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

PRINTED: 03/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185364		02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENTON CENTER	905 HWY 127 NORTH OWENTON, KY 40359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health Survey was conducted from 02/18/14 through 02/20/14 and a Life Safety Code survey was conducted on 02/19/14. Deficiencies were cited with the highest scope and severity of an "E".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owenton Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident group interviews and review of the facility's policy, it was determined the facility failed to make efforts to resolve grievance related to labeling and distributing clothing from laundry according facility policy. The findings include: Review of the Healthcare Services Group Incorporated, Processing Resident Personal Clothing policy, dated 02/01/03, revealed all resident laundry should be labeled before going into the resident's new room upon admission. The Housekeeping/Laundry Manager should coordinate with Admissions and Social Services to go through all resident clothing to update labeling. Tracking resident clothing through the facility included having an accurate list. Do not let unmarked clothing accumulate in the laundry. Staff are to bring any unmarked clothing from that	F 166	1. The Administrator and/or Social Services Director met with residents B, C, D, E and F on 3/14/14 to see if there were additional grievances that had not been resolved. There were no new concerns noted. All previous concerns for these residents were addressed and missing items were found or replaced at center's expense.	04/05/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Tresa A Roman
TITLE: X Administrator
(X6) DATE: X 3-26-14

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 166	Continued From page 1 day up to the units for identification by Certified Nursing Assistants (CNA). Label unmarked clothing as soon as it is identified. Review of the facility's Grievance/Concern policy, revised 06/10/13, revealed all patients and or their representatives may voice grievances/concerns and recommendations for changes. Center leadership would investigate, document, and follow up on all formal concerns and grievances registered by any patient or patient representative. Social Services personnel would serve as patient advocates in the grievance/concerns process. The purpose of the policy was to assure prompt receipt and resolution of patient/representative grievance/concern. Completed grievance/concerns form would be reviewed and retained by the Administrator to assure the patient's interest had been addressed. Review of grievances/concerns forms during the Quality Improvement Committee meeting was to identify trends. Review of the Resident Council Minutes for four (4) months, revealed a meeting held, on 02/19/14 at 2:30 PM, had several residents in attendance and they voiced concerns about missing laundry items. Interview with a total of eight (8) residents during the Group Quality of Life meeting, on 02/18/14 at 4:00 PM, revealed five (5) residents, Unsampled Resident B, C, D, E, F had general complaints about laundry items not being returned to them consistently. Three (3) of the five (5) residents stated they gave there concerns to the Social Services Director (SSD). Unsampled Resident C revealed he/she had	F 166	2. The Administrator met with residents B, C, D, E and F as well as the entire Resident Council on 3/14/14 to identify whether any other residents had been affected or had concerns related to missing clothing. No other resident council member reported missing clothing items or unresolved grievances. On 3/26/14, the Administrator and/or the Social Services Director, and/or the Director of Admissions interviewed all interviewable residents to determine if any had missing clothing items or a grievance that had not been resolved. No concerns were identified. The Administrator drafted a letter to all residents and family members explaining the policies and requesting them to report any missing clothes or grievance to the Administrator, Director of Nursing or Social Services Director upon receipt of the letter. The letter was mailed to all residents' responsible parties on 3/27/14. The Administrator also reviewed the grievance policy and procedure, lost and found, no name laundry,	

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F 166	Continued From page 2 labeled diabetic shoes missing about four (4) months ago and reported this to the SSD. Unsampled Resident E, revealed he/she was missing a labeled blue shirt about four (4) months ago and this too was reported to the SSD. Unsampled Resident F, revealed he/she was missing a labeled black sweat suit about five (5) months ago and reported it to the SSD and the Administrator. Observation of the Laundry room closet, on 02/20/14 at 9:20 AM, revealed seven (7) bags of unlabeled clothes. Two (2) undated pieces of paper pinned to the wall inside the laundry room, one labeled 100 unit and the other 200 unit. Interview with Laundry Staff #1, on 02/20/14 at 9:20 AM, revealed the seven (7) bags of laundry were unlabeled resident clothing. She stated she did the laundry on day shift for the 100 unit, missing items are put on a piece of paper pinned on the wall. She looks for the items and will put resident names in them if she can identify who they belong too. She stated she asked the CNA's on the floor to assist with identification of resident's clothing, but sometimes some items can not be identified. Interview with Director of Housekeeping and Laundry, on 02/20/14 at 9:35-9:45 AM, revealed his staff kept a list of missing resident items for each unit; however, they are not dated when the missing item was discovered. He did not give the missing item sheets to the Social Service Director until the sheet was filled up. He confirmed he was not able to track when the items were reported missing. The Director stated he did not understand why so many items were missing and the 200 unit had more missing items which were	F 166	missing clothes and labeling of personal clothes/items and identified areas that required clarification or change. These areas included adding a policy specific to lost or no name clothing and the implementation of a monthly schedule for residents to check no name laundry. 3. The Administrator and/or Assistant Director of Nursing/Nurse Educator will re-educate staff, including Healthcare Services Group employees, on the center's grievance policy and procedure by 04/01/14. The policy and procedure for "no name laundry" and "lost and found" has been updated by the Administrator as of 4/4/14 to include specific measures to take when items are either lost or found and to include a monthly schedule when residents can check the no name laundry. The Administrator	

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F 166	Continued From page 3 washed during second shift. He further stated there was not a system in place for a facility wide lost and found return event for residents and families. The Director stated it's a big problem and the residents do get upset when their items are missing. Interview with CNA #3, on 02/20/14 at 2:15 PM, revealed when a resident had missing laundry, she would let the nurse know, but would also search the resident room, go to laundry and let the social worker know if the item was not found. The CNA stated she would assist the resident to the laundry room door to speak with staff about the laundry item and inform them of a missing item. Interview with 200 Unit Manager, on 02/20/14 8:50 AM, revealed lost items are searched for in the resident rooms and in the laundry. If the items are not found she would inform the Social Services Director. She further stated any grievances were reviewed in the 9:00 AM team meeting. The Unit Manager also stated each resident on admission should have had an inventory of all personal items listed, but stated sometimes that gets missed. Interview with the Social Services Director (SSD), on 02/20/14 at 2:30 PM, revealed no grievance was completed for Unsampled Resident C for diabetic shoes and stated she was not aware of the resident missing any shoes. She reported the resident had a bra missing that was labeled 4-6 months ago and was replaced. The SSD stated Unsampled Resident D reported socks missing but were found in the Resident bedside table. The SSD further stated no grievance was made by Unsampled Resident F	F 166	and/or Assistant Director of Nursing/Nurse Educator and/or Housekeeping/Laundry Manager will re-educate staff on the policies and procedures for missing clothes and labeling of personal clothes/items by 4/4/14. The Administrator, Housekeeping/Laundry Manager and the Activity Director have established a monthly schedule to bring unmarked clothing to the Activity Room (Joy Room) for residents to identify missing items. The Administrator will notify residents and family members in writing as of 4/1/14 on no name laundry, lost and found, grievance policy and procedure, missing clothes and labeling of personal clothes/items.	

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F 166	Continued From page 4 for a missing black sweat suit 4-5 months ago, but on 08/07/13 unsampled Resident F reported multiple clothing items missing and after a search for the items, they were not found, and the facility replaced the items. In Oct 2013 Unsampled Resident F also reported missing items at another time to her, but these items were found in the residents room and the issue was resolved. The SSD stated the system was broken regarding making sure inventory sheet are up to date and she had not updated the inventory sheets as she ordered new items for residents in the past. She further stated the facility needed a better system for tracking resident clothing and the residents are upset about the topic. She further stated it was an ongoing issue in the Resident Council meetings. The SSD stated after three (3) months of clothes accumulating they are donated and some overflow items are stored outside in the locked building. Observation with the Director of Housekeeping and Laundry Services, on 02/20/14 at 3:25 PM, revealed five (5) large bags full of clothing in the locked building in the back of the facility. Interview with the Director of Housekeeping and Laundry Services, on 02/20/14 at 3:25 PM, revealed the clothing belonged to the residents, but which resident, he did not know and he had no documentation or a way to identify any of the items in the five bags. Interview with Activities Director, on 02/20/14 at 3:30 PM, revealed she had not received any information from the Laundry Department about a pile up of unlabeled clothing items. She further stated a newsletter was provided to families and the State Guardianship workers to inform them of	F 166	4. Compliance will be monitored monthly in the Performance Improvement meeting. The Administrator will bring all grievances to the meeting for review and further recommendation for a period of six months or until compliance has been achieved for three consecutive months. To ensure continued compliance, the Administrator and/or Social Services Director will review the Facility Grievance Log five days a week ongoing to determine compliance with prompt resolutions to grievances including missing clothes. Any areas of concern noted will be addressed at this time. The Administrator and/or Social Services Director will present a summary of the review findings to the monthly Performance Improvement Committee for six months for review and further recommendations.	

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F 166	Continued From page 5 the lost and found clothing items, but the Activities Director was not able to provide a copy of the newsletter during survey. Interview with Business Office Manager, on 02/20/14 at 3:40 PM, revealed she had never held an event to assist facility residents with lost and found items. Interview with Administrator, on 02/20/14 at 3:40 PM, revealed she took over the complaints for the SSD due to the increase in complaints about the Laundry Services. The Administrator further stated the service was contracted and the facility was getting a new director. She further stated the system for Laundry Services could improve with better tracking of resident's laundry.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 privacy of the body during dressing for one (1) of twenty (20) sampled residents, (Resident #16) and failed to ensure staff sat while feeding residents for one (1) of six (6) unsampled residents, (Unsampled Resident A). Staff failed to close the door to the hallway when assisting Resident #16 with putting on a shirt. In addition, staff failed to sit while assisting	F 241	1. Resident A and resident # 16 were evaluated by the Social Services Director 3/13/2014 to determine if any negative outcomes had occurred. There was no evidence of a negative outcome for resident A and # 16. Findings from the Social Service Directors evaluation is documented in the Social Service notes in resident A and # 16 medical records.	04/05/14

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F 241	Continued From page 6 Unsampled Resident A with eating. The findings include: Review of the Patients Bill of Rights and Responsibilities, dated 09/01/13, revealed each resident should be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for personal needs. 1. Review of Unsampled Resident A's clinical record revealed the facility admitted the resident with Alzheimer Disease, Difficulty in walking, Abnormal Posture and Dysphagia. Review of the Minimum Data Set (MDS), dated 02/09/14, revealed the facility assessed Unsampled Resident A with a BIM score of 03, which meant the resident was not interviewable. Observation of Unsampled Resident A, on 02/19/14 at 12:20 PM, revealed Certified Nursing Assistant (CNA) #1 was standing up while assisting Unsampled Resident A with eating his/her lunch in the Joy Room. Further observation revealed there was a chair located at the same table on the left side of the resident that was not utilized. Interview with CNA #1, on 02/19/14 at 12:50 PM, revealed CNA #1 remembered being in the Joy Room assisting Unsampled Resident A with eating his/her meal. CNA #1 stated she did not realize she was standing while assisting Unsampled Resident A. CNA #1 stated when she stood up to assist Unsampled Resident A it could have made the resident feel awkward and could have been a dignity concern.	F 241	2. The Director of Nursing, Nurse Practice Educator and the Unit Managers completed observations on 2/21/14 during resident care and meal service to determine care was provided with consideration, respect and dignity to include privacy. No concerns were identified. 3. The Nursing Staff were re-educated on 2/21/2014 by the Director of the Nursing and the Nurse Practice Educator on Residents Rights to include providing privacy during resident care and promoting dignity by sitting during meal service while assisting residents to eat meals. A post test was given to the Nursing Staff on 3/31/14 by the Nurse Practice Educator or the Unit Manager to determine competency of education provided. All new hire	

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F 241	Continued From page 7 Interview with the Unit Manager of the 100 Hall, on 02/20/14 at 1:20 PM, revealed when staff assist residents with their meals, the staff should not be standing. The feeling of having someone stand over you was not comfortable. Interview with the Director of Nursing (DON), on 02/20/14 at 1:54 PM, revealed staff should not stand up when assisting residents with eating. The DON stated it could be a dignity issue because the resident could feel like they were an inconvenience or a bother to the staff. 2. Review of the clinical record revealed the facility admitted Resident #16, on 02/13/14, with Pneumonia and a history of unspecified Intellectual Disabilities and Convulsions. The MDS had not been completed as it was not due. The nurses note dated 02/15/14, revealed Resident #16 was non-verbal. Observation, on 02/20/14 at 8:00 AM, revealed Resident #16's door was wide open and the privacy curtain was not pulled to obstruct the view from the hallway. Resident #16 was sitting on the edge of the bed wearing only an adult brief exposing the breast area. Certified Nursing Assistant (CNA) # 2 had her back to the door while assisting Resident #16 with a shirt. Attempted Interview with Resident #16, on 02/20/14 at 8:15 AM, revealed when the Resident was asked a question, he/she did not answer and only looked at the questioner.	F 241	employees will be educated by the Social Service Director on Residents Rights to include privacy and Dignity during new hire orientation. The Nurse Practice Educator will provide re-education to Nursing Staff with annual competencies and/or when an issue is identified with Residents Rights to include sitting during meals. 4. The Director of Nursing, Nurse Practice Educator, Unit Managers and /or Nursing Supervisor will complete rounds 7 days a week for four weeks then monthly for five months observing meal service and resident care area to determine care is provided with consideration ,respect and privacy to promote dignity and individuality of the residents. Areas of concern will be corrected when found. The Director of Nursing will submit results of the rounds to the Performance Improvement Committee monthly for further review and recommendations.	

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F 241	Continued From page 8 Interview with CNA #2, on 02/20/14 at 2:00 PM, revealed CNA # 2 was provided training on resident rights which included dignity during her orientation approximately five (5) months ago. The CNA stated the door to Residents #16's room was left open while she assisted the resident with putting on clothing. She further stated she should have shut the door while dressing Resident #16. Interview with CNA #3, on 02/20/14 at 2:15 PM, revealed when providing personal care to the residents it was important to shut the doors and pull the curtains to provide privacy. She further stated she would have wanted the door closed if she was undressed. Interview with the Director of Nursing (DON), on 02/20/14 at 4:05 PM, revealed staff should have closed the resident's door and pulled the curtain if it applied, when personal care was provided. She further stated no one wants to be seen in the nude and privacy should have been provided. The DON stated all facility staff was provided training on dignity, and not doing so, was not their standard of practice.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure the outside smoking areas were maintained and free of trash.	F 253	1. The Maintenance Director and Housekeeping/Laundry Manager have cleaned the courtyard and front porch on 2/21/14 and disposed of all trash and cigarette butts. The Administrator and Housekeeping/Laundry Manager established a cleaning schedule for the cleaning of the porch and courtyard as of 4/4/14.	04/05/14

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F 253	Continued From page 9 The facility had two (2) designated smoking areas for residents, the front porch and a courtyard. Both of the two (2) smoking areas were littered with cigarette butts in the landscape mulch and the flower containers. This is a repeat deficiency from the 03/21/13 Standard Survey. The findings include: The facility did not provide a policy related to cigarette trash and disposal. Observation, on 02/18/14 at 8:30 AM and 02/19/14 at 8:35 AM, revealed hundreds of cigarette butts in the snow of the landscape mulch, on the ground, and in flower containers on both sides of the front porch. On 02/19/14 at 10:11 AM, the Maintenance Director was observed to pick up cigarette butts in the courtyard landscape. Continued observation on, 02/20/14 at 2:19 PM, revealed the courtyard had dozens of cigarette butts in the landscape mulch. Interview, on 02/20/14 at 1:40 PM, with Certified Nurse Assistant (CNA) #2 revealed she was unaware who was responsible to maintain the two (2) resident smoking areas. She stated as an aide it was not her responsibility. The aide indicated the CNAs were responsible to monitor residents who were supervised smokers. She further indicated cigarette butts should be disposed into the designated receptacle and if a resident was not capable, the aide would dispose of the cigarette for the resident. The CNA stated she had picked up cigarette butts and had seen the Maintenance Director pick up cigarette butts in the past. She indicated she was unsure how often cigarette trash should be picked up. The	F 253	2. Rounds were conducted on 2/21/14 by the Maintenance Director and Administrator to determine further issues with trash and cigarette butts and/or other environmental concerns. This was done by using the preventive maintenance checklist. All identified issues were corrected immediately. There were no issues noted that affected other residents. 3. The Maintenance Director and Housekeeping/Laundry Manager were re-educated by the Administrator on 3/26/14 on proper cleaning of facility grounds including the removal of cigarette butts to maintain a sanitary, orderly and comfortable environment. The Administrator and/or Maintenance Director will complete environmental audits including disposal of trash and cigarette butts.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185364		02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENTON CENTER	905 HWY 127 NORTH OWENTON, KY 40359

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F 253	Continued From page 10 aide stated disposing of cigarette butts into the landscaping was a risk to residents due to the potential for the landscape to catch fire. On 02/20/14 at 1:55 PM, interview with Licensed Practical Nurse (LPN) #3 revealed the nurses did not maintain the smoking areas and it was the responsibility of housekeeping to clean up the cigarette butts. She stated the cigarette trash should not be in the landscaping. LPN #3 stated she had picked up cigarette butts from the grounds in the past. LPN #3 indicated the facility conducted smoking evaluations for residents to determine if the resident could smoke unsupervised. She further indicated unsupervised smokers may have disposed of cigarette trash on the grounds. LPN #3 stated the cigarette butts in the landscape could cause a fire at the facility. Interview with both the Director of Housekeeping (DH) and the Maintenance Director jointly, on 02/20/14 at 2:19 PM, revealed the DH stated housekeeping swept the smoking areas; however, did not remove cigarette trash from the landscaping. Maintenance stated he had removed cigarette trash from the landscaping and grounds; however, housekeeping was responsible to clean cigarette trash for disposal. He indicated he was unaware housekeeping was not removing cigarette butts from the landscape and grounds. Maintenance further indicated he was not doing rounds of the smoking areas and it was the responsibility of housekeeping. He stated if the cigarette butts were disposed of in the landscape there was a risk of fire to the facility. Interview, on 02/20/14 at 2:25 PM, with the Director of Nursing (DON) revealed she thought it may have been the responsibility of	F 253	4. The Administrator and/or Maintenance Director will conduct environmental audits of the facility and facility grounds five times a week for two months then weekly ongoing to determine compliance with a sanitary, orderly, and comfortable environment including removal of trash and cigarette butts from the facility grounds. Any concerns identified will be addressed at that time. A summary of the audit findings will be submitted monthly to the Performance Improvement Committee for six months for further review and recommendations.	

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F 253	Continued From page 11 housekeeping and maintenance to maintain the smoking areas. The DON indicated the CNAs who monitor residents smoking should ensure the cigarette butts were not thrown to the ground, and should pick up the trash if the cigarettes were thrown to the ground. She stated she did not conduct outside rounds of the facility. The DON indicated the CNAs should monitor and cue residents to dispose of their cigarette trash in appropriate receptacles. The DON further indicated throwing cigarettes into the landscape was a safety risk and could cause a fire. Additionally, the DON stated cigarette butts in the landscape did not appear homelike and she would not want her home to look like the facility's smoking areas. On 02/20/14 at 2:55 PM, interview with the Administrator revealed housekeeping and maintenance were responsible to maintain the smoking areas. She stated she usually completed daily rounds and completed a round yesterday. The Administrator indicated during yesterday's rounds she identified cigarette butts in the snow of the landscape at the front porch however she did not round in the courtyard. She further indicated she had spoken to the DH and Maintenance about cigarette trash; however, was unable to recall when the discussion occurred. The Administrator stated the CNAs were responsible to monitor and cue residents who needed to be supervised of where to dispose of cigarettes. Additionally, residents that the facility assessed as able to smoke unsupervised could smoke at any time. The Administrator stated there was not any staff members assigned to follow up with unsupervised smokers to ensure cigarette trash was disposed in an appropriate receptacle.	F 253		

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility	F 431	1. The medication carts for the 100 hall were cleaned by a Licensed Practical Nurse on 2/20/2014. 2. The Director of Nursing completed an audit of all other medication /treatment carts to determine cleanliness on 2/21/2014. No other areas of concern were identified. 3. The Nurse Practice Educator provided education on Infection Control to include cleaning of medication carts to the Registered Nurses, Licensed practical nurses, and Kentucky Medication Assistants on 2/21/2014. A cleaning schedule was implemented on 2/20/2014 by the Director of Nursing for Licensed Practical Nurses, registered Nurses and Kentucky Medication Assistants.	04/05/14

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F 431	Continued From page 13 policy review, it was determined the facility failed to ensure sanitation was maintained for two (2) of four (4) medication carts. The findings include: The facility did not provide a policy on maintaining medication carts. Interview with the Director of Nursing (DON), on 02/20/14 at 2:10 PM, revealed the facility does not have a policy on maintenance of the medication carts. The DON stated cleaning the medication carts was not an assigned task for any one person to do. Observation of four medication carts, on 02/20/14 at 9:30 AM, revealed the medication carts for 100 Back Hall and 100 Front Hall had yellow and brown sticky substances with brown particles in the bottom drawers. Interview with LPN #2, on 02/20/14 at 9:50 AM, revealed the drawers in the medications carts should be cleaned on a regular basis. She stated it was an infection control problem when the drawers were allowed to get sticky and dirty. Interview with LPN #1, on 02/20/14 at 10:00 AM, revealed she did not know whose responsibility it was to clean the medication carts. She stated it was an infection control issue when the drawers were allowed to get so sticky. She stated it was hard to keep those drawers clean because liquids get spilled on the outside of the bottles and that gets in the drawer. Interview with 100 Hall Unit Manager, on 02/20/14 at 11:15 AM, revealed it was all nurses	F 431	4. The Director of Nursing, Nurse Practice Educator and /or the facility Unit Managers will conduct drug record, storage and Biological audits including cleanliness of the medication/treatment carts and the daily cleaning schedules five times a week for four weeks then monthly to determine compliance with Drug records, label and storage of drugs/biologicals. Areas of concerns will be corrected when identified. The Director of Nursing will submit a summary of the audit findings to the Performance Improvement Committee monthly for six months for further review and recommendations.	

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F 431	Continued From page 14 responsibility to keep the medication carts clean. She stated the girls have tried to clean the drawers with no success. She stated the sticky substance in the drawer was an infection control problem due to the dirt. Further interview with the Director of Nursing (DON), on 02/20/14, revealed she looked at the drawers in the two 100 Hall medication carts and agreed they were "nasty". She stated it looked like it was spilled liquid medication. The DON stated the spilled sticky substance in the drawers collect dust and dirt and was an infection control problem.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	1. Resident # 2 was assessed by the Unit Manager on 2/20/2014 for signs and symptoms of infection. No signs or symptoms of infection were identified. LPN #1 was re-educated on infection control and aseptic technique for dressing changes on 2/21/2014 by the Director of Nursing	04/05/14

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F 441	Continued From page 16 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure an infection control program was followed for one (1) of twenty (20) sampled residents, (Resident #2). Staff failed to wash their hands when moving from dirty to clean during a treatment for Resident #2. The findings include: Review of the facility's policy regarding Wound Dressing: Aseptic, revised 01/02/14, revealed the staff was to expose the area to be treated, then apply clean gloves and remove the soiled dressing. Discard the dressing and gloves according to the infection control policy. The staff should cleanse their hands, apply gloves, then cleanse or irrigate the wound as ordered. If the gloves become contaminated, remove the gloves, cleanse hands and then apply clean gloves. Apply the treatment medication with clean gloves then	F 441	2. The Director of Nursing, Nurse Practice Educator and /or the Unit managers conducted an audit of all residents receiving wound treatments to determine infection control practices were followed to include washing hands, applying and removing gloves on 2/21/14. No areas of concern were identified. A review of the Infection Control log was completed by the Director of Nursing on 3/26/14 for current residents listed and for the previous three months to determine if infections results from hand hygiene technique. No areas of concern were identified. 3. The Nurse Practice Educator re-educated the Licensed Nursing staff on the facility Infection Control Policy related to hand	

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F 441	Continued From page 16 apply and secure the clean dressing. Review of the Hand Hygiene policy, revised 10/01/13, revealed the staff was to wash their hands with soap and water in the following situations: after removing gloves; or other personal protective equipment. Review of Resident #2's clinical record revealed the facility readmitted Resident #2 on 09/28/13, with diagnoses of Pressure Ulcer, Obesity and Chronic Hepatitis C. Review of the Minimum Data Set (MDS) Quarterly Assessment, dated 11/29/13, revealed Resident #2 had a pressure to his/her coccyx, right toe and the heel. Observations of Licensed Practical Nurse (LPN) #1, on 02/19/14 at 10:56 AM, revealed LPN #1 washing her hands and donning gloves. LPN #1 then removed Resident #2's flotation boots from the left heel and then cleaned Resident #2's wound. LPN #1 then removed her gloves without washing or sanitizing her hands and donned new gloves. LPN #1 then applied Santyl (ointment) and Alginate to the left heel and wrapped it with Kerlix. Interview with LPN #1, on 02/19/14 at 11:10 AM, revealed she realized she did not wash her hands when moving from dirty to clean. LPN #1 stated she should have washed or sanitized her hands. LPN #1 stated she had sanitizer in her pants pocket and did not use it. LPN #1 stated she should have washed her hands because it prevented the spread of germs to the clean wound. Interview with the 100 Hall Unit Manager, on 02/20/14 at 1:20 PM, revealed LPN #1 should	F 441	washing and applying and removing gloves as of 4/4/14. A post test will be given to determine competence. Newly hired licensed nurses will be educated by the Nurse Practice Educator on infection control practices, including hand washing and appropriate use of gloves, in orientation and ongoing. 4. The Director of Nursing and /or Unit Managers will complete infection control audits five times a week for one month, weekly for two months and then monthly for three months to determine compliance with infection control practices and procedures including hand washing and appropriate use of gloves. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of the audits to the Performance Improvement Committee monthly for six months for further review and recommendations.	

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F 441	Continued From page 17 have started her process all over again if she did not complete the dressing change well. LPN #1 should have washed her hands when donning new gloves. The 100 Hall Unit Manager stated they washed their hands for infection purposes. Interview with the Director of Nursing (DON), on 02/20/14 at 1:54 PM, revealed nurses should wash their hands when removing gloves and between changing a dirty dressing and cleaning the resident wound. Staff should wash their hands because it is a universal precaution and prevents the spread of infection.	F 441		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to record the number of hours the Certified Nursing Assistants (CNA's) attended an inservice class for a one year period,	F 497	1. The Director of Nursing conducted rounds of the facility and observed Certified Nursing Assistances providing care to residents on 3/14/2014 to determine if there were any negative out comes as a result of the 12 hours of in-service education documentation, no concerns were identified.	04/05/14

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F 497	Continued From page 18 2013. The findings include: Review of the inservice education records for CNAs revealed each CNA had an education sheet in a binder which listed inservice programs they had attended, but there was no documented evidence of the length of time for each inservice attended. Interview with the Director of Nursing (DON), on 02/20/14 at 3:30 PM, revealed she was unable to validate the time frames for each of the in-service programs listed. Therefore, it was impossible to state the current CNA staff had attended twelve (12) hours of in-service education. Interview with the Manager of Clinical Operations (MCO), on 02/20/14 at 3:45 PM, revealed the length of time should have been documented on the education log for each CNA in order to validate the CNA had attended the required twelve (12) hours of yearly in-service education. In addition, both the DON and the MCO were unable to locate in the facility's computer system a list of education inservice with the length of time for each program.	F 497	2. Certified Nursing Assistants education records were audited by the Director of Nursing /Nurse Practice Educator on 3/14/2014, to determine education hours needed. Hours were calculated and added to the education record by the Director of Nursing/Nurse Practice Educator on 3/14/2014. 3. The Director of Nursing re-educated the Nurse Practice Educator on the requirement of 12 hours of yearly in-service education for Certified Nursing Assistances on 3/6/2014. Education included the documentation of hours obtained by the Certified Nursing Assistant during in-services was the responsibility of the Nurse Practice Educator. The Nursing Assistant Education Tracking tool was implemented as of 4/4/14 by the Director of Nursing to track education hours.	

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{F 000}	INITIAL COMMENTS Based upon the implementation of the acceptable POC, the facility was deemed to be in compliance, 04/05/2014, as alleged.	{F 000}		

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

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENTON CENTER	**905 HWY 127 NORTH** **OWENTON, KY 40359**

(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 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, as of 04/05/2014, 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.

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

PRINTED: 02/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185364		02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENTON CENTER	905 HWY 127 NORTH OWENTON, KY 40359

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1977 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V, Protected Construction. SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system with smoke detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II, 200 KW generator, installed in 1991. Fuel source is diesel. A standard Life Safety Code survey was conducted on 02/19/14. Owenton Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire.) The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	4. The Director of Nursing and /or the Nurse Practice Educator will review ten Certified Nursing Assistants' education records weekly for one month, twice a month for one month, then monthly for three months. Areas of concern will be corrected when identified. The Director of Nursing will submit results of the audits to the Performance Improvement Committee monthly for further review and recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Lisa A Komens
TITLE: X Administrator
(X6) DATE: X 3-26-14

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	Continued From page 1 Fire).	K 000	1. There were no residents affected by this alleged deficient practice.	04/05/14
	Deficiencies were cited with the highest deficiency identified at "E" level.			
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was ninety-six (96) on the day of the survey. The findings include: Observations, on 02/19/14 between 10:12 AM and 11:18 AM, with the Maintenance Director revealed the doors to the Storage Room in the	K 029	2. Self-closing devices were installed on the doors of the Storage Room in the 100 Long Hall, the Storage Closet within the Assistant Director of Nursing office, and the Medical Records Room within the Copier room on 2/21/14 by the Director of Maintenance. The Storage Closet in the Administrator's office was emptied as of 4/4/14 by the Maintenance Director and/or the Health Information Manager and the room will no longer be used for storage. 3. The Maintenance Director was re-educated by the Regional Maintenance Director as of 4/4/14. Education included review of the life safety regulations specifying the use of self-closing doors. The Maintenance Director will conduct weekly rounds to validate self closing doors are being used appropriately and the room is not being used for storage.	

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K 029	Continued From page 2 100 Long Hall, the Storage Closet within the Assistant Director of Nursing Office, the Medical Records Room within the Copier Room, and the Medical Records Room within the Administrator's Office did not have self-closing devices installed on the doors. Interviews, on 02/19/14 between 10:12 AM and 11:18 AM, with the Maintenance Director revealed he was not aware of the doors to the Storage Room in the 100 Long Hall, the Storage Closet within the Assistant Director of Nursing's Office, the Medical Records Room within the Copier Room, and the Medical Records Room within the Administrator's Office did not have self-closing devices installed on the doors. Interview, on 02/19/14 at 1:09 PM, with the Administrator revealed she was not aware of the doors to the four (4) rooms storing combustible materials not being equipped with self-closing devices. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the	K 029	4. Results of the weekly rounds will brought to the Performance Improvement meeting monthly for further review and recommendation until compliance has been achieved for three consecutive months and then monthly thereafter. The Administrator or Maintenance will bring a summary of the results of the rounds for further review and recommendations.	

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K 029	Continued From page 3 following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a means of egress, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was ninety-six (96)	K 130	1. There were no residents affected by this alleged deficient practice. 2. The Maintenance Director and the Administrator made rounds of the facility on 3/26/14 to validate no other unapproved locks were in use in the facility. There were no issues identified. The padlock on the Storage Closet in the Administrator's office was removed by the Maintenance Director and the closet was emptied by the Maintenance Director and Health Information Manager as of 4/4/14 and the	04/05/14

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K 130	Continued From page 4 on the day of the survey. The findings include: Observation, on 02/19/14 at 11:18 AM, with the Maintenance Director and the Administrator revealed an unapproved lock [pad lock type] was installed on the egress side of the door to the Medical Records Room within the Administrator's Office. Interview, on 02/19/14 at 11:18 AM, with the Maintenance Director and the Administrator revealed they were unaware the pad lock was prohibited and could be a deterrent to exiting the room in the event of an emergency. 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 use of a tool or key from the egress side.	K 130	room will no longer be used for storage. 3. The Maintenance Director will conduct weekly rounds to validate there are no areas in the center that have an unapproved lock on the door and that the room in the Administrator's office is not being used for storage. 4. Results of the weekly rounds will brought to the Performance Improvement meeting monthly for further review and recommendation until compliance has been achieved for three consecutive months and then monthly thereafter. The Administrator or Maintenance will bring a summary of the results of the rounds for further review and recommendations.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect each one (1) of four (4) smoke	K 147	1. There were no residents affected by this alleged deficient practice.	04/05/14

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K 147	Continued From page 5 compartments, approximately twenty-five residents, staff and visitors. The facility had one-hundred (100) certified beds and the census was ninety- six (96) on the day of the survey. The findings include: Observation, on 02/19/14 at 10:28 AM, with the Maintenance Director revealed access to an electrical panel located within a Utility Room in the 100 Short Hall had been blocked with a work cart stored within 3 feet of access to the panel. Interview, on 02/19/14 at 10:28 AM, with the Maintenance Director revealed he was unaware of the work cart being temporarily stored within three (3) feet of the electrical panel. Interview, on 02/19/14 at 1:09 PM, with the Administrator revealed she was not aware of the Work Cart being temporarily stored in front of an electrical panel. Reference: NFPA 70 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while	K 147	2. On 2/21/14, the Maintenance Director and Regional Maintenance Director conducted rounds of the facility to ensure no other areas were affected by this. No areas of concern were noted and no other areas had improper storage. The Maintenance Director taped off an area in front of the electrical panel on 2/21/14 to alert staff not to place anything within 3 feet of access to the panel. 3. The Administrator and/or Maintenance Director will conduct daily rounds Monday through Friday to validate nothing is being stored within 3 feet of the electrical panel access. The weekend manager will conduct rounds on the weekend. If items are found to be stored within the 3 feet range, it will be corrected immediately. Nursing and Housekeeping staff will be re-educated by the Maintenance Director on this process as of 4/4/14.	

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K 147	Continued From page 6 energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground Minimum Clear Distance Condition 1 Condition 2 Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft) 1.2 m (4 ft)	K 147	4. Daily rounds will be conducted for a period of one month, weekly rounds will be conducted for a period of two months and monthly rounds will be conducted thereafter. Results of these rounds will be brought to the Performance Improvement Committee monthly meetings by the Administrator for further review and recommendations.	

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