

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

Printed: 04/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505099	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPOKANE VAL		STREET ADDRESS, CITY, STATE, ZIP CODE EAST 17121 EIGHTH AVENUE SPOKANE VALLEY, WA 99016		
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K 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Good Samaritan Society in Spokane Valley, Washington on 4/2/15 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Social and Health Services (DSHS) health survey teams. During the physical tour of the facility I was accompanied by the Facility Maintenance Director who witnessed any deficiency noted during this survey.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. This facility is a one story structure of Type V- 1 hour construction with exits to grade and is protected by a Type 13 sprinkler system and an Automatic / Manual Fire Alarm System with corridor smoke detection. Single station smoke detectors are installed in all resident rooms. The facility is licensed for 97 residents. The current census is 86 residents.</p> <p>The memory care wing has been approved by the Spokane Valley Fire Department to have 30 second delayed egress doors.</p> <p>The facility is not in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The following citations were documented during the survey:</p> <p>The surveyor was:</p> <p>David Rogers Deputy State Fire Marshal Nursing Home Surveyor</p>	K 000	<p>K 018 SS = E</p> <p>It is the policy of the facility to maintain resident room doors that close and latch as required.</p> <p>Part 1: Individual Corrective Action</p> <p>No individual resident identified.</p> <p>Corrective action will include:</p> <ol style="list-style-type: none"> 1) repairs to and/or replacement of the memory care dining room East door latch so that it latches properly when closed; 2) repairs to and/or replacement of the memory care dining room door closing coordinator so that the door closes and latches properly; 3) repairs to and/or replacement of the Northwest dining room door into the corridor so that the self-closure force closes and latches the door properly. <p>Part 2: Identifying Residents at Risk</p> <p>To protect residents in similar situations, the Environmental Services Director and/or designee will conduct a room by room audit to ensure all doors close and latch as required. Any door identified as not meeting the requirement, including hardware necessary to properly close and latch the door, will be adjusted, repaired or replaced if necessary in order to meet the requirement.</p>	5/5/15

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

TITLE

(X6) DATE

[Signature]

Administrator

4/10/15

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

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K 018	<p>Continued From page 2</p> <p>Based upon observations and staff interviews on 4/02/15 between 0930 and 1415 hours the facility has failed to maintain doors capable of resisting fire for at least 20 minutes. This could result in toxic products of combustion getting into the room and into the exit corridor which would endanger the residents, staff and/or visitors within the smoke compartment.</p> <p>The findings include, but are not limited to: The memory care dining room East door into the corridor did not latch when closed.</p> <p>The memory care dining room north door had an inoperative door closing-coordinator, preventing the door from closing and latching.</p> <p>The Northwest Dining room door into the corridor did not have enough self-closer force to fully close and latch.</p> <p>The above was discussed with the Maintenance Director.</p>	K 018	<p><u>Part 1: Individual Corrective Action</u></p> <p>No individual resident identified.</p> <p>Corrective action will include:</p> <ol style="list-style-type: none"> 1) self-closing device will be installed on the transportation network room door; 2) self-closing device will be installed on the #352 room door; 3) the penetration in the wall of the Morningside supply room will be sealed. <p><u>Part 2: Identifying Residents at Risk</u></p> <p>To protect residents, the Environmental Services Director and/or designee will conduct a room by room audit to ensure all doors to hazardous areas meet this requirement and that all wall penetrations meet this requirement. Any door identified as not meeting this requirement will be equipped to meet the requirement. Any unsealed wall penetration identified will be sealed.</p>	
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>	K 029	<p><u>Part 3: Systemic Changes</u></p> <p>To ensure that the problem does not recur, Environmental services and Housekeeping Staff will be provided education and training by May 5, 2015. All staff will be provided education and training May 5, 2015. Education and training will include facility procedures for identifying, reporting and equipping doors and wall penetrations to meet this requirement.</p>	

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K 029	Continued From page 3 This Standard is not met as evidenced by: Based upon observations and staff interviews on 4/02/15 between 0930 and 1415 hours the facility has failed to maintain hazardous areas as being smoke resistant and doors to hazardous areas as self or automatic closing. This could result in the spreading of the toxic products of combustion into the corridor in the event of a fire which would endanger residents, staff and/or visitors. The findings include, but are not limited to: The transportation network room is being used as a storage room over 50 square feet and is not equipped with a self-closer. Room 352 is being used as a storage room over 50 square feet and is not equipped with a self-closer. There was an unsealed penetration in the wall of the Morning side supply room. The above was discussed and acknowledged by the Maintenance Director.	K 029	<u>Part 4: Assurance of On-Going Compliance</u> The Environmental Services Director and/or designee will conduct routine focus audits to ensure doors to hazardous areas meet this requirement and ensure wall penetrations meet this requirement. Concerns/trends will be reported to the facility Quality Assurance Committee and the facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Housekeeping Supervisor, Administrator to ensure correction. K 043 SS = F	5/5/15
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2 This Standard is not met as evidenced by: Based upon observations and staff interviews on 4/02/15 between approximately 0930 and 1415 hours the facility has failed to maintain the ability of delayed egress exit doors to operate in accordance with NFPA 101 7.2.1.6.1. This could	K 043	It is the policy of the facility that patient room doors are arranged so that the patient can open the door from the inside without using a key. Patient room doors are arranged in this manner and were arranged in this manner during the Fire and Life Safety re-certification survey. It is the policy of the facility to maintain delayed egress exit doors so that they operate properly. In addition, it is the policy of the facility that staff members know the combination to the Memory Care courtyard exit gate.	

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K 043	<p>Continued From page 4</p> <p>cause an inability or delay in the evacuation of residents in the event of a non-fire related emergency which would endanger residents, staff and/or visitors.</p> <p>The findings include, but are not limited to:</p> <p>The delayed egress door in the Memory Care wing by room #437 does not unlock after the 30 second countdown when the door is activated by resident's wander-guard devices.</p> <p>The above was discussed and acknowledged by the Maintenance Director.</p> <p>Based upon observations and staff interviews on 4/02/15 between approximately 0930 and 1415 hours the facility has failed to maintain the ability for staff to readily unlock means of egress doors in accordance with NFPA 101 18.2.2.2.4 Exception no. 1. This could delay / prevent egress from the memory care wing in the event of an emergency, placing staff, residents and visitors in danger.</p> <p>The findings include, but are not limited to:</p> <p>The Memory care courtyard exit gate has a combination code pad-lock preventing egress and 5 staff members assigned to the wing did not know the combination or where the combination was written down when interviewed.</p> <p>The above was discussed and acknowledged by the Maintenance Director.</p>	K 043	<p>Part 1: Individual Corrective Action</p> <p>No individual resident or individual resident room door identified.</p> <p>Corrective action will include:</p> <ol style="list-style-type: none"> 1) the delayed egress door in the Memory Care wing located near room #437 will be repaired and/or replaced ensuring that the door unlocks after the 30 second countdown once activated by the resident's wander guard device; 2) staff members will receive education related to the combination and the location of written information regarding the combination for the Memory care courtyard exit gate combination pad-lock. <p>Note: No individual patient/resident room doors were identified as not meeting this requirement.</p> <p>Part 2: Identifying Residents at Risk</p> <p>To protect residents, the Environmental Services Director and/or designee will conduct delayed egress door audit to ensure all delayed egress doors meet this requirement. Any delayed egress door identified as not meeting this requirement will be repaired and/or replaced to meet the requirement. In addition, the Memory Care wing Unit Manager, will provide pad-lock combination education (including the combination and the location of written</p>	
K 046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p>	K 046		

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K 046	Continued From page 5 This Standard is not met as evidenced by: Based upon observations and staff interviews on 4/2/15 between 0930 and 1415 hours the facility has failed to maintain emergency lighting of at least 1 and 1/2 hour duration. This could place staff, visitors and residents in danger in the event of a power outage. The findings include, but are not limited to: The facility is not properly conducting / documenting the monthly 30 second and annual 90 minute testing of their battery backup lighting devices. The above was discussed and acknowledged by the Maintenance Director.	K 046	information regarding the combination) to all staff members assigned to this unit. <u>Part 3: Systemic Changes</u> To ensure that the problem does not recur, Environmental Services and Memory Care Unit Staff will be provided education and training by May 5, 2015. All staff will be provided education and training May 5, 2015. Education and training will include facility procedures for identifying, reporting and equipping delayed egress exit doors and will also include pad-lock combination information. <u>Part 4: Assurance of On-Going Compliance</u> The Environmental Services Director, Memory Care Unit Manager and/or designee will conduct routine focus audits to ensure delayed egress exit doors meet this requirement and that staff members understand/know the pad-lock combination information. Concerns/trends will be reported to the facility Quality Assurance Committee and the facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Memory Care Unit Manager, Administrator to ensure correction.	
K 062 SS=E	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, 9.7.5 This Standard is not met as evidenced by: Based upon observations and staff interviews on 4/2/15 between 0930 and 1415 hours the facility has failed to maintain the fire sprinkler system as required. This could result in a delay of sprinkler activation in the event of a fire allowing the fire to increase in size and intensity which would endanger the residents, staff and/or visitors within the facility.	K 062		

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K 062	Continued From page 6 The findings include, but are not limited to: The fusible link on the sprinkler head above the kitchen pass-through window was painted over. The fusible link on the sprinkler head in the main housekeeping closet was painted over. The above was discussed and acknowledged by the Maintenance Director.	K 062	K 046 SS = E It is the policy of the facility to maintain emergency lighting as required. This includes monthly 30 second testing, annual 90 minute testing and maintaining a record of testing.	5/5/15
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 upon observations and staff interviews on 4/2/15 between 0930 and 1415 hours the facility has failed to restrict the use of multi-plug outlets (power strips) to providing power to permitted electrical equipment and in restricting the use of unauthorized multi-plug power taps. This could result in a fire from overheating of the plug strip due to the heavy power draw endangering the residents, staff and/or visitors within the facility. The findings include, but are not limited to: There was a powerstrip in use with a fish tank in the Phone room. There was multi-plug cube style adaptor without overcurrent protection in resident room #24. The above was discussed and acknowledged by the Maintenance Director.	K 147	Upon request April 2, 2015, during the Fire and Life Safety re-certification survey, the facility did not provide the correct record of testing for emergency lighting. At that time, the staff member provided a written record of prior testing. The staff member should have provided the current electronic record. On April 3, 2015 the facility did provide the current electronic record of testing for emergency lighting. A copy of this record was forwarded/emailed to the Fire Marshal for review. The copy identified work history for the past 12 months. The required monthly 30 second testing and the required annual 90 minute testing were included in the electronic record of testing. The facility believes that the standard has been met and is therefore requesting an informal dispute resolution process (IDR). See attached request as well as the emergency lighting electronic work history record. <u>Part I: Individual Corrective Action</u> No individual resident identified.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:	K 211	Standard has been and is being met.	

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K 211	<p>Continued From page 7</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on 4/2/15 between approximately 0930 and 1415 hours the facility has failed to properly install alcohol based hand rub dispensers. Dispensers installed improperly could result in hand rub coming in contact with an electrical source resulting in a fire causing potential endanger to residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to:</p> <p>There was an ABHR device installed directly above an electrical outlet in the employee breakroom.</p> <p>The above was discussed and acknowledged by the Maintenance Director.</p>	K 211	<p>Electronic record for testing attests to this. Staff member was reminded/instructed to provide electronic record of testing for emergency lighting during future Fire and Life Safety surveys.</p> <p><u>Part 2: Identifying Residents at Risk</u></p> <p>Residents are not at risk at this time. Testing has occurred and is currently occurring as required. Documentation of this has taken place and continues to take place. The appropriate documentation existed but was not provided during the survey. It was however provided the following day.</p> <p><u>Part 3: Systemic Changes</u></p> <p>To ensure that a delay of this nature does not recur, Environmental Services staff will be provided education and training by May 5, 2015. Education and training will include facility procedures for providing the appropriate electronic record of testing for emergency lighting during the actual survey.</p> <p><u>Part 4: Assurance of On-Going Compliance</u></p> <p>The Environmental Services Director and/or designee will continue to conduct and electronically document testing of emergency lighting as required.</p>	

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			<p>Environmental Services Director, Administrator to ensure correction.</p> <p>K 062 SS = E</p> <p>It is the policy of the facility to continuously maintain in reliable operating condition the automatic sprinkler system and ensure that it is inspected and tested periodically.</p> <p>Part 1: Individual Corrective Action</p> <p>No individual resident identified.</p> <p>Corrective action will include:</p> <ol style="list-style-type: none"> 1) the fusible link in the sprinkler head above the kitchen pass-through window will be cleaned of paint and/or replaced if needed; 2) the fusible link on the sprinkler head in the main housekeeping closet will be cleaned of paint and/or replaced if needed. <p>Part 2: Identifying Residents at Risk</p> <p>To protect residents, the Environmental Services Director and/or designee will conduct a room by room audit to ensure all doors to hazardous areas meet this requirement and that all sprinkler head fusible links are free of paint. Any fusible link identified with paint on it will be cleaned of paint and/or replaced if needed to meet the requirement.</p>	5/5/15

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

TITLE

(X6) DATE

[Handwritten Signature]

9/10/15

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			<p><u>Part 3: Systemic Changes</u></p> <p>To ensure that the problem does not recur, Environmental Services and Housekeeping staff will be provided education and training by May 5, 2015. All staff will be provided education and training by May 5, 2015. Education and training will include facility procedures for identifying, reporting and maintaining fusible links free of paint.</p> <p><u>Part 4: Assurance of On-Going Compliance</u></p> <p>The Environmental Services Director and/or designee will conduct routine focus audits to ensure sprinkler head fusible links are free of paint. Concerns/trends will be reported to the facility Quality Assurance Committee and the facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Housekeeping Supervisor, Administrator to ensure correction.</p> <p>K 147 SS = D</p> <p>It is the policy of the facility to ensure electrical devices (wiring and equipment) are used properly.</p>	5/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *4/10/15*

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			<p><u>Part 1: Individual Corrective Action</u></p> <p>No individual resident identified.</p> <p>Corrective actions will include:</p> <ol style="list-style-type: none"> 1) removing the power strip used for the fish tank in the Phone room; 2) remove the multi-plug cube style adaptor from resident room #24. <p>Approved electrical devices will be used instead.</p> <p><u>Part 2: Identifying Residents at Risk</u></p> <p>To protect residents in similar situations, the Environmental Services Director and/or designee will conduct a room by room audit to ensure approved electrical devices (wiring and equipment) are used. Replacement devices will be installed/provided as needed.</p> <p><u>Part 3: Systemic Changes</u></p> <p>To ensure that the problem does not recur, Environmental Services and Housekeeping Staff will be provided education and training by May 5, 2015. All staff will be provided education and training by May 5, 2015. Education and training will include facility procedures for identifying, reporting and replacing electrical devices (wiring and equipment) that are not approved for use.</p>	

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

TITLE

(X6) DATE

[Signature] Administrator 4/10/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505099	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPOKANE VAL		STREET ADDRESS, CITY, STATE, ZIP CODE EAST 17121 EIGHTH AVENUE SPOKANE VALLEY, WA 99016		
(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
			<p><u>Part 4: Assurance of On-Going Compliance</u></p> <p>The Environmental Services Director and/or designee will conduct routine focus audits to ensure electrical devices (wiring and equipment) are used properly. Concerns/trends will be reported to the facility Quality Assurance Committee and the Facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Housekeeping Supervisor, Administrator to ensure correction.</p> <p>K 211 SS = D</p> <p>It is the policy of the facility to ensure alcohol based hand rub (ABHR) dispensers are installed properly.</p> <p><u>Part 1: Individual Corrective Action</u></p> <p>No individual resident identified.</p> <p>Corrective actions will include removing the ABRH installed above an electrical outlet in the employee break room. The ABHR will be re-installed in an appropriate location.</p> <p><u>Part 2: Identifying Residents at Risk</u></p> <p>To protect residents in similar situations, the Environmental Services Director and/or designee will conduct a room by room audit to ensure all ABHR locations meet the requirement.</p>	5/5/15

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

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

Printed: 04/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505099	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPOKANE VAL	STREET ADDRESS, CITY, STATE, ZIP CODE EAST 17121 EIGHTH AVENUE SPOKANE VALLEY, WA 99016
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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
			<p><u>Part 3: Systemic Changes</u></p> <p>To ensure that the problem does not recur, Environmental Services staff and Housekeeping staff will be provided education and training by May 5, 2015. All staff will be provided education and training by May 5, 2015. Education and training will include facility procedures for identifying and reporting inappropriate locations for ABHR locations. Also included will be education and training for identifying appropriate ABHR locations.</p> <p><u>Part 4: Assurance of On-Going Compliance</u></p> <p>The Environmental Services Director and/or designee will conduct routine focus audits to ensure ABHR locations meet this requirement. Concerns/trends will be reported to the facility Quality Assurance Committee and the Facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Housekeeping Supervisor, Administrator to ensure correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator DATE 4/10/15

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