

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

PRINTED: 09/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2013
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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/10/13, as alleged.</p>	{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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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	
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F 000	INITIAL COMMENTS A recertification survey was conducted on 08/14/13 through 08/16/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "E".	F 000	Lake Way acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	Correction is submitted as a written allegation of compliance. Lake Way Nursing and Rehabilitation Center response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency accurate. Further, Lake Way Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding. F157 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician for resident #7 was notified by the day shift LPN and new orders received and implemented on 8/14/2013 as	09/10/2013

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

Selma Beall, NHA

TITLE

Administrator

(X6) DATE

09-03-2013

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

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility's investigation review, and review of the facility's policy and procedure, it was determined the facility failed to ensure timely notification of the physician for one (1) of sixteen (16) sampled residents (Resident #7), after experiencing a significant change in condition. Resident #7 complained of pain to his/her right pinkie toe on 08/13/13, at approximately 8:00 PM, after his/her foot was caught between the lift and wheelchair during a transfer with one person assist and the physician was not notified until 08/14/13 at 10:20 AM.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Notification Of Physician For Change In Resident's Condition", dated 08/12, revealed, " It is the policy to notify the physician when a significant change in a resident's condition occurs with documentation contained in the medical record."</p> <p>Record review revealed the facility admitted Resident #7 on 12/03/11 with diagnoses which included Chronic Airway Obstruction, Stage IV Chronic Kidney Disease, Diabetes Type II, Coronary Artery Disease, Heart Failure, Hypertension, Respiratory Failure, and Chronic Pain.</p> <p>Review of the facility's investigation, dated 08/14/13, revealed on 08/13/13 at approximately</p>	F 157	<p>reflected by the clinical documentation. The responsible party was also notified on 8/14/2013. Residents care plan and care guide were updated on 8/14/2013 by the registered nurse MDS coordinator.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All current in house residents who are transferred with a lift device were re-assessed by the licensed nurse staff for any change in condition through interviews or skin audits, starting on 08/14/2013 and completing on 08/27/13 to include the Director of Nursing and Assistant Director of Nursing. No other residents were identified.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>A checklist packet for conducting an assessment after an event is kept at the nurses' station in the binder titled Assessment & observation of a nursing home resident "binder" All licensed nursing staff were re-educated on the policy and procedure and their responsibility to notify the physicians and responsible party of any unusual event, even if no noticeable injury</p>		

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F 157	<p>Continued From page 2</p> <p>8:00 PM, one State Registered Nurse Aide (SRNA) was transferring Resident #7 with a "Hoyer" (mechanical lift) lift and caught the resident's right foot between the lift and the wheelchair. The resident complained of pain after the transfer and the Licensed Practical Nurse (LPN) administered pain medication but failed to call the physician related to the incident.</p> <p>Interview with LPN #1, on 08/14/13 at 4:55 PM, revealed she assessed the Resident #7 after SRNA #8 reported to her the resident's foot/leg was hurting because it got hit on the lift during a transfer. The LPN stated when she assessed the resident there were no obvious signs of injury but the resident was complaining of pain. The LPN stated she did not notify the physician of the incident because there was no evidence of injury.</p> <p>Further review of the facility's investigation revealed on 08/14/13, a day shift SRNA (#1) reported to the day shift LPN #2 that while getting Resident #7 up the resident complained of pain in the right fifth toe. LPN #2 assessed the resident and noted bruising to the right fifth toe. The resident voiced some discomfort and explained his/her toe had been bumped during a transfer to the bed the previous night. LPN #2 notified the Assistant Director of Nursing (ADON) of the above incident at 9:40 AM and contacted the physician. LPN #2 obtained a physician's order on 08/14/13 at 10:10 AM for an x-ray of the right pinkie toe related to pain and bruising. X-ray results received on 08/14/13 revealed a nondisplaced fracture of the fifth proximal phalanx involving the articular surface of the MTP joint.</p> <p>An interview with the Advanced Registered Nurse</p>	F 157	<p>has occurred and to document it in the progress note. The Education was conducted by the Staff Development Coordinator starting on 08/14/2013 with staff on duty and continuing until all licensed nurses have been re-educated with a goal completion date of 09/06/2013. A follow up nursing quiz was given to all licensed nursing staff to verify understanding of training.</p> <p>The Director of Nursing, Assistant Director of Nursing and Administrator will review daily the resident progress notes, to include Resident # 7, using the QI Tool for monitoring Acute Changes/Incidents to ensure resident changes in condition, Incidents and accidents are documented and identify any unreported resident changes in condition which will then be reported to the resident physician and responsible party. The QI nurse, MDS Nurse and Admissions Coordinator Nurse will audit progress notes and incident and accidents in the absence of Director of Nursing, Assistant Director of Nursing or Administrator.</p> <p>Licensed nurse caring for resident when incident occurred was given a final written warning by the Director of Nursing for resident # 7 as well as re-education on 08-</p>		

in regards to the policy and procedure and their responsibility to notify the physicians and responsible party of any unusual event, even if no noticeable injury has occurred and to document it in the progress note.

Indicate how the facility plans to monitor its performance to ensure that solutions are sustained

QI Nurse will do a daily audit Monday-Friday for timely notification, using the audit tool for timely notification of MD, to physician and responsible party x 4 weeks and then monthly x 2. On Saturday and Sunday the Administrative Nurse on call will audit. Any concerns found on the audit will require immediate education to the nurse and will be brought before the Friday morning department meeting for the QI Team to review and implement plan of action if needed.

The Executive QI Committee with the Medical director will review quarterly compiled QI report information review trends, and review corrective actions taken and the dates of completion. The Executive QI committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will

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F 157	Continued From page 3 Practitioner (ARNP), on 08/16/13 at 11:05 AM, revealed she ordered the x-ray and it revealed a non-displaced fracture. She stated the resident was already on a pain management routine and she was not going to order anything else.	F 157	be responsible for ensuring Committee concerns are addressed through further training or other interventions. The Administrator or DON will report back to the QI Committee at the next scheduled meeting.		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy/procedure review it was determined the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable environment related to wheelchairs, pads and assistive positioning devices for one (1) resident (#8), in the selected sample of sixteen (16) residents, and one unsampled resident (#17). Observations revealed the residents' equipment (gerichair, five piece foam positioning device, pommel cushion, and dycem pad) to have a very strong odor of urine and there was dried residue of undetermined matter on the seat of the gerichair. The findings include: View of the facility's policy, dated 08/2005, and	F 253	F253 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Housekeeping supervisor immediately removed resident on 08/15/2103 #8 and resident #17 wheel chair pads and replaced them. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Housekeeping Supervisor and Maintenance Supervisor completed a 100% room to room audit, starting on 08/21/13	09/10/2013	

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F 253	<p>Continued From page 4</p> <p>titled, Cleaning and Maintenance of Equipment Policy, revealed; "Equipment in this facility will be cleaned and disinfected according to manufacturer's recommendations. Resident care equipment will be cleaned and disinfected between resident uses. Equipment will be cleaned of surface material by using soap and water and then decontaminated with an EPA approved disinfectant. After cleaning and disinfecting, equipment will be returned to storage areas for reuse.</p> <p>1. Record review revealed the facility admitted Resident #17 on 03/01/12 with diagnoses which included Altered Mental Status, Malignant Neoplasm of Frontal Lobe of Brain, Scoliosis, Thoracic Spondylosis, Obstructive Hydrocephalus, Alzheimer's Disease, Nonpsychotic Mental Disorder Following Brain Damage and Abnormal Posture. According to the quarterly Minimum Data Set (MDS) assessment, dated 07/04/13, the facility assessed Resident #17 with severe cognitive impairment and required extensive assistance with all activities of daily living including positioning while in bed and when up in a gerichair. The resident's plan of care specified he/she was to have side and torso support when up in a gerichair as well as aommel cushion and dycem pad.</p> <p>Observation, on 08/15/13 at 9:00 AM, revealed Resident #17 was in a gerichair in the hall area just outside his/her room. The resident was non-verbal and was dressed and groomed; however, there was an overwhelming odor of urine. The Administrator verified the urine odor and instructed staff to change the resident's clothing. Resident #17 was moved to his/her room and transferred per e mechanical lift to the</p>	F 253	<p>and finishing on 08/23/13, checking all wheelchair pads and any other resident items that needed replaced or cleaned. Items identified were cleaned or replaced.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>On 08/19/13 the Housekeeping staff were in-serviced by the Staff Development Coordinator on checking wheelchair cushions for odors wear and discard if unable to get odor out or if worn.</p> <p>On 08/26/13 the Administrator in-serviced the Maintenance Director and Maintenance Assistant on auditing geri-chairs, wheelchairs, ecnochairs etc monthly for needed repairs and to replace immediately or take out of service until repairs can be done.</p> <p>The Housekeeping Supervisor and the Maintenance Supervisor will complete weekly room audits, to include resident #8 and #17, utilizing the wheelchair/cushion weekly audit tool to identify any odors, wheel chair repairs or torn items. The audits will be completed weekly for four weeks then monthly for three months and quarterly after that.</p>		

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F 253	<p>Continued From page 5</p> <p>bed. The resident's clothing was clean and dry. However, the gerichair, a five (5) piece foam positioning device, pommel cushion and Dycem pad were all noted to have a very strong urine odor and dried residue of undetermined matter was observed on the seat of the gerichair.</p> <p>Interview with State Registered Nurse Aide (SRNA) #12, on 08/15/13 at 9:50 AM, revealed she had assisted Resident #17 up in the morning about 6:30 AM and provided a shower and clean clothes to the resident. SRNA #12 stated the resident had a urine odor when she got him/her up in the morning (08/15/13) as he/she was "a heavy wetter". The SRNA stated she did not notice any odor of urine when the resident was placed back into the gerichair with the positioning devices but it was hard to tell in the shower room where there are dirty linen bags that have urine odor at times. SRNA #12 additionally stated she had noticed other times in the morning when there was a urine odor. The SRNA stated resident equipment that has an odor should be washed with a cleaning solution and if needed sent to housekeeping for cleaning.</p> <p>2. Record review revealed Resident #8 was admitted to the facility on 10/02/07 with diagnoses which included Abnormal posture, Vascular Dementia with Delusions, Presenile Dementia with Delusional Feature and Alzheimer's Disease. Review of the Quarterly MDS assessment, dated 07/05/13, revealed the facility assessed the resident as moderately cognitively impaired and required extensive assistance with activities of daily living. The resident was mobile per wheelchair and utilized a pommel cushion to the wheelchair for positioning.</p>	F 253	<p>Indicate how the facility plans to monitor it performance to ensure that solutions are sustained</p> <p>The results of the Housekeeping and Maintenance Supervisors audits will be brought to the Friday department head meeting for review of compliance and to be reviewed by QI team at this time for any needed further action plan. These audits will be forwarded to the Executive QI Committee for review quarterly for follow-up as deemed appropriate and to determine the frequency and /or need for continued QI monitoring as necessary.</p>		

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F 253	<p>Continued From page 6</p> <p>Observation, on 08/15/13 at 1:45 PM, revealed Resident #8 was in bed sleeping. An overwhelming odor of urine was noted from the resident's wheelchair andommel cushion which was located next to the resident's bed. Licensed Practical Nurse (LPN) #4 verified the urine odor at the time of the observation and removed the chair from the resident's room.</p> <p>An interview with LPN #4, at the time of the observation, revealed the SRNA that had assisted the resident to bed would have been responsible to ensure the wheelchair andommel cushion were cleaned to remove the urine odor.</p> <p>An interview with SRNA #10, on 08/15/13 at 1:55 PM, revealed she had no idea when Resident #8's chair andommel cushion had last been cleaned and stated "I obviously should have notified housekeeping and taken the cushion to be cleaned'.</p> <p>Interview with SRNA #11, conducted on 08/15/13 at 2:10 PM, revealed she had wiped urine off of Resident #8's chair when she assisted SRNA #10 to put Resident #8 to bed after lunch but failed to take theommel cushion to housekeeping to be cleaned and she should have taken the cushion.</p> <p>Interview, conducted on 08/16/13 at 9:25 AM, with the Assistant Director of Nursing (ADON) revealed both Resident #8 and #17's cushions should have been cleaned or even replaced. She said it was a dignity issue for the residents and the chairs and positioning devices (cushions, foam positioners) "should not have have been that way".</p> <p>Interview with the Administrator, on 08/16/13 at</p>	F 253			

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F 253	Continued From page 7 9:45 AM, revealed there was a schedule to clean resident equipment such as chairs and positioning devices at night and felt they were just wiping the cushions off and putting them back in the resident's chairs instead of cleaning them properly. She stated those cushions should have been discarded.	F 253			
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 facility policy review it was determined the facility failed to ensure care was provided in accordance with each resident's written plan of care for two (2) residents (#7 and #8), in the selected sample of sixteen (16) residents. Resident #7 was transferred by mechanical lift with one (1) staff assist instead of two (2) staff assist as per the plan of care and the resident sustained a fractured right toe. Resident #8 who had a history of falls, was observed on two (2) occasions without the safety alarm as per the plan of care. The findings include: Review of the facility's policy titled "Resident Care Plan", dated 08/2012, revealed, it is the policy of the facility to provide an interdisciplinary written care plan based on the physician's orders and the	F 282	F282 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician for resident #7 was notified by the Day Shift LPN and new orders received and implemented on 8/14/2013 by the day shift LPN as reflected by the clinical documentation. The responsible party was also notified on 8/14/2013. Residents care plan and care guide were updated on 8/14/2013 by the MDS Nurse. SRNA caring for resident # 7 when incident occurred is no longer employed by the facility. Licensed nurse caring for resident # 7 when incident occurred was given a final written warning and re-education on 08/14/2013. Resident #8 alarm was checked by the QI Nurse on 08/15/2013 and was found to be working correctly. SRNA#10 caring for resident during the time that was cited was given a written warning and re-education on 08/19/2013 related to the importance of the alarm being on when the resident is up in a wheelchair or any other resident with	09/10/2013	

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F 282	Continued From page 8 assessment of the resident's needs." 1. Record review revealed the facility admitted Resident #7 on 12/03/11 with diagnoses which included Chronic Airway Obstruction, Stage IV Chronic Kidney Disease, Diabetes Type II, Heart Failure, Hypertension, Respiratory Failure and Chronic Pain. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/26/13, revealed the facility assessed Resident #7 as requiring extensive to total assist of two (2) staff with transfers. Review of the Comprehensive Care Plan titled, "Requires total assistance for Transferring from one position to another", initiated 07/30/13, revealed staff should use a Viking Lift and two (2) person assist for transfers due to the resident having no control over his/her legs. Interview with State Registered Nursing Assistant (SRNA) #8, on 08/14/13 at 4:40 PM, revealed she had put Resident #7 to bed with a "Viking" (mechanical lift) lift and had assisted the resident with the transfer alone. The SRNA stated the resident was in an electric wheelchair and his/her feet were turned inward related to the resident's contractures to his/her lower extremities. The SRNA stated as she was moving Resident #7 to the bed with the lift, the resident was complaining of pain. The resident's right fifth toe got caught between the chair and the lift and the resident began to curse and scream at SRNA #8, telling her she didn't know what she was doing. The SRNA stated she reported the incident to the charge nurse. SRNA #8 switched with another SRNA so she wouldn't have to go back into the	F 282	counseling and re-education on 08/28/2013. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All resident alarms were audited by the QI Nurse on 08/14/2103 and no other alarms were found not to be in place as directed by the care guide. All nursing staff were re-educated by the Staff development Coordinator related to ensuring that resident alarms are turned on at the appropriate times. starting on 08/26/2013 and continuing until all nursing staff are re-educated with goal completion date of 09/06/2013. All residents' with alarms, to include resident #8, care guides and care plans were audited and checked for accuracy by the MDS Coordinators with assistance of the Regional Nurse Consultant on 08/29/2013 utilizing the weekly alarm audit tool. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;		

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F 282	<p>Continued From page 8</p> <p>resident's room. The SRNA stated the resident's care guide indicated the need for two (2) persons to use the lift for transfers.</p> <p>Interviews with SRNAs #4, #5, #6, and #7, on 08/15/13 at 4:30 PM, 4:35 PM, 4:45 PM and 4:52 PM respectively revealed they had been trained to follow the resident care guide to determine how much assist a resident needed for transfers. The SRNAs stated they would not attempt a "Viking" (mechanical lift) lift transfer alone nor had they ever used the lift along.</p> <p>2. Record review the facility admitted Resident #8 on 10/02/07 with diagnoses which included Abnormal posture, Vascular Dementia with Delusions, Presenile Dementia with Delusional Features and Alzheimer's Disease. Review of the Quarterly MDS assessment, dated 07/05/13, revealed the facility had assessed the resident as moderately cognitively impaired and required extensive assistance with activities of daily living. The resident was mobile per wheelchair and utilized a pommel cushion and lap buddy to the wheelchair for positioning.</p> <p>Review of Resident #8's record revealed he/she sustained an unwitnessed fall from the bed on 03/06/13. Review of the Comprehensive Care Plan for potential for falls, revealed the plan of care was revised on 03/02/13 to include a pull away safety alarm while in bed and when in wheelchair.</p> <p>Observation, on 08/14/13 at 2:25 PM, revealed Resident #8 propelled his/herself in a wheelchair. The pull away safety alarm was observed in</p>	F 282	<p>The nursing staff have been re-educated by the Staff Development Coordinator related to following the care plan and resident care guides starting on 08/14/2013 and continuing until all nursing staff have been re-educated with goal date of 09/06/2013. A written test was used to ensure competency a written test was given to all nursing staff.</p> <p>The MDS Nurse/ Coordinators will audit all bed and chair alarms weekly for four weeks then monthly for two months. Alarms found not working will be immediately turned on by the MDS Nurse /Coordinators and then reported to the Director of Nursing or Assistant Director of Nursing for further action. The MDS coordinators will question five nursing staff members weekly, to include staff caring for Resident # 7, on how to safely transfer a resident they are caring for to verify that SRNA knows what their care guide is directing them to do or that the SRNA immediately looks at care guide without being prompted. The quiz will include all three nursing shifts.</p> <p>All Nursing staff were given a quiz, starting on 08/23/13 and continuing until all have been tested, to verify understanding of training provided, goal completion date of 09/06/2013.</p>		

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F 282	<p>Continued From page 10</p> <p>place, however, the indicator light was not on, indicating the alarm was not in the function mode.</p> <p>Interviews with State Registered Nurse Aides (SRNA) #14 and #15, at the time of the observation, revealed the previous shift had assisted Resident #8 to the wheelchair and should have ensured the alarm was turned on to the function mode.</p> <p>Further observation, on 08/15/13 at 1:45 PM, revealed Resident #8 was laying in bed with eyes closed. There was not e pull away safety alarm in place and functioning as per the resident's plan of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, at the time of the observation, revealed there was to be a pull away alarm in place to alert staff to Resident #8's attempts to self transfer. Further interview revealed the SRNA that had assisted Resident #8 to bed was responsible to ensure the alarm was placed appropriately and in the function mode.</p> <p>Interview with SRNA #10, on 08/15/13 at 1:55 PM, revealed she had assisted Resident #8 to the bed and knew he/she was to have a pull away safety alarm placed to alert staff of attempted self transfers. SRNA #10 did not know why she had failed to place and activate the pull away safety alarm for Resident #8.</p> <p>Interview with SRNA #11, on 08/15/13 at 2:10 PM, revealed she also had assisted Resident #8 to bed and the alarm was on the resident's plan of care. She stated "I forgot to put the alarm on the bed".</p>	F 282	<p>Indicate how the facility plans to monitor it performance to ensure that solutions are sustained</p> <p>The MDS Nurse/ Coordinator will present alarm audits and the care guide audits to the Friday morning department head meeting for review by the QI team and will be forwarded to the Executive QI meeting Quarterly for review of compliance. These audits will be reviewed quarterly for follow-up as deemed appropriate.</p>		

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F 282	Continued From page 11 Interview with the Director of Nursing (DON), on 08/16/13 at 9:00 AM, revealed she expected the plan of care interventions to be implemented.	F 282			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents (Resident #4), received the appropriate care and services related to an Indwelling urinary catheter. The findings include: Record review revealed the facility admitted Resident #4 on 03/21/13 with diagnoses which included weakness and fatigue, Diabetes Mellitis, Urinary Frequency, and Obesity. Review of the Admission Minimum Data Set (MDS) assessment, dated 3/28/13, revealed the facility assessed Resident #4 as cognitively independent, non ambulatory and required extensive assistance with all activities of daily	F 315	F315 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 11 was assessed for catheter comfort on 8/13/2013 by the QI nurse as clinical documentation reflects after placing foley catheter for diagnosis of Urinary Retention. The Task for urinary output was added by the Assistant Director of Nursing on 08/14/2013 for SRNA 's to recorded resident #11 output. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All other residents with catheters were reviewed to see if the urinary output task was available for SRNA's to use on 08/14/2013 by the Assistant Director of Nursing and no concerns were found. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	09/10/2013	

Re-education has been provided to all nursing staff related to checking residents foley catheter bag at least twice a shift, at each contact and empty as needed and to not let bag fill completely by the staff development coordinator starting on 08/14/2013 and continuing until all nursing staff have been educated with goal date of 09/06/2013.

On 08/14/2013 Licensed Staff were In-serviced on to add task for SRNA's anytime they receive a foley catheter order.

The QI nurse will audit catheters, to include resident #11 utilizing the foley catheter audit tool, for being full or in need of emptying weekly for four weeks then monthly for two months. Upon the identification of any potential concern, the QI Nurse will follow up immediately with the Unit Nurse and/or SRNA as necessary.

The QI nurse will bring catheter audits to the Friday department head meeting for review by the QI team. These audits will be forwarded to the Executive QI Committee for review quarterly for follow-up as deemed appropriate and to determine the frequency and /or need for continued QI monitoring as necessary.

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F 315	Continued From page 12 living. Review of the physician's orders revealed the resident had the catheter placed on 08/13/13 due to urinary retention. Observation, on 08/14/13 at 11:20 AM, revealed Resident #4 was resting in bed with a urinary drainage bag to bedside. The drainage bag had 1500 milliliters (ml.) of yellow urine. Further observations that same day at 12:00 noon and 1:20 PM, revealed there was 1700 ml. and 2000 ml. of urine respectively, in the drainage bag. Interview with Licensed Practical Nurse #2, on 8/14/13 at 2:20 PM, revealed the catheter bag was emptied at 2:00 PM and she charted 2000 ml of output for her shift. The LPN stated the resident had the catheter placed yesterday and the patient's care plan had not been updated. The LPN further stated the State Certified Nursing Assistant (SRNA) working with this resident today had not been informed of the resident's new catheter and the need to obtain intake and output (I&O).	F 315			
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 prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F323 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician for resident #7 was notified by the day shift LPN and new orders	09/10/2013	

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F 323	<p>Continued From page 13</p> <p>by: Based on interview, record review, facility policy and procedure review, and review of the facility's investigative report it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#7), in the selected sample of sixteen (16) residents. Resident #7 sustained a fractured toe during an inappropriate transfer with a mechanical lift.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Safe Resident Handling and Movement Policy", last revised 05/26/09, revealed "Staff will follow the movement and handling procedures for each resident as individually determined through the admission/re-entry admission process and the RAI process. Use mechanical lifting devices and other approved resident handling aids for resident handling and movement tasks, i.e. gait belts, except when manual lifting is necessary. Use mechanical lifting devices and other approved resident handling aids, i.e. gait belts, in accordance with instructions and training."</p> <p>Record review revealed Resident #7 was admitted to the facility on 12/03/11 with diagnoses which included Chronic Airway Obstruction, Stage IV Chronic Kidney Disease, Diabetes Type II, Heart Failure, Hypertension, Respiratory Failure, and Chronic Pain.</p> <p>Review of the Comprehensive Care Plan, dated 07/30/13, revealed the staff should use a mechanical lift (Viking Lift) and two (2) person assist for transfers due to the resident having no control over his/her legs.</p>	F 323	<p>clinical documentation. The responsible party was also notified on 8/14/2013. Residents care plan and care guide were updated on 8/14/2013 by the MDS Nurse.</p> <p>SRNA caring for resident # 7 when incident occurred is no longer employed by the facility.</p> <p>Licensed nurse caring for resident # 7 when incident occurred was given a final written warning and re-educated on 08/14/2013.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All current in house residents who are transferred with a lift device were re-assessed by the licensed nurses to include the Director of Nursing, Assistant Director of Nursing. These audits were done through interview or skin audits starting on 08/14/2013 and completing on 08/27/2013. No other residents were identified.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>SRNA caring for resident # 7 when incident occurred is no longer employed by the facility.</p>		

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F 323	<p>Continued From page 14</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/26/13, revealed the facility assessed Resident #7 as requiring the extensive to total assist of two (2) persons with transfers.</p> <p>Review of the facility's investigation, dated 08/14/13, revealed on 08/13/13 at approximately 8:00 PM, one State Registered Nurse Aide (SRNA #8) was transferring Resident #7 with a "Viking" (mechanical lift) lift and caught the resident's right foot between the lift and the wheelchair.</p> <p>Interview with SRNA #8, on 08/14/13 at 4:40 PM, revealed she had put Resident #7 to bed with a Viking lift and had assisted the resident with the transfer alone. The SRNA stated the resident was in an electric wheelchair and his/her feet were turned inward related to the resident's contractures to his/her lower extremities. The SRNA stated as she was moving Resident #7 to the bed with the lift, the resident was complaining of pain. The resident's right fifth toe got caught between the chair and the lift and the resident began to curse and scream at SRNA #8, telling her she didn't know what she was doing. The SRNA stated she reported the incident to the charge nurse and switched with another SRNA so she wouldn't have to go back into the resident's room. The SRNA revealed the process to transfer a resident with a Viking Lift was to have one (1) person operate the remote while the other person guided the resident to the bed and made sure the bed was locked.</p> <p>Interview with LPN #1, on 08/14/13 at 4:55 PM, revealed she assessed Resident #7 after SRNA #8 reported to her the resident's foot/leg was</p>	F 323	<p>Licensed nurse caring for resident # 7 when incident occurred was given a final written warning and re-education On 08-14-2013.</p> <p>All nursing staff were re-educated by the Staff Development Coordinator on the Safe Resident Handling and Movement Policy starting on 08/14/2013 and completing on 08/27/2013 and will continue with each new hire.</p> <p>Starting on 08/14/2013 and continuing with educated until all Licensed staff are educated with goal date of 09/06/2013 by the Staf Development Coordinator on the importance of documenting when an unusual event occurs, even if no noticeable injury and their responsibility in notifying the physician and responsble party.</p> <p>Starting on 08/14/2013 and continuing until all SRNA's are In-serviced by the Staff Development Coordinator on their responsibility in reviewing care guide before all transfers with goal date of 09/06/2013.</p> <p>A quiz was given to verify understanding of education.</p>		

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F 323	<p>Continued From page 15</p> <p>hurting because it got hit on the lift during a transfer. The LPN stated when she assessed the resident there were no obvious signs of injury but the resident was complaining of pain. The LPN stated she administered pain medication to the resident but did not notify the physician of the incident because there was no evidence of injury.</p> <p>Interview with SRNA #1, on 08/16/13 at 10:50 AM, revealed the midnight shift SRNA had reported to her on day shift that Resident #7's toe had gotten stuck in the lift and it was not bruised. The SRNA stated when Resident #7 was being transferred out of bed the following morning around 9:00 AM, it was discovered Resident #7's right fifth toe was bright purple and the resident screamed when the toe was touched. SRNA #1 stated she informed the charge nurse on day shift about the resident's toe.</p> <p>Further review of the facility's investigation, dated 08/14/13, revealed LPN #2 assessed the resident and noted bruising to the right fifth toe. The resident voiced some discomfort and explained his/her toe had been bumped during a transfer to the bed the previous night. LPN #2 notified the Assistant Director of Nursing (ADON) of the above incident at 9:40 AM and contacted the physician. LPN #2 obtained a physician's order on 08/14/13 at 10:10 AM for an x-ray of the right pinkie toe related to pain and bruising. X-ray results received on 08/14/13 revealed a nondisplaced fracture of the fifth proximal phalanx involving the articular surface of the MTP joint.</p> <p>Interviews with SRNAs #4, #5, #6, and #7, on 08/15/13 at 4:30 PM, 4:35 PM, 4:45 PM and 4:52 PM respectively revealed they had been trained</p>	F 323	<p>Indicate how the facility plans to monitor it performance to ensure that solutions are sustained</p> <p>The Director of Nursing and Assistant Director of Nursing will conduct three staff members lift techniques, to include resident # 7, utilizing the lift audit tool, per week x 4 weeks then monthly x 2 for compliance. Results of audits will be brought before the Friday morning department head meeting to be reviewed and forwarded to the Executive QI Committee with the Medical Director quarterly.</p> <p>MDS Coordinators will audit 5 SRNA's per week for compliance with care guides weekly x 4 weeks then monthly x 2 for compliance. Results of audits will be brought to the Friday morning department head meeting to be reviewed by the QI team and results forwarded to the Executive QI Committee with the Medical Director quarterly.</p> <p>The Executive QI Committee with the Medical director will review quarterly compiled QI report information review trends, and review corrective actions taken and the dates of completion. The QI committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will</p>		

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F 323	Continued From page 16 to follow the resident care guide to determine how much assist a resident needed for transfers. The SRNAs stated they would not attempt a "Viking" (mechanical lift) lift transfer alone nor had they ever used the lift along. Interview with the Staff Development Coordinator, on 08/15/13 at 11:15 AM, revealed SRNAs were trained by watching videos on the Viking Lift as well as other lifts and the video explained how to choose the appropriate sling size for the resident and how to check for maintenance on the lift. She further explained that the need for a Viking lift and the assist needed for use of the lift was determined by the admitting nurse and therapy. She stated the SRNAs had been trained on the use of the lift, two (2) person transfers and the use of the care guides for the residents. The Staff Development Coordinator stated the care guides were kept in the resident rooms on the inside of the closet door for easy access.	F 323	be responsible for ensuring Committee concerns are addressed through further training or other interventions. The Administrator or DON will report back to the QI Committee at the next scheduled meeting.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F371 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 08/14/2013 Dietary employee was removed from tray line and instructed to	09/10/2013	

cover her hair completely by the Dietary manager.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

All residents' that ate lunch before Dietary manager removed employee have a potential to be affected in a manner in which a hair could get into their food.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

All Dietary staff have been Re-educated on 08/16/2013 by the Dietary Manager related to ensuring that their hair is covered at all times when preparing or serving food and ensuring other contaminants do not enter their food. The dietary manager will complete a hair net audit weekly, utilizing the weekly hair net audit tool, for four weeks then monthly for two months. Upon identification of any hairnet concern, the Dietary Manager will immediately follow up with the involved employee as appropriate.

Indicate how the facility plans to monitor its performance to ensure that solutions are sustained;

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 17</p> <p>Based on observation, interview and facility policy review it was determined the facility failed to ensure food was prepared and served under sanitary conditions. On 08/14/13, an observation during the meal tray preparation, revealed a kitchen staff in all areas of the kitchen with her hair not adequately restrained.</p> <p>The findings include:</p> <p>Review of the facility's policy dated 08/2010, titled "Personal Hygiene", revealed "Long hair (male or female) will be restrained and employees will wear head coverings that cover the entire head".</p> <p>Observation, on 08/14/13 starting at 11:20 AM, revealed Kitchen Staff #1 was circulating in all areas of the kitchen during the lunch meal tray preparation. Further observation revealed Kitchen Staff #1 had a hair restraint in place, however, long strands of hair on the side and back of the head were protruding from the hair restraint and moving in the air as the Kitchen Staff moved around all areas of the kitchen including the walk in refrigerator, walk in freezer, and along the tray preparation area.</p> <p>Interview with the Dietary Manager, on 08/14/13 at 11:50 AM, revealed she would have instructed Kitchen Staff #1 to reapply the hair restraint appropriately, but she had not noticed the kitchen staff's hair not appropriately restrained.</p>	F 371	The Dietary manager will present the results of the audits weekly on Friday at the department head meeting for the QI team to review. These audits will be forwarded to the Executive QI Committee for review quarterly for follow-up as deemed appropriate and to determine the frequency and /or need for continued QI monitoring as necessary.		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and</p>	F 441	<p>F441</p> <p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p>	09/10/2013	

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F 441	<p>Continued From page 18</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy, it was determined the facility failed to ensure it maintained an effective infection control</p>	F 441	<p>The licensed nurse completing the medication pass was re-educated related to using hand sanitizer or washing her hands before and after giving a resident medication by the Director of Nursing on 08/14/2013.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>Residents receiving medications during state medication pass audit have the potential to be affected.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>All licensed staff have been re-educated on the infection control policy and procedure for hand washing by the Staff Development Coordinator starting on 08/14/2013 and completing on 08/27/13 and will continue with all new hires.</p> <p>The QI nurse will complete hand washing audits during medication pass on two llcensed staff per week for four weeks then monthly for two months and quarterly after that. The audit will consist of a pass or fail</p>		

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F 441	<p>Continued From page 19</p> <p>program related to hand sanitation during a medication administration pass for five (5) unsampled residents (#19, #20, #21, #22 and #23).</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Administration of Oral Medication", not dated, revealed under the procedure section; "1. Wash hands (towelettes and/or hand sanitizer acceptable)".</p> <p>On 08/14/13 at 3:25 PM, an observation during a medication pass revealed Licensed Practical Nurse (LPN) #4 administered three (3) medications to Resident #21. LPN #4 then administered six (6) medications to Resident #20. Resident #22 was then administered two (2) medications; LPN then administered two (2) medications to Resident #19. Observation revealed LPN #4 failed to wash or sanitize her hands between administering medications to Residents #19, #20, #21 and #22.</p> <p>Further observation revealed LPN #4 was asked to obtain a resident's temperature by a family member at 3:50 PM. LPN #4 obtained a tympanic thermometer and made two (2) attempts to obtain a temperature on the resident; then returned to the medication cart and prepared two (2) medications for Resident #23 and administered them. Observation revealed LPN #4 failed to wash or sanitize her hands after attempting to obtain the tympanic temperature on a resident and before the administration of medication to Resident #23.</p> <p>Interview with LPN #4, on 08/14/13 at 4:55 PM,</p>	F 441	<p>result for the licensed nurse and results given to the Licensed nurse upon completion of the audit with re-education if necessary.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained;</p> <p>Results of the hand washing audit during medication pass will be presented at the Friday department head meetings, weekly, for review by the QI team. These audits will be forwarded to the Executive QI Committee for review quarterly with the Medical Director for follow-up as deemed appropriate and to determine the frequency and /or need for continued QI monitoring as necessary.</p>		

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F 441	<p>Continued From page 20</p> <p>revealed she did not realize she had not washed or sanitized her hands between administering medications to Residents #19, #20, #21 and #22. Additionally, she stated she should have washed her hands after attempting to obtain a temperature on a resident and before administering medications to a resident. She stated she thought the procedure would be to sanitize between residents and wash her hands every third resident when administering medications.</p> <p>An interview with the Director of Nursing, on 08/14/13 at 4:05 PM, revealed staff administering medications could use sanitizer between administering medication to residents and she would expect them to wash their hands every third resident.</p>	F 441			

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/10/2013 as alleged	{K 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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1978 and upgraded in 2005 with 26 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1978.</p> <p>GENERATOR: Type II generator installed in 1979. Fuel source is Liquid Propane.</p> <p>A Standard Life Safety Code Survey was conducted on 08/14/2013. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) 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>Lake Way Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Lake Way Nursing and Rehabilitation Center response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor is that any deficiency accurate. Further, Lake Way Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Selena Beall N/A

TITLE

Administrator

(X6) DATE

09-03-2013

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

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K 000 K 027 SS=E	Continued From page 1 Fire). Deficiencies were cited with the highest deficiency identified at a S/S "F" level. NFFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) on the day of the survey. The facility failed to ensure one (1) set of cross corridors doors would close properly once released from the magnetic locks. The findings include: Observation, on 08/14/13 at 2:30 PM with the Maintenance Supervisor, revealed the	K 000 K 027	K027 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; A new coordinating cross coordinator door closure device has been installed by Commerical Door and Hardware on 09/06/2013, the doors now close completely. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All doors in the facility have been inspected by the Maintenance Director on 08/30/2013 to ensure that they close completely. No other doors were identified as not closing completely. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Maintenance director has been re-educated by the administrator related to the requirements of life safety code tag K027 on 08/28/2013. The Maintenance director will check the cross corridors doors	09/10/2013

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K 027	Continued From page 2 cross-corridor doors located at the kitchen area did not close completely when tested. This was due to the doors not having a coordinating device properly installed on the doors. Interview, on 08/14/13 at 2:30 PM with the Maintenance Supervisor, revealed the coordinators were recently installed and he was unaware of how they worked properly. Reference: NFPA 101 (2000 Edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	In the dining room weekly times four weeks and then monthly times 2 months to ensure that they close completely. Indicate how the facility plans to monitor it performance to ensure that solutions are sustained The Maintenance director will bring all door audits to the Friday Department Head meeting for review by the QI Team. The Executive Quality Improvement committee will review monthly logs , quarterly for compliance and then decide if the cross corridor doors closing are a continued concern, or if there is a need for continued monitoring by the Quality assurance committee.		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K038 Address what corrective action will be accomplished for those residents found to	09/10/2013	

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) on the day of the survey. The facility failed to ensure all egress doors had the proper signage for delayed egress doors. The findings include: Observation, on 08/14/13 at 1:55 PM with the Maintenance Supervisor, revealed all exit doors in the facility were equipped with signage for the delayed egress doors with no contrasting background on the signs. Interview, on 08/14/13 at 1:55 PM with the Maintenance Supervisor, revealed he was unaware the signs must have a contrasting background. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the	K 038	have been affected by the deficient practice; The delayed egress signs in the facility have been replaced with a contrasting background by the maintenance director on 08/23/2013. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All fire exit signs for the delayed egress doors and other exit doors have been inspected by the Maintenance director All doors identified that did not have contrasting background signage has been replaced to meet life safety code standard K038 on 08/23/2013. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator has re-educated the Maintenance director and his Assistant on 08/28/2013 related to the life safety code regulation K038 and ensuring that all exit doors in the facility are equipped with signage that has a contrasting background. The maintenance Director will check all exit doors monthly to ensure that the		

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K 038	Continued From page 4 use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors	K 038	contrasting signage is present and log the results of the audit. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained The Maintenance director will bring all exit doors signs audit to the Friday Department Head meeting for the QI Team to review. The Executive Quality Improvement committee will review quarterly for compliance and then decide if the fire exit contrasting background signage is a continued concern, or if there is a need for continued monitoring by the Quality assurance committee.	

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K 038	Continued From page 5 of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An Irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 048 SS=F		K 048	K048 Address what corrective action will be accomplished for those residents found to	09/10/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2013
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	<p>Continued From page 6</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>This STANDARD is not met as evidenced by: Based on interview and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) on the day of the survey. The facility failed to ensure smoke compartment evacuations and entire building evacuations were addressed in the fire safety plan.</p> <p>The findings include:</p> <p>Review of the Fire Safety Plan, on 08/14/13 at 11:34 AM with the Maintenance Supervisor, revealed the facility's Fire Safety Plan and Procedure Policy did not address the evacuation of a smoke compartment or the evacuation of the entire facility in the event of a fire.</p> <p>Interview, on 08/14/13 at 11:34 AM with the Maintenance Supervisor, revealed he was unaware the smoke compartments evacuations and entire facility evacuations were not addressed in the fire safety plan.</p> <p>Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1</p>	K 048	<p>have been affected by the deficient practice;</p> <p>The Administrator re-educated the Maintenance director and his Assistant on 08/28/2013 related to the fire evacuation policy and procedure plan that does include the evacuation of a smoke compartment/partial, total evacuation.</p> <p>The Maintenance director with assistance from the Staff Development Coordinator has re-educated all licensed/charge nurses related to the fire evacuation policy and procedure and it's location starting on 08/29/2013 and continuing until all have been educated with goal completion date of 09/06/2013.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All residents could have the potential to be affected.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>The Administrator has re-educated the Maintenance director related to the evacuation plan policy and procedure and the life safety code regulation K048 on 08/28/2013. All licensed nurses/charge nurses have been re-educated related to</p>	

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K 048	Continued From page 7 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the	K 048	the fire safety evacuation plan by the maintenance director and staff development coordinator starting on 08/29/2013 and completing on 09/02/2013. The Maintenance director will complete a quarterly evacuation drill in the facility. Indicate how the facility plans to monitor it performance to ensure that solutions are sustained The Maintenance director will bring all fire drills and evacuation drills to the Safety Meeting monthly. The Executive Quality Improvement committee will review quarterly for compliance and then decide if the fire evacuations are a continued concern, or if there is a need for continued monitoring by the Quality Improvement committee.	

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K 048	Continued From page 8 fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy 's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and	K 048		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062	K062 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;	09/10/2013

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K 062	Continued From page 9 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) on the day of the survey. The facility failed to ensure the dry sprinkler system had a full flow trip test since 07/13/2010. The findings include: Review of the Sprinkler inspection documentation on 08/14/13 at 11:15 AM with the Maintenance Supervisor, revealed the facility failed to provide documented evidence that the dry sprinkler system had a full flow trip test performed in the last three (3) years. Documentation revealed the last full flow trip test was performed on 07/13/10. Interview, on 08/14/13 at 11:15 AM with the Maintenance Supervisor, revealed he was unaware the trip test was past due since the sprinkler company had scheduled the test on the next quarterly inspection. Reference: NFPA 25 (1998 Edition). 9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve	K 062	A full flow sprinkler trip test was done on 08/20/2013 by the Premier sprinkler company Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All resident in the facility have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The administrator has re-educated the Maintenance director and his assistant related to the life safety code regulation K062 on 08/28/2013. Indicate how the facility plans to monitor it performance to ensure that solutions are sustained The maintenance director will bring the full flow sprinkler trip test log to the monthly safety meeting. The Executive Quality Improvement committee will review quarterly full flow sprinkler trip test log for the next year to monitor compliance and need to continue monitoring by the Quality Improvement committee.	

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K 062	Continued From page 10 fully open and the quick-opening device, if provided, in service.	K 062		
K 066 SS=D	<p>9-4.4.2.2* During those years when full flow testing in accordance with 9-4.4.2.2.1 is not required, each dry pipe valve shall be trip tested with the control valve partially open.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by:</p>	<p>K066</p> <p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The cigarette butts located in front of short hall East were cleaned up by the housekeeping supervisor and the maintenance director is aware that they should not be anywhere on the grounds on 08/14/2013.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All outside area's that have no smoking signs were inspected for cigarette butts, any cigarette butts that were found were cleaned up by the housekeeping supervisor or the maintenance director on 08/14/2013.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p>	09/10/2013	

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K 066	<p>Continued From page 11</p> <p>Based on observation and interview, it was determined the facility failed to ensure a no smoking area was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, forty-five (45) residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) on the day of the survey. The facility failed to ensure cigarette butts were not littering the ground in a no smoking area.</p> <p>The findings include:</p> <p>Observation, on 08/14/13 at 11:55 AM with the Maintenance Supervisor, revealed the area at the short hall east exit was being used as a smoking area due to all the cigarette butts on the ground in the landscaping and the grass. The area did not provide an approved ashtray and was not listed as a smoking area at the facility. Further observation revealed a no smoking sign placed in the ground where the smoking was taking place.</p> <p>Interview, on 08/14/13 at 11:55 AM with the Maintenance Supervisor, revealed he has had a constant problem with smoking in this area and had a no smoking sign placed on the building which was torn down. He then placed the no smoking sign on the pole; however, smoking continued in this area.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment</p>	K 066	<p>The maintenance director and housekeeping supervisor have been re-educated related to the smoking policy and procedure on 08/29/2013.</p> <p>All staff has been re-educated related to the policy and procedure for smoking by the staff development coordinator starting on 08/29/2013 and continuing until all staff have been re-educated with goal date of completion on 09/06/2013.</p> <p>The maintenance director will complete a weekly cigarette butt audit. The audit will be completed weekly for four weeks and then monthly for two months.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained</p> <p>The maintenance director will bring cigarette butt audits to the Friday Department Head morning meeting. The Executive Quality Improvement committee will review monthly for compliance and then decide if the cigarette butts are a continued concern, or if there is a need for continued monitoring by the Quality improvement committee.</p>	

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K 066	Continued From page 12 where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice; A battery powered light has been installed in the area where the transfer switch is located. The battery powered light was installed by the Maintenance Director on 08/23/2013.	09/10/2013

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K 144	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of seventy-seven (77) on the day of the survey. The facility failed to ensure there was battery backup lighting at the generator transfer switch. The findings include: Observation, on 08/14/13 at 11:34 AM with the Maintenance Supervisor, revealed the facility did not have a battery-powered light installed in the area where the transfer switch for the emergency generator was located. Interview, on 08/14/13 at 11:34 AM with the Maintenance Supervisor, revealed he was not aware of the requirement for the battery backup lighting. Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the	K 144	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator re-educated the maintenance director on 08/28/2013 related to the life safety code tag K144 and ensuring there is a battery powered light for backup lighting be by the emergency generator switch. The Maintenance director will check the emergency battery powered lighting monthly. Indicate how the facility plans to monitor it performance to ensure that solutions are sustained The Maintenance director will bring the emergency battery powered lighting switch check off to the safety meeting monthly. The Executive Quality Improvement committee will review the log for compliance and the need for continued monitoring.	

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K 144	Continued From page 14 transfer switch.	K 144		