor. Residents B and C have not exhibited any adverse effects.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? - Residents admitted to the facility with enteral tubes have the potential to be affected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? - Licensed nursing staff will be reeducated related to verification of enteral tube placement by Administrative Director of Nursing, Directors of Care Delivery and Clinical Services Consultant by 10/04/11. Skills validation of enteral tube verification for licensed nursing staff to be completed by Administrative Director of Nursing, Directors of Care Delivery and Clinical Services Consultant by 10/04/11.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?- Ongoing monitoring will be completed by the</p>		



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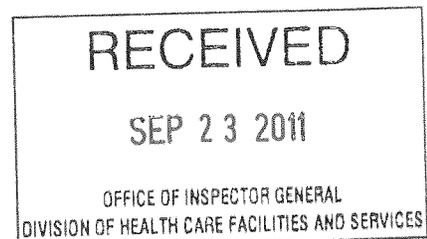
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F 281	Continued From page 8 Interview, on 08/24/11 at 10:45 AM, with RN #1 revealed the process for medication to be given down a G-tube involves checking the placement of the tube first by aspiration of stomach contents with a syringe. Interview, on 08/25/11 at 2:30 PM, with the Administrative Director of Nursing Services (ADNS) revealed before you give medication through a G-tube, you should always verify placement.	F 281	Administrative Director of Nursing Services and Directors of Care Delivery through observation of five licensed nursing staff's performance of verification of enteral tube placement weekly for one month and then monthly for two months. Findings will be reported to the Quality Assurance Committee for review until the issue is deemed resolved.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy and procedure review it was determined the facility failed to follow the nursing care plan for one (1) of twenty-four (24) sampled residents (Resident #7). The facility failed to ensure Resident #7 was assisted to bed after meals and therapy. The findings include: Observation of Resident #7, on 08/23/11 at 11:15 AM, 12:10 PM and on 08/25/11 at 9:25 AM, 10:00 PM and 11:00 AM, revealed the resident sitting in his/her room in a wheelchair with his/her feet	F 282	F282 It is the practice of this facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? – Activities of Daily Living Care Plans, Patient Information Worksheet and tasks on Point of Care changed to reflect current status of Resident # 7 by Director of Care Delivery on 09/08/11. Resident # 7 has not exhibited any adverse effects. How will you identify other residents having the potential to be affected by the same deficient practice? – Residents that need to lay down after meals or therapy have the potential to be	10/05/11



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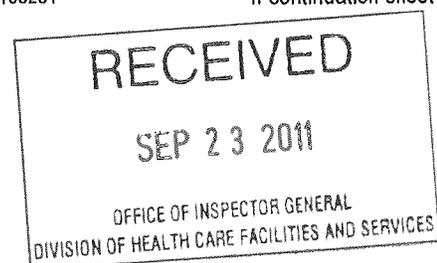
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F 282	Continued From page 9 resting on the floor. Interview with Resident #7, on 08/23/11 at 12:50 PM and on 08/24/11 at 11:00 AM, revealed the resident was tired and had asked to go to bed; however, resident stated staff would not put him/her to bed. Resident stated he/she did not know why they could not go back to bed. Review of the clinical record for Resident #7 revealed the resident was admitted to the facility status post Right Total Knee Replacement, Deep Vein Thrombus (DVT) and Diabetes. The resident received a blood thinner to prevent the recurrence of the DVT. The facility completed an admission Minimum Data Set (MDS) assessment on 08/19/11 which revealed the resident required the extensive assistance of two (2) persons to transfer and toilet and he/she was at risk for developing pressure ulcers. The resident's range of motion in the right lower extremity was impaired. The resident had frequent pain which impacted the resident's activities and sleep. The resident had a urinary tract infection and received an antibiotic. Review of Resident #7's care plan, dated 08/12/11, revealed the staff was to assist the resident to reposition frequently and encourage rest after medication to facilitate pain relief. Review of the nurse aide assignment sheet revealed the resident had a special need and had to be up for meals and therapy. In addition, the	F 282	affected by this deficient practice. Potential residents were identified by review of the Activities of Daily Living Care Plans and revision of care plans as needed by the Directors of Care Delivery on or before 09/23/11. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – Directors of Care Delivery will ensure residents that need to lay down after meals or therapy have updated Activities of Daily Living Care Plans, Patient Information Worksheet and tasks on Point of Care to reflect current status of patient on or before 10/04/11. Directors of Care Delivery to update Patient Information Worksheets to reflect special instructions in Point of Care for residents that need to lay down after meals or therapy on or before 10/04/11. Administrative Director of Nursing and/or, Directors of Care Delivery will educate Licensed Nursing Staff and Certified Nursing Assistants on change to Patient Information Worksheets to reflect those that must be laid down after meals on or before 10/04/11.	



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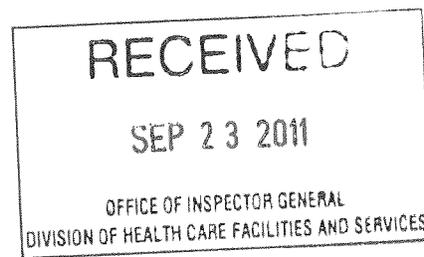
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/25/2011
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F 282	Continued From page 10 resident was to be put back to bed after meals and therapy. Interview with Certified Nurse Aide (CNA) #5, on 08/24/11 at 2:00 PM, revealed she received instructions on caring for residents daily. She stated she knew Resident #7 needed to be sitting up for meals; however, she did not know the resident needed bedrest after meals and therapy. She stated the resident's need was addressed on the care plan assignment sheet. She stated she did not know how sitting up in the wheelchair affected the resident's risk for blood clots or pain. Interview with Licensed Practical Nurse (LPN) #3, on 08/24/11 at 4:00pm, revealed the CNAs were expected to follow the care plan assignment sheet for all residents. She stated the resident had pain and needed rest after therapy. She stated she did not know if there was a policy for following care plans.	F 282	How does the facility plan to monitor its performance to ensure that solutions are sustained? – Administrative Director of Nursing and/or Directors of Care Delivery will monitor weekly for one month and then monthly for two months, that patients are laid down as ordered. Findings will be reported to the Quality Assurance Committee for review until the issue is deemed resolved.		
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	F 371	F371 It is the practice of this facility to (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.	10/05/11	



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F 371	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy for Hair Restraints, and Glove Usage, it was determined the facility failed to follow proper sanitation and food handling practices. 1. One (1) kitchen staff member with facial hair did not wear a beard restraint. 2. One (1) kitchen staff member served food from the tray line with gloved hands, without the use of utensils. 3. Three (3) staff members were observed to serve ready to eat food with bare hands. 4. One (1) Certified Nursing Assistant (CNA) on the 100 Unit, picked up a meal ticket which had fallen to the floor and placed it on an unserved resident meal tray.</p> <p>The findings include:</p> <p>1. Review of the facility policy for Hair Restraints revealed hair restraints were worn to keep hair away from food, and to minimize touching or handling of hair during food production. The policy stated hair restraints should be worn by anyone in the kitchen, and that beard and facial hair should be covered by hair restraints.</p> <p>Observation, on 08/24/11 at 11:25 AM, revealed Kitchen Staff #1, with a mustache and beard, working on the tray service line without a beard restraint.</p> <p>Interview, on 08/25/11 at 10:30 AM, with the Food Service Manager (FSM) revealed that the facility policy regarding hair restraint stated that all facial hair should be covered while in the kitchen. The FSM stated that Kitchen Staff #1 was a new staff member, and she did not notice he had facial hair</p>	F 371	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? – No residents have been identified as affected by the deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? – Residents who receive a meal tray have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – Dietary staff has been inserviced on the use of hair and facial hair restraints, utensil usage, handwashing and glove usage by the Food Service Manager or Dietary Consultant on 09/16/11. Nursing and Therapy staff inserviced on proper serving of ready to eat foods by facility Dietitians, Administrative Director of Nursing or Directors of Care Delivery by 10/04/11.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained? – Dietary manager on duty will educate new employees and monitor current employees for compliance weekly for one month and then monthly for two months. Facility dietitians will monitor</p>	



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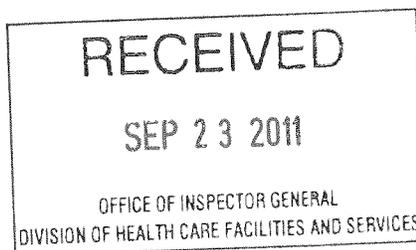
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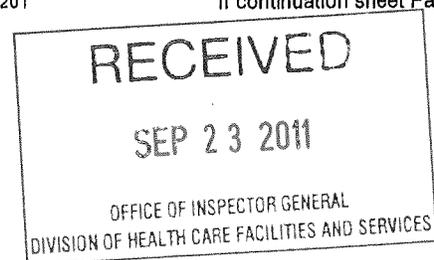
F 371	<p>Continued From page 12 or she would have advised the staff member to wear a hair restraint.</p> <p>2. Review of the facility policy for Glove Usage, revealed staff can use gloves to prevent bare-hand contact with ready-to-eat foods, but use of utensils such as tongs, spoodles, etc. is preferable since gloves can become contaminated and must be frequently changed.</p> <p>Observation, on 08/24/11 at 11:30 AM, revealed Cook #2 was serving food on the tray service line while wearing gloves. Cook #2 was observed to pick up cooked hamburger patties from the stove with gloved hands and place them on plates to be served to residents. Cook #2 also served sliced cornbread onto plates with gloved hands. The tray of cornbread and the container of hamburgers on the stove did not include a serving utensil.</p> <p>Interview, on 08/25/11 at 10:30 AM, with the FSD revealed that all kitchen staff have been instructed to use utensils while serving food on the tray service line. The FSD stated it is not acceptable to handle food with gloves, as gloves can become contaminated from other surfaces. The FSD stated that she was checking every tray served on the tray service line on 08/24/11 at 11:30 AM, and did not notice that Cook #2 served the hamburgers and cornbread without the use of utensils.</p> <p>3. Review of the facility policy for Glove Usage, revealed when food is served to highly susceptible populations such as a nursing home, bare-hand contact with ready-to-eat foods is not allowed.</p>	F 371	<p>compliance with food service for ready to eat foods weekly for one month and then monthly for two months. Follow-up education to be provided as needed and findings reported to Quality Assurance Committee until deemed corrected.</p>	
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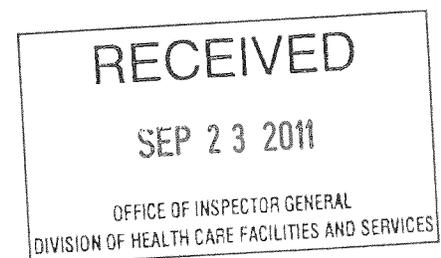
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F 371	Continued From page 13 Observation, on 08/23/11 at 11:45 AM, of lunch served in the 200 Dining Room, revealed an Unsampled Resident sitting at a table with Speech Therapist (ST) #1. The Unsampled Resident refused the food on the tray which was served and ST #1 provided a bologna sandwich in a wrapper, as an alternative. The Unsampled Resident requested a condiment for the sandwich. ST #1 removed the sandwich from the wrapper, opened the sandwich, and applied the condiment with bare hands and a knife, then handed the sandwich to the Unsampled Resident. The Unsampled Resident requested jelly on a biscuit, and ST #1 picked up the biscuit, split it, and applied the jelly with bare hands. Interview, on 08/25/11 at 10:00 AM, with CNA #2 revealed she tries not to touch the resident's food as much as possible, but that the main concern is that the hands are clean. CNA #2 said if she needed to put jelly on a biscuit, she would wash her hands first. Interview, on 08/24/11 at 10:10 AM, with CNA #3 revealed the facility provided in-services regarding passing of resident trays, and were advised bare hand contact of resident food was not allowed and this policy served to avoid cross-contamination. Interview, on 08/25/11 at 8:50 AM, with ST #1 revealed that he was not sure of the requirements of the facility policy regarding service of ready-to-eat food. ST #1 stated that if the hands are washed and clean, it is acceptable to handle resident's food.	F 371			



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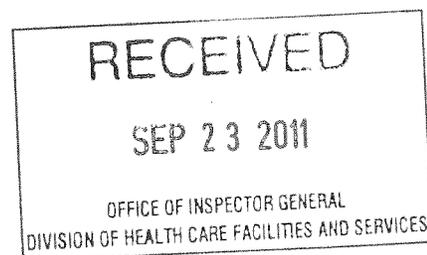
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F 371	Continued From page 14 Interview, on 08/25/11 at 2:25 PM, with the Administrative Director of Nursing Services (ADNS) revealed that staff have been trained in resident food service and told never to handle resident food with bare hands.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	F431 It is the practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition to all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that and account of all controlled drugs is maintained and periodically reconciled. It is the practice of the facility that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. It is the practice of the facility in accordance with State and Federal laws to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	10/05/11



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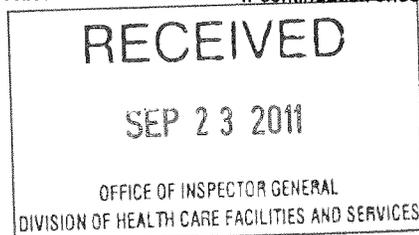
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F 431	<p>Continued From page 15 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Pharmacy Services and Procedures Manual it was determined the facility failed to store medications and biological products in a safe and sanitary manner. Pill crushers were dirty on six (6) of the nine (9) med carts observed. Med storage drawers were dirty on the inside of two (2) carts observed and were dirty on the outside drawers on two (2) of the nine (9) med carts observed. Temperatures recorded for the Pathway Unit Med Refrigerator were too cold for eleven (11) out of twenty-four (24) days in August. Two (2) vials of opened Novolin R, (insulin), not labeled with open date, were observed on the 300-400 Unit Med Cart. Three (3) Treatment Carts were observed during this survey. Four (4) containers of unopened skin care products were observed in the Arcadia Treatment Cart for a resident that had been discharged from the facility on 07/26/11. One (1) opened container of Dakin's Solution with an open date of 07/11/11 was observed in the 300-400 Treatment Cart.</p> <p>The findings include:</p> <p>Review of the facility's Pharmacy Services and Procedures Manual on 08/24/11 revealed that all insulin vials should be dated when opened and Novolin R (insulin) could be used up to 42 days from opening. Once an order to discontinue a medication is received the facility staff should</p>	F 431	<p>It is the practice of the facility to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - The medication of the discharged resident was immediately removed from the treatment cart by the Nurse Supervisor. The pill crushers were cleaned in the dish machine by the Director of Housekeeping on 08/29/11. The med cart storage drawers were cleaned by the Nurse Supervisor on 08/25/11.</p> <p>The Dakins solution and 2 vials of Insulin which did not show an open date were discarded by the Nurse Supervisor immediately and new insulin was ordered the same day.</p> <p>The thermometer was replaced in the medication refrigerator on the Pathways Unit by the Pathways Director of Care Delivery on 08/25/11. The temperature of the medication refrigerator on the</p>	



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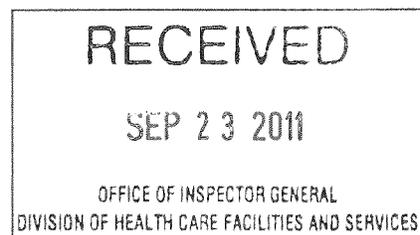
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F 431	<p>Continued From page 16</p> <p>remove this medication from the resident's drug supply. The facility should place all discontinued medications or out-dated medications in a designated, secure location, which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction.</p> <p>Observation, on 08/23/11 at 8:30 AM, of the Treatment Cart on the Arcadia Unit revealed two (2) unopened tubes of Vasolex Ointment and two (2) unopened jars of Wanda's Butt Cream for a resident that had been discharged from the facility on 07/26/11.</p> <p>Observation, on 08/23/11 at 8:50 AM, of the Treatment Cart on the 300-400 Unit revealed one (1) opened container of Dakins Solution labeled with an open date of 07/11/11. The Dakin's Solution had a label on the bottle that read "discard unused portion thirty (30) days after dispensing". Observation of the of the Med Cart for the 300-400 Unit at this time revealed two (2) vials of opened insulin not labeled with the opening date.</p> <p>Interview, on 08/23/11 at 9:00 AM, with Licensed Practical Nurse (LPN) #6 revealed the tubes of Vasolex Ointment and the jars of Wanda's Butt Cream were left in the Treatment Cart because the resident's niece was suppose to come by to pick up the products. LPN #1 was aware that treatment products are suppose to be removed from the Treatment Cart when a resident is discharged or transferred to another facility.</p> <p>Interview, on 08/23/11 at 9:20 AM, with LPN #4 revealed that she was aware that insulin vials are</p>	F 431	<p>Pathways unit was adjusted to maintain the temperature within the parameters outlined in the regulation by the Pathways Director of Care Delivery on 08/25/11.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice? – Residents with medication stored in medication carts, treatment carts and medication refrigerators have the potential to be effected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? – A medication temperature log was instituted for the Pathways Unit Med refrigerator on 08/26/11 by the Pathways Director of Care Delivery that designates the parameters of the temperatures for medication storage to comply with the regulation. The pharmacy will continue to do monthly audits of the medication carts. The Directors of Care Delivery will validate the medications of discharged residents are removed from the medication and treatment carts within 24 hours of discharge through the use of the Eagle Room Discharge Tool. Licensed Nursing Staff educated on cleaning medication and treatment carts, labeling</p>



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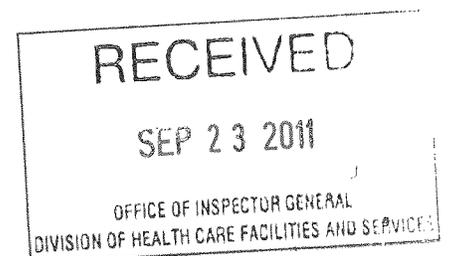
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F 431	<p>Continued From page 17</p> <p>supposed to be labeled with the opening date. LPN #4 said she was going to order new vials of insulin for the two (2) residents. LPN #4 pulled the stickers off the undated vials of insulin and discarded the vials in the sharps container.</p> <p>Interview, on 08/25/11 at 2:30 PM, with registered nurse (RN) #3, Director of Care Delivery (DCD) for the 300-400 Unit, revealed the facility's policy was to label vials of insulin and treatment products with the opening dates and to remove medications and treatment products from the carts when they are discontinued. RN #3 revealed that she checks the treatment carts weekly.</p> <p>Interview, on 08/25/11 at 3:10 PM, with the Administrative Director of Nursing Services (ADNS) said that the DCD's should be checking the Med and Treatment Carts weekly and that the staff nurses should check the carts daily. ADNS revealed that she checks the carts whenever she tours. ADNS revealed she tours weekly or sometimes daily. ADNS revealed that the nursing staff needs inservice on labeling medications and treatment products when opening and removing medications and treatment products from the carts when discontinued or expired.</p> <p>Observation on 08/24/11 during the medication room inspection of the Pathways medication refrigerator located within the nurses station revealed the refrigerator temperature log for eleven (11) days of the twenty-four (24) days in August 2011 had the temperature too cold. The proper temperature is between thirty-six (36) and forty-six (46) degrees. The log yielded temperatures thirty (30) degrees to thirty-four (34) degrees on August 7, 8, 9, 11, 14, 16, 19, 21, 22, 23 and 24.</p>	F 431	<p>of medications, medication return guidelines and temperature logs by Administrative Director of Nursing or Directors of Care Delivery by 10/04/11.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained? – A Quality Assurance medication cart audit will be completed weekly on eleven medication carts and two treatment carts for one month and then monthly for two months by the Administrative Director of Nursing Services, or Directors of Care Delivery to ensure deficient practices have been corrected. Audits will be taken to QAA for evaluation and monitoring by QAA committee until issue is deemed resolved.</p>	



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F 431	Continued From page 18 Interview, on 08/25/11 at 8:40 AM, with the Pathways Director of Clinical Delivery (DCD) revealed certain medications cannot be stored under a certain degree, just as they cannot be stored over a specific temperature. The temperature log the staff had filled out daily had a top temperature listed as forty (40) degrees to not go over but did not list a temperature that would be too cold for the medications stored in the refrigerator. Interview, on 08/25/11 at 2:30 PM, with the Administrative Director of Nursing (ADNS) revealed she did not know what the correct temperature the medication refrigerator needed to be set. Observation, on 08/24/11 during the medication cart inspection in the Pathways area of the facility, revealed two (2) bottom medication cart drawers, where liquids are stored on two (2) of three (3) carts checked, to have spilled liquid in the bottom of the drawers. Three (3) of three (3) pill crushers stored on top of the medication carts were also observed unclean with dust build-up and dark particles about the area where the crushing takes place. Interview, on 08/24/11 at 10:45 AM, with Registered Nurse (RN) #1 revealed whoever notices the medication carts being dirty is responsible to clean them. She stated the night shift does the real cleaning of them. However, there is no log or documented record of the cleaning. Interview, on 08/24/11 at 12:15 PM, with the	F 431		



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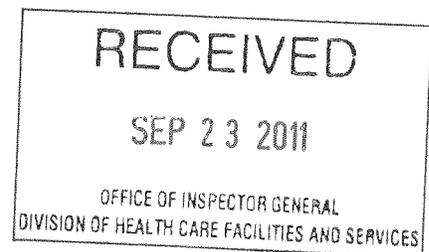
PRINTED: 09/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220
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F 431	<p>Continued From page 19</p> <p>Pathways DCD revealed the night shift is responsible for the cleaning of the medication carts and pill crushers. There is no check off list or documentation to assure the carts are clean, however, she stated she inspects the carts for cleanliness. The pill crushers are cleaned by being "wiped down".</p> <p>Interview, on 08/25/11 at 2:30 PM, with the ADNS revealed a lot of the cleaning is delegated to the night shift. There is no documentation of the cleaning being completed. She stated "you just look" to verify it was done.</p>	F 431		
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SEP 23 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING B. WING _____ <small>OFFICE OF SUPERVISOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</small>	(X3) DATE SURVEY COMPLETED 08/23/2011
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NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1970</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Eleven (11)</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed</p> <p>GENERATOR: Type II generator installed in 2006. Fuel source is diesel</p> <p>A standard Life Safety Code survey was conducted on 08/23/2011. Christopher East Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and seventy-eight (178) beds and the census was one-hundred and thirty-four (134) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>K056</p> <p>It is the practice of this facility to ensure that the automatic sprinkler system is properly maintained in accordance with NFPA 25, and that 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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Facility added the roof overhangs located at the Pathways Unit courtyard and the Service Corridor</p>	10/05/11
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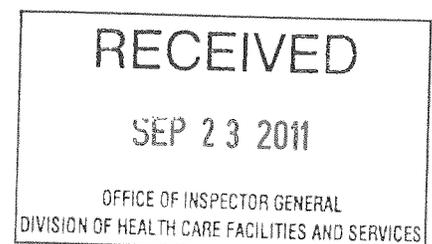
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Paul Ott</i>	TITLE <i>X Asst. Administrator X</i>	(X8) DATE <i>09/23/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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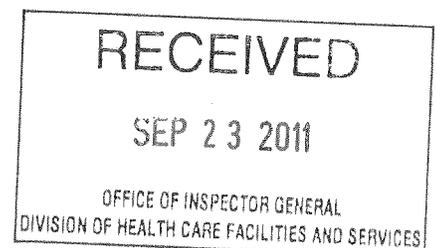
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/23/2011
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	
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K 000 K 056 SS=E	<p>Continued From page 1 Fire)</p> <p>Deficiencies were cited with the highest deficiency identified at E level.</p> <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, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and seventy-eight (178) beds and the census was one-hundred and thirty-four (134) on the day of the survey.</p> <p>The findings include:</p>	K 000 K 056	<p>to the automatic sprinkler system on 09/12/11.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice – Residents have the potential to be affected by this deficiency.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur – Sprinkler systems in these and all other areas will continue to be monitored by Director of Maintenance in addition to inspection by an outside contractor semi-annually.</p> <p>How the corrective action(s) will be monitored to ensure that solutions are sustained – Maintenance Director will report any issues from the inspections to the QAA committee until the issue is deemed resolved.</p>



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K 056	Continued From page 2 Observation, on 08/23/11 between 9:35 AM and 10:25 AM with the Maintenance Director, revealed two (2) exterior roof overhangs located at the Pathways Courtyard and the Service Corridor, were constructed of combustible materials and not protected with automatic sprinkler coverage. Interview, on 08/23/11 at 9:35 AM with the Maintenance Director, indicated he was not aware that the roof overhangs were required to be sprinkled for complete coverage. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056			
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store a helium tank in a safe manner, per NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and seventy-eight (178) beds and the census was one-hundred and thirty-four (134) on the day of	K 130	K130 It is the practice of this facility to ensure that compressed or liquefied gas cylinders in use or in storage be secured to prevent them from falling or being knocked over. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice – Helium tank was secured immediately upon detection 08/23/11.	10/05/11	



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K 130	Continued From page 3 the survey. The findings include: Observation, on 08/23/11 at 10:30 AM with the Maintenance Director, revealed a 2200 cubic foot cylinder of helium sitting on the floor near the entrance door to the activities room, located in the basement of the facility. The cylinder had no safety chain or strap on it to keep it from being knocked over. Interview, on 08/23/11 at 10:30 AM with the Maintenance Director, revealed that he was not aware of the helium cylinder not being secured with a chain or strap. Reference: NFPA 55, 1998 Edition) 6-6 Securing Cylinders. Compressed or liquefied gas cylinders in use or in storage shall be secured to prevent them from falling or being knocked over. Exception No. 1: Compressed gas cylinders in the process of examination, servicing, and refilling. Exception No. 2: At cylinder-filling plants and distributors ' warehouses, the nesting of cylinders shall be permitted to secure cylinders.	K 130	How you will identify other residents having the potential to be affected by the same deficient practice – Helium tank located in non-resident area. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur – Safety Committee Members will ensure helium tank is secured during monthly safety rounds. How the corrective action(s) will be monitored to ensure that solutions are sustained – Human Resources Director will monitor to ensure safety rounds are completed and will report findings to the Quality Assurance Committee for review until issue is deemed corrected	

