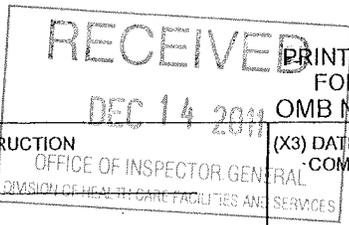


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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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
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F 000	INITIAL COMMENTS A Standard Health Survey was conducted 11/07/11 through 11/10/11 and a Life Safety Code survey was 11/07/11. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey was conducted 11/07/11 through 11/10/11 investigating KY17051 and KY17308. The Division of Health Care unsubstantiated the allegation due to lack of sufficient evidence; however, Federal deficiencies were cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the Resident Trust Statements/Discharges and Medicaid Eligibility Policy, it was determined the facility failed to convey within 30 days of resident death, funds and final accounting of those funds, to individuals administering the resident estate, for two (2) of five (5) unsampled residents. Unsampled Residents A and B. The findings include:	F 160	F160 CONVEYANCE OF PERSONAL FUNDS UPON DEATH 1. Resident #A's account was closed on 09-13-11. Resident #B's account was closed on 09-20-11. 2. The Executive Director (ED) and Business Office Manager (BOM) conducted an audit of all residents that have died in the past 30 days and found that all accounts were closed timely. 3. The ED and BOM will complete a weekly review of all residents who have expired to ensure accounts are closed within the thirty day requirement. 4. The Regional Manager of Field Accounting (RMFA) will conduct a monthly audit for the next 90 days to ensure compliance with requirement.	12/20/11

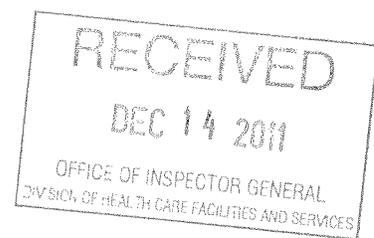
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Paula Perm. Dr.* TITLE *Executive Director* (X6) DATE *12-12-11*

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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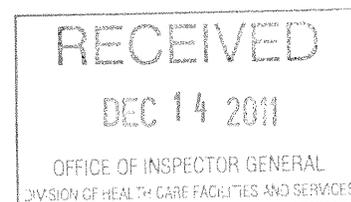
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F 160	Continued From page 1 Review of the Resident Trust Statements/Discharges and Medicaid Eligibility Policy, revised 9/1/05, revealed per Federal Regulations, upon the death of a resident with a Resident Trust Fund deposited with the facility, the facility must disburse that resident's funds within 30 days, and a final accounting of those funds provided to the responsible party, state agency or probate jurisdiction administering the estate. Record review of Resident #A, revealed he/she expired on 08/12/11. The facility closed Resident #A's account on 09/13/11. Interview with the Business Office Manager, on 11/10/11 at 3:00 PM, revealed she owed the family money and had to wait on the corporate office to provide a full refund before she could write the check. Record review of Resident #B, revealed he/she expired on 08/12/11. The facility closed Resident #B account on 09/20/11. Interview with the Business Office Manager, on 11/10/11 at 3:00 PM, revealed she remembered closing the account. She further stated she was aware the accounts should be closed within 30 days of the Residents death. Interview with the Administrator, on 11/10/11 at 3:40 PM, revealed she monitored accounts every other week, depending on the circumstance and did not know why the accounts were not closed timely. The Administrator further stated she was aware that accounts were to be closed within 30 days of death.	F 160	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> The BOM is responsible to report all findings to Performance Improvement Committee (PIC) Meeting monthly for the next 90 days or until solutions are sustained. F205 NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFER 1. Resident #6 currently resides in the facility. Resident #6 will be provided a copy of Bed-Hold Policy if hospitalization or therapeutic leave occurs. Residents #8, #19, #20 and #21 no longer reside in facility. 2. An audit was conducted by ED and Assistant Executive Director (AED) of all residents who have been hospitalized or on therapeutic leave within the last 30 days. Any resident identified without Bed-Hold Policy notification was corrected at this time.	12/20/11
F 205 SS=E	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	F 205		



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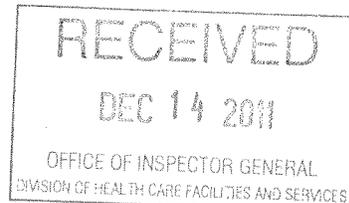
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F 205	Continued From page 2 Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the Transfer and Discharge policy, it was determined the facility failed to provide five (5) of twenty-one (21) sampled residents written information about a Bed hold upon transfer for Resident's #6, #8, #19, #20 and #21. The findings include: Review of the Transfer and Discharge Policy, revised 04/28/10, revealed at the time of transfer/discharge, the resident and a family member or legal representative would be provided a written notice of the bed-hold policy	F 205	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 3. The Director of Nursing Services (DNS) and Assistant Director of Nursing Services (ADNS) conducted in-servicing with all licensed nurses on the Bed-Hold Policy form that will be provided by upon discharge to the hospital or for therapeutic leave. This education was completed on 11/14/11. 4. The DNS and ADNS will review all discharged residents in the morning stand-up meeting, daily, to ensure bed hold policy was provided upon discharge. In addition, the ED and BOM will audit all discharged residents on a weekly basis to ensure Bed-Hold Policy documentation was provided to all residents discharging from the facility. The DNS will report all findings to the PIC monthly for the next 90 days or until solutions are sustained.	12/20/11



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F 205	<p>Continued From page 3 that specifies the duration of the bed-hold and readmission criteria after the bed-hold period ends.</p> <p>Record review of Resident #6's chart revealed the facility transferred Resident #6 to the Hospital on three (3) occasions, 09/01/11, 09/13/11 and 10/20/11 for treatment. The facility could not provide evidence of a written bed hold for this resident.</p> <p>Record review of Resident #8's chart revealed the facility transferred Resident #8 to the hospital for end stage cancer on 11/02/11. The facility could not provide evidence of a written bed hold for Resident #8.</p> <p>Record review of Resident #19's chart revealed the facility transferred Resident #19 to the hospital for toxic metabolic encephalopathy on 06/07/11. The facility could not provide evidence of a written bed hold for the resident.</p> <p>Record review of Resident #20's chart revealed the facility transferred Resident #20 to the hospital on two (2) occasions. Resident #20 was transferred on 07/06/11 for J-tube placement and on 09/01/11 for pancreatic cancer. The facility could not provide evidence of a written bed hold for 07/06/11 or 09/01/11.</p> <p>Record review of Resident #21's chart revealed the facility transferred Resident #21 to the hospital on 10/24/11 for shortness of breath and increased anxiety. The facility could not provide evidence of a written bed hold for Resident #21.</p> <p>Interview with family member #1, on 11/07/11 at</p>	F 205			



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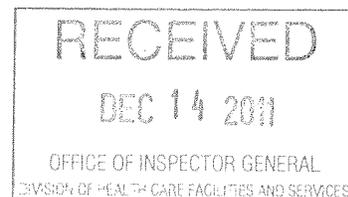
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F 248	Continued From page 5 determined the facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial needs for two (2) of twenty-one (21) sampled resident. Resident #6 and #7. The findings include: Record review of the facility policy on Activity Programs (Revised 06/30/06), stated a resident's interests and needs were identified and a recreation (Activity) program was designed to appeal to his/her interests and enhance the resident's highest practicable level of physical, mental or psychosocial well being. Record review revealed, the facility admitted Resident #7 on 06/04/08 with diagnoses to include Spinal Stenosis, Spasm of Muscle, Colostomy, Diabetes, Hypertension and Anemia. The resident was confined to a wheelchair and required the assistance of staff to get out of bed into the wheelchair to be able to attend activities. Review of the care plan for Resident #7, addressing activities, listed the resident as rarely attending activities out of his/her room by his/her choice. The care plan also listed the resident enjoying watching television and socializing with others at times. The goal outlined for Resident #7 was "I will work on independent act (activities) pursuits daily as desired". The approach was to "respect my right to not attend out of room activities". Interview with the Activities Director, on 11/10/11 at 10:00 AM, revealed the goals for Resident #7 on the care plan were not realistic and did not have an obtainable goal.	F 248	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> the physical, mental, and psychosocial needs. Any revisions identified as needed were made at the time of the audit. 3. The Activities Director will provide all residents with activities calendars monthly for participation as well as make daily announcement prior to the start of each activity to notify residents of activities that will be occurring. 4. The AD and AED will conduct a random audit of 5 residents weekly for the next 90 days to ensure activities, interests and the physical, mental and psychosocial needs are met for each resident. All findings will be reported to PIC by the AD monthly for the next 90 days or until solutions are sustained.	12/20/11
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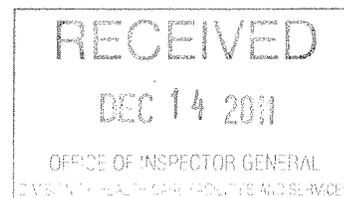
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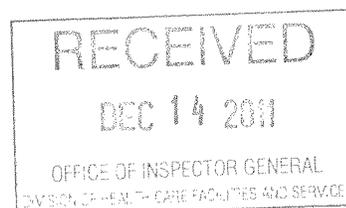
F 248	<p>Continued From page 6</p> <p>Observations, on 11/07/11 at 4:00 PM, 11/08/11 at 9:10 AM, and 11/09/11 at 2:20 PM and 3:30 PM, of Resident #7 revealed the resident in his/her room, lying in bed, not engaged in any activity. The television was on during the observation on 11/08/11 at 9:10 AM.</p> <p>Interview, on 11/09/11 at 2:20 PM, with Resident #7 revealed he/she gets out of bed for two (2) hours a day to attend therapy or work on the computer. He/she was "not really" involved in activities. Activities did provide the computer he/she did work on. However, Resident #7 stated if he/she did not see the calendar of activities posted on the wall while out of bed, he/she would not know what activities were provided. He/she stated a significant interest in books and revealed the activity department did not help him/her with books.</p> <p>Interview, on 11/10/11 at 11:00 AM, with the Activities Director revealed Resident #7 could request to get up to use the computer. He/she was not asked or offered computer use by activities. The facility did not provide an ongoing activities program for Resident #7. Resident #7 would not know what activities were going on in the facility because at present there was not a system in place to notify residents in their room of the activities. She further stated each department was responsible for their part of the care plan and to keep the care plan updated.</p> <p>Record review of the Minimum Data Set (MDS) dated 04/19/11 revealed the facility admitted Resident #6 on 08/18/09 with diagnoses to include Paraplegia, Diabetes Mellitus, Immobility</p>	F 248		
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F 248	<p>Continued From page 7</p> <p>Syndrome and Pressure. The resident was confined to bed and required extensive staff assistance to transfer. Further review of the MDS revealed Resident #6 had no mood or behavior concerns. Continued review revealed the facility assessed Resident #6's activity preferences, which are very important to him/her included: reading; listen to music; doing his favorite activities such as playing cards; exercises; and talking. Review of Resident #6 Nursing Care Plan goals revealed the resident would participate in out of room activities of choice daily and would attend at least one (1) or more out of the room activities per week thru the next period 12/06/11.</p> <p>Observation, on 11/07/11 at 3:00 PM and 4:00 PM, on 11/08/11 at 9:10 AM, 9:50 AM, 10:30 AM and on 11/09/11 at 8:25 AM, 9:30 AM, 10:30 AM, revealed Resident #6 remained in bed with the room dark and wearing a hospital gown. Further observation of Resident #6, on 11/08/11 at 9:10 AM, revealed resident remained in bed while a music activity was being conducted in the North Day room by the Director of Activities and Assistant Director of Activities.</p> <p>Interview, on 11/08/11 at 9:50 AM, with Resident #6 revealed no staff had offered for him/her to attend any activities. He/She would enjoy getting out of his/her room, watching basketball and talking to other residents at times.</p> <p>Interview, on 11/08/11 at 9:55 AM, with CNA #5 revealed she cared for Resident #6 often. She stated she was aware of the activities being conducted in the North Day Room on 11/08/11; however, she did not offer Resident #6 the opportunity to participate in that particular activity.</p>	F 248		



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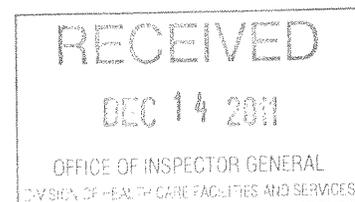
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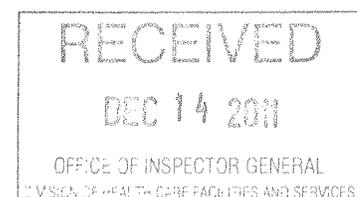
F 248	Continued From page 8	F 248	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 279 SS=D	<p>Interview, on 11/09/11 at 11:40 AM, with the Director of Activities revealed prior to her employment of 10/03/11 no activity documentation or assessments were preformed. She also stated that all residents should be offered the opportunity to attend activities. Resident's not offered the opportunity to be involved in activities could cause psychosocial harm.</p> <p>Review of the activity attendance log sign in sheet, dated 10/01/11 thru 11/08/11, revealed no documentation that Resident #6 had attended one (1) activity the facility offered during this time frame.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment</p>	F 279	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F279 DEVELOP COMPREHENSIVE CARE PLANS</p> <p>1. Resident #5's comprehensive care plan was completed for activities by the AD on 11/10/11.</p> <p>Resident #7's comprehensive care plan was revised by the AD on 11/10/11 to include measurable goals and approaches which would involve the resident in activities.</p> <p>2. The AD, AA, SSD, SSA, MDSC, AED, DNS and ADNS conducted an audit of all resident's care plans to ensure the care plan includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. Any revisions identified as needed were made at the time of the audit.</p>	12/20/11



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F 279	Continued From page 9 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Activity Program's policy and the Comprehensive Plan of Care policy, it was determined the facility failed to use the results of the comprehensive assessment to develop a comprehensive care plan for two (2) of twenty-one (21) sampled residents. Resident #5 had no care plan for activities. In addition, the facility failed to have measurable objectives or timetables on the comprehensive care plan for Resident #7 related to activities. The findings include: Record review of the facility's policy on Activity Programs (Revised 06/03/06) revealed a resident's interests and needs were identified and a recreation (Activity) program was designed to appeal to his/her interests and to enhance the resident's highest practical level of physical, mental, and psychosocial well being. Record review of the facility policy on Comprehensive Plan of Care (Revised 05/28/08) revealed a comprehensive care plan was developed for each resident within seven (7) days after completing the comprehensive assessment. The policy also stated the care plan was to be evaluated to ensure the resident's progress toward goal achievement was evaluated and the developed goals and approaches were resident-centered for each problem or concern.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 3. Education was completed for entire Interdisciplinary Team on care planning process, timetables and measureable objectives on 11/17/11 by DNS and ED. 4. The AD and AED will conduct an audit of 5 comprehensive care plans monthly for the next 90 days and then quarterly thereafter until solutions are sustained. The audit will validate that a comprehensive care plan is developed to meet all residents care needs and revised as necessary. In addition, the ED will randomly audit 5 residents care plans monthly to ensure completion and revision according to policy and procedure and regulation.	12/20/11



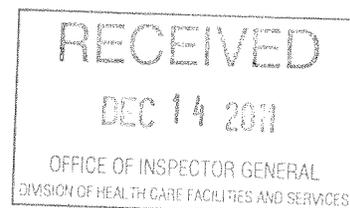
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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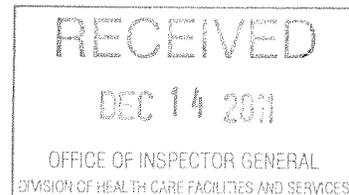
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F 279	<p>Continued From page 10</p> <p>Record review for Resident #5 revealed there was no care plan for activities developed. Interview, on 11/10/11 at 11:00 AM, with the Activities Director revealed there was no care plan for Resident #5 for activities. The Activities Director could not respond as to how the Interdisciplinary Team (IDT) could meet to develop a comprehensive care plan and not develop an activities plan of care for Resident #5.</p> <p>Review of the plan of care for Resident #7 revealed no measurable goals and no approaches listed which would involve the resident in activities. The problem noted for activities included Resident #7 enjoyed the use of the computer and socializing at times. No goal or approach was documented related to computer access, assisting in computer use or socializing activities.</p> <p>Observation, on 11/08/11 at 9:10 AM, revealed Resident #7 in his/her room watching television while in bed. During additional observations on 11/07/11 at 4:00 PM, 11/08/11 at 7:40 AM. Resident #7 was out of the facility for a medical appointment on 11/09/11 until approximately 2:00 PM. At 2:20 PM and 3:30 PM revealed the resident in his/her room not engaged in any activity.</p> <p>Interview with Resident #7, on 11/09/11 at 2:20 PM, revealed he/she gets out of bed for two (2) hours a day to attend therapy or work on the computer. There was not much involvement in activities. However, Activities did provide the computer he/she worked on. Resident #7 indicated if the activity calendar was not posted</p>	F 279		



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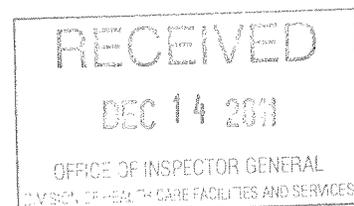
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F 279	Continued From page 11 on the wall, while out of bed, he/she would not know what activities were occurring that day. He/she had a significant interest in books and revealed the activity department did not help him/her with obtaining books. Continued interview with the Activities Director revealed Resident #7 could request to get up to use the computer. He/she was not asked or offered computer use by activities. She revealed the goals for Resident #7 on the care plan were not realistic and did not have an outcome. Resident #7 would not know what activities were going on in the facility because at present there was not a system in place to notify residents in their room of the activities. She revealed the goals for Resident #7 on the care plan were not realistic and did not have an outcome. Resident #7 would not know what activities were going on in the facility because at present there was not a system in place to notify residents in their room of the activities. She revealed the goals for Resident #7 on the care plan were not realistic and did not have an outcome.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
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	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1. All discharged resident's medications were returned to pharmacy and all Sure Step Pro strips were discarded and new were purchased. 2. A complete review of both unit medication rooms was conducted on 11/11/11 by the DNS and ADNS to identify any further medications that needed to be returned. The DNS and ADNS conducted an audit of all Sure Step Pro Strips on 11/11/11 to ensure no expired strips were present. Any identified needed corrections were made during the audits. 3. Education was completed with all licensed nurses related to the return of medications and expired Sure	12/20/11	



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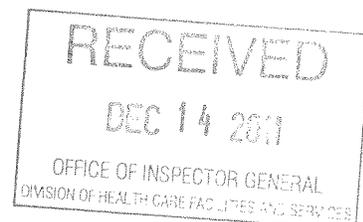
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F 431	<p>Continued From page 12</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State 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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to properly discard resident medication after being transferred from the facility. One (1) un-sampled resident (Resident C) had five (5) vials of IV medication available for use approximately seven (7) months after transfer. The facility failed to dispose of expired biological products, one (1) bottle of expired glucose test strips available for residents use.</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Step Pro Strips on 11/14/11 by the DNS and the Staff Development Coordinator (SDC).</p> <p>4. The DNS, ADNS and Unit Managers (UM) will conduct a weekly audit of all discontinued medications to ensure they are returned to pharmacy within 7 days. Audits will be completed for the next 90 days or until solutions sustained.</p> <p>The DNS, ADNS and UMs will conduct a monthly audit of Sure Step Pro Strips to validate expired vials are not in use. Audits will be completed for the next 90 days or until solutions are sustained.</p> <p>All findings will be reported by the DNS to the PIC monthly for the next 90 days or until solution is sustained.</p>
			12/20/11



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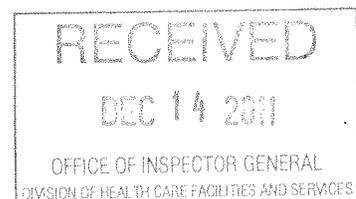
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F 431	<p>Continued From page 13</p> <p>The findings include:</p> <p>Review of the facility policy on Storage of Medications, dated 02/23/11, revealed if a resident was discharged or the medication was discontinued, remove the medication and return to pharmacy for credit or dispose of the medication according to procedure. Further reviews of the facility policy revealed biologicals are stored under manufacture's recommendation.</p> <p>Observation of the North Medication Room with the Director of Nursing (DON), on 11/10/11 at 8:30 AM, revealed five(5) vials of IV Lorazepam in the refrigerator for Un-sampled Resident C.</p> <p>Review of Un-sampled Resident C's Physician Orders revealed the Lorazepam order was dated 03/25/11. Further review of the Condition Change Form revealed Un-sample Resident C, was transferred to the hospital on 03/27/11.</p> <p>Observation of the South Medication Room with the Unit Manager, on 11/10/11 at 10:15 AM, revealed one (1) container with twenty-four (24) of twenty-five (25) Sure Step Pro test strips were to be used to verify blood glucose > 400. Further observation of the Sure Step Pro strips revealed an expiration date of March 2011.</p> <p>Interview, on 11/10/11 at 8:30 AM, with the DON revealed the nursing staff were trained to remove, discard and or return medications to the pharmacy when a resident was transferred to the hospital. She stated she was unsure why the Lorazepam was overlooked.</p> <p>Interview, on 11/10/11 at 10:15 AM, with the</p>	F 431		



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F 431	Continued From page 14 South Unit Manager revealed the staff were trained to remove expired biologicals. She further stated using expired Sure Step Pro strips on a resident could cause an incorrect blood glucose reading and treatment.	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		



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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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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: 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/07/11. Kindred Transitional Care and Rehab - Northfield was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and three (103) 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Paula Kim, Jr.* TITLE *Executive Director* (X6) DATE *12-12-11*

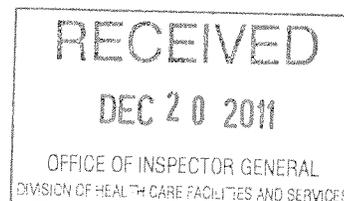
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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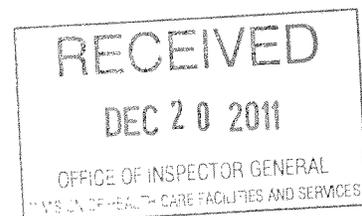
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K 000	Continued From page 1 Fire)	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
K 029 SS=D	Deficiencies were cited with the highest deficiency identified at E level. NFPA 101 LIFE SAFETY CODE STANDARD One 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 of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and three (103) on the day of the survey. The findings include: Observation, on 11/07/11 at 2:35 PM, with the Acting Maintenance Director and the	K 029	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K-029 NFPA 101 Life Safety Code Standard It is the practice of Northfield Centre to meet the requirements of Protection of Hazards, per NFPA Standards. Corrective Action for those affected by the alleged deficient practice: Dry storage area located in Kitchen installed a self closing device on the door. Self closing device was installed on 11-11-11 by Maintenance Director. To identify residents who may be affected by alleged deficient practice: All residents would have the potential to be affected by alleged deficient practice. Facility immediately installed closing device on Dry storage room in kitchen on 11-11-11.	12/20/11	



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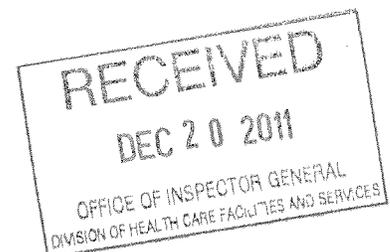
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K 029	Continued From page 2 Maintenance Assistant revealed the door to the Dry Storage Room located in the Kitchen, did not have a self closing device installed on the door. Interview, on 11/07/11 at 2:35 PM, with the Acting Maintenance Director and the Maintenance Assistant revealed they were not aware the Dry Storage Room was considered a hazardous area and the door was required to be equipped with a self closing device. 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 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	K 029	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Measures put in place to assure the alleged deficient practice does not reoccur: Maintenance Director install Self closing device on Dry storage door in Kitchen on 11-11-11. To monitor solutions are sustained: Maintenance Director will monitor door to ensure closer is working properly for the next 90 days. All finding will be reported Maintenance Director to Performance Improvement committee monthly or until solutions are sustained.	12/20/11



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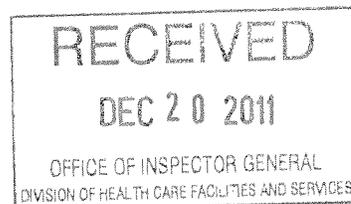
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K 029	Continued From page 3 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered 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	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 038 SS=E	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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained according to National Fire Protection Association (NFPA) standards. The deficiencies had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and three (103) on the day of the survey. The findings include:	K 038	K-038 NFPA 101 Life Safety Code Standard It is the practice of Northfield Centre that all exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Corrective action for those affected by alleged deficient practice: Egress door located on the Northeast exit of facility placed required signage on the door stating the door was equipped with a fifteen second delay before opening on 11-07-11 by Maintenance Assistant. Exterior door located in the Dining Area and exiting into an enclosed Courtyard had a sign placed on 11-07-11 stating the door was not an exit. To identify other residents to be affected by alleged deficient practice: All residents have the potential to be affected by alleged deficient practice.	12/20/11



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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222	
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K 038	<p>Continued From page 4</p> <p>Observation, on 11/07/11 at 2:30 PM, with the Acting Maintenance Director and the Maintenance Assistant revealed the delayed egress door, located at the Northeast exit, did not have the required signage stating the door was equipped with a fifteen (15) second delay before opening. Further observation, at 3:00 PM with the Acting Maintenance Director, revealed the exterior door located in the Dining Area and exiting into an enclosed Courtyard, was not identified as "No Exit".</p> <p>Interview, on 11/07/11 at 2:30 PM, with the Acting Maintenance Director and Maintenance Assistant revealed they were not sure why the delayed egress signage was removed from the exit door. Further interview, at 3:00 PM with the Acting Director of Maintenance, revealed a confirmation that the exterior door located in the Dining Area discharged into an enclosed Courtyard and did not lead to a public Right of Way and was a potential hazard.</p> <p>Reference: NFPA 101 (2000 edition) 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</p>	K 038	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Maintenance Director audited all egress door to ensure proper signage posted for doors are equipped with fifteen second delay and no exit.</p> <p>Measures put in place to assure the alleged deficient practice does not reoccur: Maintenance Director audited all egress doors to find all door had properly signage according to Life Safety Code Standards on 11-07-11.</p> <p>To monitor the solutions are sustained: The Maintenance Director will monitor weekly for next 90 days to ensure all egress door have required signage stating the door was equipped with a fifteen second delay before opening and no exit posting. Executive Director will complete a weekly review to ensure monitoring is sustained. Maintenance Director is responsible for reporting all findings to Performance Improvement Committee for next 90 days or until solutions are sustained.</p>	12/20/11



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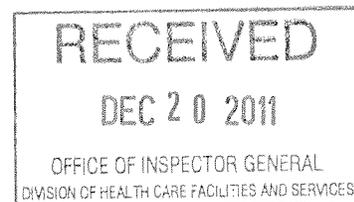
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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K 038	Continued From page 5 accordance with 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 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.	K 038		
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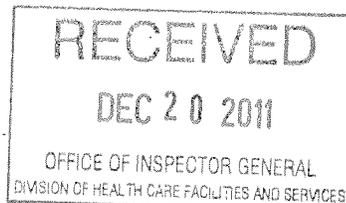
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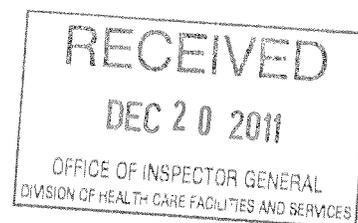
K 038	<p>Continued From page 6</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, per NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and three (103)</p>	K 038	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K-130 NFPA Miscellaneous. Other LSC Deficiency not on 2786</p> <p>It is the practice of Northfield Centre to maintain doors within a required means of egress, per NFPA standards.</p> <p>Corrective action for those affected by alleged deficient practice: Three slide bolt locks were removed on Public Restrooms located in Front Lobby , Rehabilitation entrance and staff lounge on 11-07-11 by Maintenance Assistant and replaced with door knob locking system. Maintenance Director and Assistant Maintenance were educated by Executive Director on 11-07-11 on slide bolt locks were not prohibited.</p>	
K 130 SS=E		K 130		



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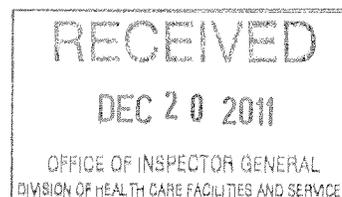
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K 130	Continued From page 7 on the day of the survey. The findings include: Observations, on 11/07/11 between 12:45 PM and 3:45 PM, with the Acting Maintenance Director and the Maintenance Assistant revealed unapproved locks (slide bolt type) were installed on three (3) doors within the facility. 1. A slide bolt lock on the door to the staff restroom located near the Front Lobby. 2. A slide bolt lock on the door to the visitor restroom located near the Front Lobby. 3. A slide bolt lock on the door to the restroom located in the Staff Lounge. Interviews, on 11/07/11 between 12:45 PM and 3:45 PM, with the Acting Maintenance Director and the Maintenance Assistant revealed they were aware of the locks installed on the doors; however they were not aware that slide bolt locks were prohibited. 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	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> To identify other residents who may be affected by the alleged deficient practice: All residents have the potential to be affected by alleged deficient practice. Three slide bolt locks were removed on Public Restrooms located in Front Lobby , Rehabilitation entrance and staff lounge on 11-07-11 by Maintenance Assistant and replaced with door knob locking system. Measures put in place to assure the alleged deficient practice does not reoccur: Three slide bolt locks were removed on Public Restrooms located in Front Lobby , Rehabilitation entrance and staff lounge on 11-07-11 by Maintenance Assistant and replaced with door knob locking system.	12/20/11
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	To monitor the solutions are sustained: Three slide bolt locks were removed on Public Restrooms located in Front Lobby , Rehabilitation entrance and staff lounge on 11-07-11 by	



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K 147	Continued From page 8 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 according to NFPA standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and twenty (120) beds and the census was one-hundred and three (103) on the day of the survey. The findings include: Observations, on 11/07/11 between 12:45 PM and 2:00 PM, with the Acting Maintenance Director and the Maintenance Assistant revealed electrical panels located in the corridors outside of the Nursing stations in both the North and South Wings were unlocked. Interviews, on 11/07/11 between 12:45 PM and 2:00 PM, with the Acting Maintenance Director and the Maintenance Assistant, revealed they were not aware of the requirement that electrical panels, located in the resident corridors, were to be locked to prevent unauthorized access. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to	K 147	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Maintenance Assistant and replaced with door knob locking system. Maintenance Director will monitor function of doors for next 90 days and be responsible to report all findings to Performance Improvement Committee monthly for the next 90 days or until solutions are sustained. K-147 NFPA 101 Life Safety Code Standard. It is the practice of Northfield Centre to comply with electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9. 1.2. Corrective action for those affected by alleged practice: Maintenance Director on 11-07-11 place locks on electrical panels located in corridors outside the Nursing station in both North and South unit.	12/20/11



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K 147	Continued From page 9 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.	K 147	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>To identify other residents who may be affected by the alleged deficient practice: All residents had the potential to be affected by alleged deficient practice. Maintenance Director on 11-07-11 place locks on electrical panels located in corridors outside the Nursing station in both North and South unit.</p> <p>Measures put in place to assure the alleged deficient practice does not reoccur: Maintenance Director will review weekly for the next 90 days the locked on all electrical panels to ensure solution is sustained.</p> <p>To monitor the solutions are sustained: The Maintenance Director and Executive Director will monitor weekly for the next 90 days the locks on the electrical panels located in corridors by North and South unit nursing station to ensure solution is sustained. All finding will be reported to Performance Improvement Committee for next 90 days or until solution is sustained.</p>	12/20/11	

