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FORM APPROVED
OMB NO. 0938-0391

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185194		08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FORUM AT BROOKSIDE	200 BROOKSIDE DRIVE LOUISVILLE, KY 40243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey was initiated on 07/30/13 and concluded on 08/01/13. A Life Safety Code survey was conducted on 07/30/13. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to develop a plan of care for an ongoing activities program for two (2) of twelve (12) sampled residents (Residents #2 and #7). The facility failed to utilize assessment information to develop an ongoing activities program for Residents #2 and #7. The findings include: Review of the facility's policy regarding Activities, dated 05/01/06, revealed an activity admission note and assessment would be completed on new admissions. The policy did not provide guidelines for completion of the activity admission note or the activity assessment.	F 248	F248 Activities meet/interests/needs of each resident. The Forum at Brookside will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Corrective Action for Residents Cited by Deficient Practice With respect to the specific residents #2 and #7 an ongoing activities program was designed and a care plan initiated to meet each resident's specific needs. Care plans were completed on 08/16/13. Identification of Other Facility Residents that may be affected by the deficient practice. With respect to how the facility will identify residents with the potential for the identified concern, The Director of Nursing and Asst. Director of Nursing conducted an audit of all resident care plans to ensure the information obtained on the assessment was	8/21/13

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bill [signature]	X Ena Dir	8-22-13

ly deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 248	Continued From page 1 Review of the facility's policy regarding Care Plans, dated 01/10/08, revealed the care plan should identify the resident's needs, problems, strengths, and risk factors. The policy did not provide further instructions for how the care plan would be developed. 1. Observation of Resident #2, on 07/30/13 at 11:30 AM, 1:28 PM, 2:13 PM, 2:50 PM, 3:45 PM and 4:26 PM, revealed the resident was lying in bed. Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Dementia with Behavioral Disturbance, Anxiety and Parkinson's Disease. The facility completed an admission Minimum Data Set (MDS) assessment on 04/09/13 which revealed the resident had a cognitive impairment with a BIMS score of six (6), short attention span, was restless and physically and verbally aggressive. The resident required extensive assistance with daily living tasks, was incontinent and received medications for Depression and Anxiety. Review of the activity admission assessment, dated 04/01/13, revealed the resident was a mechanical worker and enjoyed art and drawing during his life. In addition, the resident enjoyed listening to the radio. Review of the comprehensive care plan, dated 04/02/13, revealed the resident had dementia with a behavior disturbance and all staff were to assist the resident to religious activities. In addition the staff were to introduce the resident to other's with similar interests and encourage out of room activities. No information was located for	F 248	utilized to develop ongoing activity programs for each resident. This audit was completed on 08/19/13. Implementation of Systemic Measures An inservice was conducted with the Activity department staff regarding utilization of resident assessment and care planning and was completed on 08/20/13. Monitoring of Corrective Action The plan of correction will be monitored on a monthly basis by the Assistant Director of Nursing and a report will be submitted to the Activity Director on a monthly basis. The Activity Director will submit a report quarterly to the Quality Assurance committee regarding all findings and solutions.	

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F 248	Continued From page 2 an ongoing activity care plan to have the resident's radio turned on, to redirect with activities when behaviors were exhibited or to invite the resident to an art related activities. 2. Observation of Resident #7, on 07/31/13 at 3:30 PM, revealed the resident up in a wheel chair propelling self around the common areas. The resident was agitated and distressed and speaking tersely to staff. The resident was muttering to self and disoriented to time and place. Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Dementia, Persistent Mental Disorder, Hypertension and was status post Hip Replacement secondary to a Fracture. The facility completed an admission MDS assessment on the resident on 07/06/13 which revealed the resident had a BIMS score of three (3), had a poor appetite and required extensive assistance with daily living tasks. The resident received an antipsychotic medication. Review of the activity admission assessment, dated 07/03/13, revealed the resident was a former nurse, enjoyed cards, music, reading and previously owned a pet. In addition, the resident had an immediate family member residing at the facility. Review of the comprehensive care plan for Resident #7, dated 07/11/13, revealed all staff were to provide the resident with a structured routine, ensure the same bedtime nightly, assist the resident to church services and provide empathetic listening. Interventions to ensure an ongoing program of activities were not located.	F 248		

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F 248	Continued From page 3 Interview with the Activities Assistant, on 08/01/13 at 1:42 PM, revealed she was responsible for the activities programs on the Health Unit. She stated she developed care plans for residents that had special needs and care. She stated she did not know Resident #2 and Resident #7 needed care plans so they were not developed. She stated she placed an activity calendar in each resident's room. She stated she was certified as a nursing facility Activity Director. Interview with the MDS Coordinator, on 08/01/13 at 2:20 PM, revealed the activity assistant was adamant regarding residents not needing care plans and she believed her to be correct. she stated she had experience as an MDS Coordinator and had received training. Interview with the Administrator, on 08/01/13 at 2:38 PM, revealed residents must have care plans based on assessments of the residents' needs.	F 248	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	F272 Comprehensive Assessments Corrective Action for Resident Cited by the Deficient Practice The Forum at Brookside ensures each resident has a comprehensive assessment of the resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. With respect to the specific resident cited, resident #2 was reassessed regarding behaviors to include activity interventions, social service interventions and nursing interventions specific to the resident's individual	8/21/13

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F 272	Continued From page 4 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy, it was determined the facility failed to adequately assess one (1) of twelve (12) sampled residents (Resident #2) for behaviors. Resident #2 had numerous behaviors not addressed in the resident Care Area Assessments (CAA). In addition, the facility failed to adequately assess Resident #2 for Activities to assist in the management of the resident's behaviors. The findings include:	F 272	needs. Identification of Other Facility Residents that may be affected by the deficient practice. An audit was conducted on 08/19/13 of all the resident care plans by the Director of Nursing and Asst. Director of Nursing to ensure all resident's care plans addressed any behavior issues, activity needs, and social service concerns and were updated to reflect any needs found. Implementation of Systemic Measures An inservice was conducted by the Director of nursing on 08/20/13 for the Activities Dept. regarding care planning, assessments, and behaviors and on 08/19/13 for the nurses and MDS nurses regarding care planning, assessments, and behaviors by the Director of Nursing. Monitoring of Corrective Actions With respect to what systemic measures that have been put into place to address the resident's needs; an audit will be conducted monthly by the Asst. Director of Nursing and a report will be given to the Activities Director, Social Worker and MDS Co-ordinator, all issues will be addressed and each department will submit a report to the Quality Assurance committee on a quarterly basis regarding findings and solutions. A monthly audit of the CAA's will be done by the MDS Coordinator of 10% of MDS's submitted to ensure all areas have been addressed.	

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F 272	Continued From page 5 Review of the facility's policy regarding Minimum Data Set (MDS) Completion, dated 03/24/09, revealed the MDS assessment must be completed in accordance with Medicare guidelines for all residents entering a skilled nursing facility. The MDS Coordinator would be available for consultation and would review the RAP process and care plans. The facility policy did not contain the process for completion of the Care Area Assessments. Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnosis of Dementia with Behavioral Disturbance. The facility completed an admission MDS assessment on the resident on 04/09/13 which revealed the resident had a BIMS score of six (6) and required extensive assistance with daily living tasks. The resident had a short attention span, was restless and was physically and verbally aggressive. The resident received medications for depression and anxiety. Review of the CAAs, dated 04/10/13, for Resident #2, revealed the resident had long-standing mental health problems associated with the behavioral disturbance. The CAA summary revealed the resident had anxiety and depression and was newly admitted to the facility and had a recent stay at a mental health facility. The resident would be followed by psychiatric services. The behavior of agitation was identified; however, other specific behaviors were not identified. Information regarding any behavioral management programs initiated at the mental health facility and the outcomes of those programs was not located. Information regarding activity's role in interventions and	F 272	and a report will be submitted quarterly to the Quality Assurance Committee with findings and solutions.	

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F 272	Continued From page 6	F 272		

successful/unsuccessful outcomes to assist in behavioral issues was not located.

Review of the progress notes, dated 07/08/13, written by the psychiatrist, revealed Resident #2 had periods of depression, agitation, inappropriate sexual behavior, racing thoughts, paranoia, anxiosness, irritation, verbal abusiveness and was demanding.

Interview with Registered Nurse (RN) #1, on 07/30/13 at 8:45 AM, revealed Resident #2 had behavior problems and was especially agitated in the evenings. She stated the resident would repeatedly turn the call light on and have staff do a task then immediately have the resident demand the staff undo whatever the resident initially wanted. She stated this behavior would be repeated for hours. She indicated the resident made sexually inappropriate remarks to staff, was restless and fell out of bed numerous times and was easily irritated.

Interview with Certified Nurse Aide (CNA) #1, on 07/31/13 at 2:00 PM, revealed Resident #2 had behavior problems. She stated the resident would turn the call light on to have the head of the bed elevated then immediately after this was completed, the resident would turn the call light on to have the head of the bed lowered. She stated this behavior would vary and could go on for hours at a time. She revealed the resident would curse staff and make rude comments. She stated the resident would fight if staff tried to provide care. She indicated the resident would become irritated over nothing.

Interview with the Activity Assistant, on 08/01/13 at 1:42 PM, revealed she did not contribute to the

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F 272	Continued From page 7 CAA process for residents. She stated the MDS Coordinator completed that task. She revealed she was responsible for the activities programs on the Health Unit. She stated she placed an activity calendar in each resident's room. She stated she was certified as a nursing facility Activity Director. Interview with the MDS Coordinator, on 08/01/13 at 2:30 PM, revealed she had been trained on the resident assessment process. She stated she felt the CAAs for Resident #2 were completed and correctly, however, she was not able to locate information in the CAA summary to identify all the risks and complicating factors related to behavior for Resident #2. Interview with the Director of Health Services, on 08/01/13 at 2:38 PM, revealed the interdisciplinary team should have collected all the available information for Resident #2's CAAs in order for the care plan for behaviors and activities to be developed completely and accurately.	F 272		
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 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.	8/21/13

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F 279	Continued From page 8 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). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop comprehensive care plans for two (2) of twelve (12) sampled residents (Residents #2 and #7). The facility failed to develop a care plan for Resident #2 to include activities, behaviors and psychotropic medications. The facility failed to develop a care plan to include activities and behaviors for Resident #7. The findings include: Review of the facility's policy regarding Developing Care Plan, dated 01/10/08, revealed the care plan shall be specific to each resident, addresses each residents needs and serves as a working guide for staff providing care to the resident. The care plan did not belong to one discipline, but rather was resident centered and interdisciplinary. Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Dementia with Behavioral	F 279	The Forum at Brookside ensures each resident has a comprehensive care plan addressing the resident's needs, which include activities, behaviors, and psychotropic medications when applicable. Corrective Action for Residents Cited by Deficient Practice With respect to the specific residents cited. Resident #2's care plan was updated to include an activities program which also addressed behaviors, behavior interventions and the use of psychotropic medications. Resident #7's care plan was also updated to include an activities program which also addressed interventions for behaviors as well as addressing the behavior issues with interventions in place. Identification of Other Facility residents that may be affected by the deficient practice. An audit was conducted on 08/19/13 of all resident's care plans by the Director of Nursing and the Asst. Director of Nursing to ensure all resident's care plans addressed any behavior issues, activity needs, and social service concerns and were updated to reflect any needs found. Implementation of Systemic Measures An inservice was conducted by the Director of nursing on 08/20/13 for the Activities dept. regarding care planning, assessments, and behaviors and on 08/19/13 for the nurses regarding care planning, assessments, and behaviors by the Director of Nursing.	

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F 279	Continued From page 9 Disturbance, Anxiety and Parkinson's Disease. The facility completed an admission Minimum Data Set (MDS) assessment on 04/09/13 which revealed the resident had a cognitive impairment with a BIMS score of six (6), short attention span, was restless and was physically and verbally aggressive. The resident required extensive assistance with daily living tasks, was incontinent and received psychoactive medications for Depression and Anxiety. Review of the CAAs, dated 04/10/13, for Resident #2, revealed the resident had long-standing mental health problems associated with behavioral disturbances. The CAA summary revealed the resident had Anxiety and Depression and was newly admitted to the facility and had a recent stay at a mental health facility. The resident would be followed by psychiatric services. The behavior of agitation was identified; however, other specific behaviors were not identified. Information regarding any behavioral management programs initiated at the mental health facility and the outcomes of those programs was not located. Information regarding activity's role in interventions and successful/unsuccessful outcomes to assist in behavioral issues was not located. Review of the comprehensive care plan for Resident #2, dated 04/02/13, 04/11/13 and 04/22/13, revealed all staff were to introduce resident to others with similar interests, encourage to come out of room and provide a structured environment. Anxiety and Depression were identified on the care plan with specific behaviors of sexual inappropriateness, fidgety behavior, refusal of care and verbal abusiveness. The resident would curse, yell and threaten staff	F 279	Monitoring of Corrective Action With respect to what systemic measures placed to address the resident's needs. An audit will be conducted monthly by the Asst. Director of Nursing and a report will be given to the Activities Director, Social Worker and MDS coordinator. All issues found will be addressed accordingly. Each department will submit a report to the Quality Assurance committee on a quarterly basis regarding the findings and solutions.	

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F 279	Continued From page 10 and others. Staff were to assess the resident's coping skills and set a goal for appropriate behavior and warn the resident about the risks of non-compliance. Goals for the resident included seeking out staff when agitated and having resident verbalize understanding of the need to control verbally abusive behaviors; however, the resident had a BIMS score, at that time, of six (6) and was cognitively impaired. No interventions were located to assist staff in managing sexually inappropriate behaviors or how to redirect the resident during behaviors. In addition, the resident received Ativan and the side effects were monitored every shift. The side effects of Ativan included confusion, depressed mood, agitation, hostility, hallucinations and hyperactivity were not located on the care plan. The resident received Zoloft and the side effects were monitored every shift. The side effects of Zoloft included tremor, sleepiness, nervousness, insomnia, headache, diarrhea, dry mouth, weight loss and mania were not located. Interview with Certified Nurse Aide (CNA) #1, on 07/31/13 at 2:00 PM, revealed Resident #2 had behavior problems. She stated the resident would turn the call light on to have the head of the bed elevated then immediately after this was completed, the resident would turn the call light on to have the head of the bed lowered. She stated this behavior would vary and could go on for hours at a time. She revealed the resident would curse staff and make rude comments. She stated the resident would fight if staff tried to provide care. She revealed the resident made sexual remarks to the staff trying to provide care. She indicated the resident would become irritated over nothing. She stated staff would have to walk away when the resident exhibited these	F 279		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185194		08/01/2013

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
200 BROOKSIDE DRIVE
LOUISVILLE, KY 40243

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F 279	Continued From page 11 behaviors. She stated she did not know what else to do. Interview with the Activities Assistant, on 08/01/13 at 1:42 PM, revealed she did not develop a care plan for Resident #2's behaviors as the resident did not have an area of interest upon which to build the care plan. Interview with the MDS Coordinator, on 08/01/13 at 2:30 PM, revealed the facility did not obtain information from the psychiatrist or mental health facility when developing the care plan for Resident #2. She had no comment regarding gathering of information to develop the care plan for the resident. Interview with the Director of Nursing, on 08/01/13 at 2:38 PM, revealed information should have been gathered to assist in the development of a care plan for Resident #2.	F 279		
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	F 280	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law. F280 Right to participate planning care-revised CP The Forum at Brookside will ensures each resident's care plan is revised with new interventions after each fall to attempt to	8/21/13

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F 280	Continued From page 12 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, record review and review of the facility's policy, it was determined the facility failed to revise the comprehensive care plan for one (1) of twelve (12) sampled residents (Resident #2). The resident had numerous falls and the facility failed to revise the care plan after these falls to prevent further falls. The findings include: Review of the facility's policy regarding Fall Management, dated 10/15/11, revealed the facility would utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assistive devices, and interventions to mange and minimize falls and identify the resident's continued needs. The DON was responsible for supervising the process of review, management and monitoring procedures. The resident care plan would be developed and would include all identified risks with appropriate interventions. A resident's care plan would be reviewed and updated with each fall which might occur. Review of the facility's policy regarding Care Plans, dated 01/10/08, revealed nursing would be	F 280	prevent further future falls. Corrective Action for Resident Cited by the Deficient Practice. With respect to the specific resident cited, resident #2 was reassessed to ensure appropriate interventions were in place and additional interventions were placed for resident #2's specific needs. Resident #2's care plan was updated with all current interventions. Identification of Other Facility Residents that may be affected by the deficient practice. An audit was conducted on 08/19/13 of all resident care plans by the Director of Nursing and the Asst. Director of Nursing to ensure all resident's care plans addressed appropriate and specific interventions and each care plan was updated accordingly. Implementation of Systemic Measures An inservice was conducted by the Director of Nursing on 08/19/13 for the Nurses regarding incident reports for falls, proper documentation, placing appropriate interventions with each fall and updating the care plan with interventions to attempt to prevent future falls. All care plans are now included to be reviewed at the weekly "At Risk Meeting" to ensure all interventions are in place and appropriate.	

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F 280	Continued From page 13 responsible for the updating of the care plan. The care plan was a work in progress and changes are made as the residents' needs change. Any sections of the care plan changed must be dated by the discipline making the change. Observation of Resident #2, on 07/30/13 at 11:30 AM, 1:28 PM, 2:13 PM, 2:50 PM and 3:45 PM revealed the resident in a low air bed with an alarmed floor mat in place as well as a sensor alarm to the bed. The privacy curtain was pulled and the resident was not visible from the doorway. The first bed in the room was not occupied. Review of the clinical record for Resident #2, revealed the facility admitted the resident with a diagnosis of Dementia with Behavioral Disturbance. The facility completed an admission MDS assessment on the resident on 04/09/13 which revealed the resident had a BIMS score of six (6) and required extensive assistance with daily living tasks. The resident had a short attention span, was restless and was physically and verbally aggressive. The resident received psychoactive medications for Depression and Anxiety. Review of the clinical record revealed Resident #2 was found on the floor in the room on 04/21/13 at 8:30 PM. It appeared the resident attempted to get out of bed alone. There were no injuries. On 04/26/13, the resident's care plan was revised to add an alarming floor mat to the already existing bed and wheelchair alarms. On 04/23/13 at 4:30 PM, the resident was discovered on the floor in the room. There were no injuries and it was determined the resident got out of bed without assistance and had a sinus infection. There was	F 280	Monitoring of Corrective Actions All care plans for those residents with falls will be reviewed weekly at the "At Risk Meeting." The Asst. Director of Nursing will audit the incident reports weekly to ensure appropriate interventions are implemented. An audit will be conducted monthly by the Asst. Director of Nursing and a report will be given to the Director of Nursing, all issues will be addressed and a report will be submitted on a quarterly basis to the Quality Assurance committee regarding the findings and solutions.	

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F 280	Continued From page 14 no evidence located to show the facility revised the care plan. On 04/27/13 at 2:00 PM, the resident was discovered on the floor of the room. There were no injuries. There was no evidence that the care plan was revised to prevent falls. The next fall occurred, on 06/23/13 at 2:25 PM, and the resident was found on the floor in the room. It was documented that the care plan was revised; however, no new interventions to prevent falls were noted. The resident sustained a laceration to the back of the head near the crown. The resident was not transported to the hospital. On 06/26/13 at 8:45 AM, the resident was found on the floor in the room without injury. The care plan was revised to include bed bolsters. On 06/30/13 at 5:00 AM, the resident was discovered on the floor in the room with no injuries. The facility requested a neurology consultation for the resident. The care plan was documented as being revised; however, new interventions to prevent further falls were not identified. On 07/14/13 at 8:00 PM, the resident was found on the floor in the room. There were no injuries. The care plan was documented as having been revised; however, new interventions to prevent falls were not located. On 07/19/13 at 10:15 PM, the resident was discovered on the floor in the room. There were no injuries. The care plan was documented as having been revised; however, no new interventions to prevent falls were located. Interview with Registered Nurse (RN) #1, on 07/31/13 at 1:15 PM, revealed the nurse was responsible for updating the care plan on a daily basis. She stated the Assistant Director of Nursing assisted in these daily care plan updates. She stated she had not updated the care plan for Resident #2 as he/she had no falls when she was on duty that she could remember. She stated it	F 280		

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F 280	Continued From page 15 was difficult to get everything completed when the unit was busy. Interview with the Minimum Data Set (MDS) Coordinator, on 08/01/13 at 2:30 PM, revealed the care plan for Resident #2 was not revised to include new interventions to prevent further falls on 04/23/13, 04/27/13, 06/23/13, 06/30/13, 07/14/13 or 07/19/13. She stated the care plan did need to be reviewed and revised. Interview with the Assistant Director of Nursing, on 08/01/13 at 3:10 PM, revealed she and the unit nurses were responsible for updating the care plan on a daily basis. She stated she reviewed the falls and ensured the falls were investigated. She stated all residents were monitored every two (2) hours and had not thought Resident #2 needed closer supervision. She stated she could not think of further interventions to protect the resident from falls and the resident continued to fall. She stated the care plan needed to be reviewed and revised. Interview with the Director of Nursing, on 08/01/13 at 2:38 PM, revealed she did briefly review all falls, however, the Assistant Director of Nursing was responsible for the bulk of the overview. She stated all falls were reviewed in the facility morning meetings held during the work week.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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	F 323	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.	8/21/13

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F 323	Continued From page 16 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure one (1) of twelve (12) sampled residents (Resident #2) received adequate supervision to prevent falls. The facility failed to monitor the care plan for effectiveness and failed to modify interventions when necessary for Resident #2. The findings include: Review of the facility policy for Fall Management, dated 10/15/11, revealed the facility would utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assistive devices, and interventions to manage and minimize falls and identify the resident's continued needs. The DON was responsible for supervising the process of review, management and monitoring procedures. The resident care plan would be developed and would include all identified risks with appropriate interventions. A resident's care plan would be reviewed and updated with each fall that might occur. Observation of Resident #2, on 07/30/13 at 11:30 AM, 1:28 PM, 2:13 PM, 2:50 PM and 3:45 PM, revealed the resident was in a low air bed with an alarmed floor mat in place, as well as, a sensor alarm to the bed. The privacy curtain was pulled and the resident was not visible from the	F 323	F 323 Free of Accidents/Hazards/Supervision/ Devices The Forum at Brookside ensures each resident receives adequate supervision and assistive devices to prevent accidents. Corrective Action for Residents Cited by Deficient Practice With respect to the specific resident cited, resident #2 was reassessed to ensure appropriate interventions were in place and additional interventions were placed for resident #2's specific needs. Resident #2's care plan was updated with all current interventions including increased supervision. Identification of Other Facility residents that may be affected by the deficient practice. An audit was conducted on 08/19/13 of all resident's care plans by the Director of Nursing and Asst. Director of Nursing to ensure all resident's care plans addressed all risks of falls and appropriate interventions and supervision were in place. Implementation of Systemic Measures An inservice was conducted by the Director of Nursing on 08/19/13 for the nurses regarding incident reports for falls, proper documentation, placing appropriate interventions with each fall and updating the care plan with interventions to attempt to prevent future falls.	

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F 323	Continued From page 17 doorway. The first bed in the room was not occupied. Review of the clinical record revealed the facility admitted Resident #2 with diagnoses of Parkinson's Disease, Dementia with Behavior Disturbance, Anxiety and Chronic Pain. The facility completed a quarterly Minimum Data Set (MDS) assessment on the resident on 06/25/13 which revealed the resident required extensive assistance with transfers, sustained two (2) falls, had a short attention span, had range of motion limitations in the upper and lower extremities, and received psychoactive medication. The resident was assessed to be at risk for falls. Review of the fall investigations completed, revealed Resident #2's first fall occurred on 04/21/13 at 8:30 PM. The resident was found on the floor and staff documented the resident attempted to get out of bed alone. There were no injuries. On 04/26/13, the resident's care plan was revised and an alarming floor mat was added to the already existing bed and wheelchair alarms. On 04/23/13 at 4:30 PM, the resident was discovered on the floor in the room. There were no injuries and it was determined the resident got out of bed without assistance. In addition, the facility cited a sinus infection that may have been a part of the reason the resident fell. There was no evidence located to show the facility revised the care plan to prevent further falls. On 04/27/13 at 2:00 PM, the resident was discovered on the floor of the room. There were no injuries. There was no evidence that the care plan was revised with assistive devices and/or increased supervision to prevent falls. On 06/23/13 at 2:25 PM, the resident was found on	F 323	Care plans for those residents with falls will also be reviewed at the weekly risk meeting to ensure appropriate interventions are in place. A post falls investigation will be be completed on each resident with a fall by the nurse on duty which will be reviewed weekly by the Director of Nursing or designee. Monitoring of Corrective Actions The Asst. Director of Nursing will audit the incident reports weekly to ensure appropriate interventions are implemented. An audit will be conducted monthly by the Asst. Director of Nursing and a report will be given to the Director of Nursing, all issues will be addressed and a report will be submitted on a quarterly basis to the Quality Assurance committee regarding the findings and solutions. The Director of Nursing will audit post fall investigations weekly and a report of all findings and solutions will be submitted to the Quality Assurance Committee quarterly.	

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F 323	Continued From page 18 the floor in the room. It was documented that the care plan was revised; however, no new interventions to prevent falls or increase supervision were noted. The resident sustained a laceration to the back of the head near the crown. The resident was not transported to the hospital. On 06/26/13 at 8:45 AM, the resident was found on the floor in the room without injury. The care plan was revised to add bed bolsters. There was no intervention to increase supervision located. On 06/30/13 at 5:00 AM, the resident was discovered on the floor in the room with no injuries. The facility requested a neurology consultation for the resident. The care plan was documented as being revised; however, no new interventions to prevent further falls or increase supervision were located. On 07/14/13 at 8:00 PM, the resident was found on the floor in the room. There were no injuries. The care plan was documented as having been revised; however, no new interventions to prevent falls or increase supervision were located. On 07/19/13 at 10:15 PM, the resident was discovered on the floor in the room. There were no injuries. The care plan was documented as having been revised; however, no new interventions to prevent falls were identified. Interview with Registered Nurse (RN) #1, on 07/30/13 at 8:45 AM, revealed Resident #2 had behavior problems and was especially agitated in the evenings. She stated the resident was restless and fell out of bed numerous times. She stated the staff did fully pull the privacy curtain in the resident's room; however, she had no information regarding why staff did this. She stated all residents were checked every two (2) hours for any needs. She stated the resident still fell and was assessed to be at risk for falls.	F 323		

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F 323	Continued From page 19	F 323		
	Interview with Certified Nurse Aide (CNA) #1, on 07/31/13 at 2:00 PM, revealed Resident #2 had behavior problems. She stated the resident would turn the call light on to have the head of the bed elevated then immediately after this was completed, the resident would turn the call light on to have the head of the bed lowered. She stated this behavior would vary and could go on for hours at a time. She revealed the resident would curse staff and make rude comments. She stated the resident would fight if staff tried to provide care. She revealed all residents were checked every two (2) hours and she had not received any instructions to check the resident more frequently. She stated the privacy curtain in the room allowed the resident more privacy; however, she did not think the resident had ever requested the privacy curtain be pulled.			
	Interview with the Assistant Director of Nursing, on 08/01/13 at 2:10 PM, revealed she was responsible for investigation of all fall reports. She stated she reviewed actions taken by nursing at the time of the fall, including actions taken to prevent further falls. She stated she ensured medications were reviewed and Resident #2 had multiple medications which could result in falls. She indicated increasing supervision for Resident #2 had not been considered as all residents were monitored every two (2) hours and residents could fall in-between checks. She stated the care plan and interventions should have been reviewed more thoroughly and interventions changed as they were proven not to work.			
	Interview with the Director of Nursing, on 08/01/13 at 2:38 PM, revealed she was responsible to supervise the nursing staff and all			

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F 323	Continued From page 20 incidents. She stated residents were already supervised every two (2) hours and this was not working for Resident #2. She stated the process needed to be reviewed.	F 323	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.	
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 be readily detected.	F 431	F431 Drug Records, Label/Store Drugs & Biologicals The Forum at Brookside will ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrective Action for Residents cited by the deficient practice. No specific residents were cited. Identification of other facility residents that may be affected by the deficient practice. With respect to the specific medication carts and wound culture tubes, all medication carts were cleaned and refridgerators were cleaned on 08/02/13 by the Director of Nursing. All expired wound culture tubes were removed and discarded. Implementation of Systemic Measures With respect to what systemic measures put into place to address the stated concerns. All nurses and certified medicine technicians were educated	8/21/13

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 08/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185194		08/01/2013

NAME OF PROVIDER OR SUPPLIER
THE FORUM AT BROOKSIDE

STREET ADDRESS, CITY, STATE, ZIP CODE
200 BROOKSIDE DRIVE
LOUISVILLE, KY 40243

(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 431	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure sanitation was maintained for two (2) of three (3) medication carts and failed to remove six (6) of six (6) expired wound culture tubes. The findings include: The facility did not provide a policy on maintaining medication carts and removing expired supplies. Observation of three medication carts, on 07/31/13 at 1:00 PM, revealed the medication cart for A Hall had two (2) loose pills in the drawers and dust and dark grainy substance in the top drawer. The medication cart for C Hall had twenty (20) loose pills of varying size and color loose in the drawer. The top drawer had a sticky substance in it and a partial label was stuck to the inside of the drawer. Another drawer had an orange grainy substance in it. Observation of the medication room, on 08/01/13 at 11:15 AM, revealed six (6) of six (6) wound culture tubes found in a biohazard refrigerator were expired. Three expired in February 2013 and three expired in April 2013. Interview with LPN #1, on 07/31/13 at 1:05 PM, revealed she did not know whose responsibility it was to clean the medication carts. She stated she had never looked in the drawers for loose pills or cleanliness. She stated dirt and grime could contaminate the resident's medication	F 431	by the Director of Nursing regarding the cleaning schedule for medication carts, treatment carts and refridgerators. A weekly cleaning schedule was implemented and will be performed by the 3rd shift nurse. All supplies are to be monitored for expiration dates at the time of cleaning. Monitoring of Corrective Action The cleaning schedule will be monitored along with the medication carts, treatment carts and refridgerators weekly for four weeks, then monthly by the Infection Control Nurse with a monthly report submitted to the Director of Nursing and a quarterly report submitted to the Quality Assurance committee with findings and solutions.	

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F 431	Continued From page 22 which would not be good. Interview with LPN #2, on 07/31/13 at 1:15 PM, revealed she did not know whose responsibility it was to clean the medication carts but could see the needed to be cleaned. She stated dirt could get stuck on the resident's liquid medication bottles and in the drawers and that could harbor bacteria that could effect the resident. Interview with LPN #1, on 08/01/13 at 11:15 AM, revealed she did not know whose responsibility it was to check the expiration dates on supplies. She stated you could get a false results if those tubes were used to obtain a wound culture. Interview with the DHS, on 08/01/13 at 1:43 PM, revealed all nurses are responsible to clean the medication carts. Each nurse was supposed to clean up after themselves. It was an infection control issue not to have those carts clean. She also stated all nurses should check for expired drugs and supplies. If the expired culture tubes had been used the test results could have been in error.	F 431		

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OMB NO. 0938-0391

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	185194		R 08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FORUM AT BROOKSIDE	200 BROOKSIDE DRIVE LOUISVILLE, KY 40243

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{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 08/21/13 as alleged.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BROOKSIDE SENIOR LIVING B. WING	(X3) DATE SURVEY COMPLETED
	185194		07/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FORUM AT BROOKSIDE	200 BROOKSIDE DRIVE LOUISVILLE, KY 40243

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1991 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story, Type III Protected. SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 2001. . SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system, upgraded in 2001. GENERATOR: Two (2) Type II generators, 125 KW and 75 KW. Fuel source is diesel. A standard Life Safety Code survey was conducted on 07/30/13. The Forum at Brookside was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate	K 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Exec Dir — (X6) DATE: 8/23/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at D level.	K 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately ten (10) residents, staff, and visitors. The facility has forty (40) certified beds and the census was thirty-seven (37) on the day of the survey. The findings include: Observation, on 07/30/13 at 9:03 AM, with the Director of Plant Operations revealed in Resident Room 37, a refrigerator and a microwave oven were plugged into a power strip. Interview, on 07/30/13 at 9:03 AM, with the Director of Plant Operations revealed he was aware of the requirements for the usage of power strips; however, he was not aware of a refrigerator and a microwave oven being plugged	K 147	K147 NFPA 101 Life Safety Code Standard The Forum at Brookside will ensure electrical wiring is maintained in accordance with NFPA standards. Corrective Action for Residents Cited by Deficient Practice With respect to the cited room #37, the power strip was removed on 7/29/13 during the facility inspection and an appropriate receptacle was installed. Identification of other facility residents that may be affected by the deficient practice. An audit of 100% of the rooms was completed on 7/29/13 during the facility inspection by the Maintenance Director, no other issues were detected. Implementation of Systemic Measures With respect to what systemic measures put into place to address the stated concerns. The resident's companions were educated regarding the use of power strips. This education was given by the Maintenance Director and completed on 7/30/13. A bi-weekly and monthly audit of all rooms will be completed	8/21/13

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K 147	Continued From page 2 into a power strip in the resident's room. Further interview at 9:05 AM, with the private duty, twenty-four (24) care-giver, present in the resident's room, indicated she was unaware of the requirements for usage of power strips within the resident's room. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	Maintenance Director or designee. Any/all issues found during the audits will be corrected at that time. Monitoring of Corrective Action The plan of correction will be monitored by the Maintenance Director, a report will be submitted to the Director of Nursing on a monthly basis regarding findings and solutions and a report will be submitted quarterly to the Quality Assurance committee regarding findings and issues.	

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