

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

PRINTED: 12/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2010
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSLEY RD. LOUISVILLE, KY 40216		
(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 and abbreviated survey was conducted 11/30 - 12/02/10. This was a Nursing Home Initiative (NHI) survey with the team entering at 6:45am on 11/30/10. A Life Safety Code Survey was conducted on 12/01/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed. Complaint KY#15445 was investigated and found not to be substantiated.	F 000			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide the necessary care and services for three (3) residents of the thirty-one (31) sampled residents (Residents #2, #9 and #11) to maintain the highest practicable physical well being, in accordance with the comprehensive plan of care. The facility failed to ensure call lights were accessible to Residents' (#2 and #9) and have a scoop mattress on the bed for Resident' (#11). The findings include: The facility was not able to provide a policy for call lights. Observation of Resident #2 on 11/30/10 at	F 309	F309 For residents #'s 2, 5, and 9 whose call bells were not accessible to them, we have re-educated employees on standards of care as it relates to patients having call bells within reach when in their room. This was completed by the Unit Manager and Assist. Unit Managers on 12/7/10. To identify other residents who may be affected by this practice all patients were checked to assure their call bell was within reach. This was done by various nursing supervisors and the results reported to the Director of Nursing. This was done on 12/22/10. (continued on page 2)	1-15-11	

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

TITLE

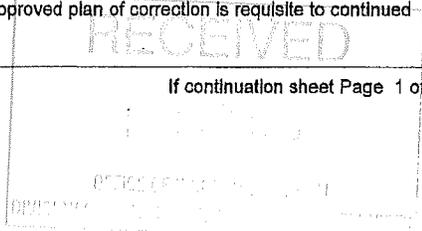
(X8) DATE

[Signature]

Administrator

12-22-10

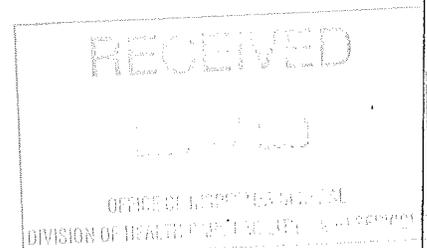
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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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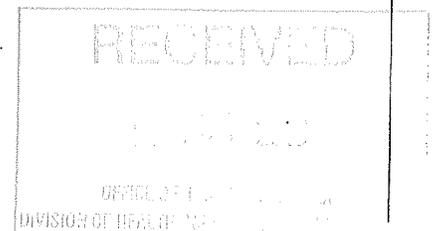
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F 309	Continued From page 1 10:50am, 11:30am and on 12/01/10 at 12:00pm revealed the resident sitting upright in a high back wheelchair toward the head of the bed with the call light located at the foot of the bed. Staff were observed entering and exiting the resident's room and the call light not accessible for the resident's use. Review of the clinical record for Resident #2 revealed the resident was admitted to the facility with diagnoses of; anoxic brain injury, myocardial infarction, dysrhythmia, status post peg tube placement, and frequent urinary tract infections. The facility completed an initial Minimum Data Set (MDS) assessment on 10/29/10 which indicated the resident was able to make their needs known. The care plan indicated the resident should have standards of care provided routinely. Interview with Certified Nurse Aide (CNA) #5 on 12/02/10 at 2:15pm revealed Resident #2's call light was out of reach and the resident was not assisted. She further stated that the call light should be within reach at all times. Observation of Resident #9 on 11/30/10 at 10:55am, 11:31am and on 12/02/10 at 1:00pm revealed the resident sitting upright in a lift chair toward the head of the bed with the call light located at the food of the bed. Staff were observed entering and exiting the resident's room and the call light not accessible for use. Review of the clinical record for Resident #9 revealed the resident was admitted to the facility with a diagnoses of; osteoarthritis, diabetes mellitus Type II, esophageal reflux, hypertension, and Parkinson's disease. The facility completed an initial MDS assessment on 07/21/10 which indicated the resident was able to understand and make needs known. The care plan indicated the resident was knowledgeable of call light usage. Interview with Resident #9 at 1:30pm revealed	F 309	F309 (continued from page 1) To assure this does not recur nursing staff will be re-educated regarding standards of care as it relates to placing call bells within reach of residents in their room. This will be done by the Assist. Director of Nursing and/or her designee. Direct care nurses will be educated on their responsibility to observe whether call bells are accessible to the residents they are responsible for. This will be done by the Unit Manager or their Assistant. These actions will be accomplished by 1/12/11. To monitor and assure these solutions are sustained, the Director of Nursing or her designee will make rounds at least monthly to assure that residents have their call bells easily accessible. They will take corrective action if necessary and report their findings quarterly to the QA Committee for their review. This will be done for 2 quarters.	



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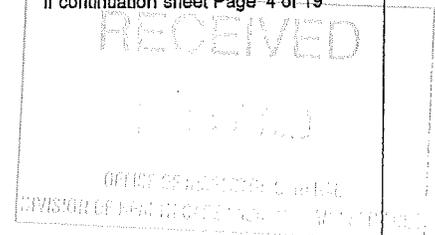
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F 309	Continued From page 2 that if he/she was unable to reach the call light, then the resident would just call out for assistance. Interview with CNA #5 on 11/30/10 at 2:25pm revealed Resident #9's call light was out of reach and the resident had no access for assistance. She further stated that the call light should be within reach at all times. Interview with the Unit Manager of the Blue Unit on 12/02/10 at 2:25pm revealed she did not notice Resident #9's call light not accessible for use upon entering or exiting the room. She further stated the call light should be accessible for resident's use at all times.	F 309			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to prepare, cook, and serve food in a safe and sanitary environment as evidenced by the kitchen hand washing sink that had brown particle build up around the edges, a soap dispenser over the sink was not mounted securely to the wall, a ceiling vent had grey particle build up, food in both the walk-in refrigerator and freezer had no	F 371	F371 The sink noted to have a brown substance around the edges and mineral buildup on the caulking was scrubbed and cleaned by the Assist. Dietary Manager on 12/1/10. There is no musty odor in this area. The loose soap dispenser was tightened on 12/3/10 by a maintenance employee. The sink area will be remodeled by removing the drywall around the sink and replace with stainless steel. This will be done by maintenance and should be completed by 1/15/11. The vent noted to have gray particles around it was cleaned on 12/3/10 by maintenance. This vent will be replaced by maintenance and will be completed by 1/15/11. (continued on page 4)	12/7/10	



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F 371	<p>Continued From page 3</p> <p>labels and one of two dumpsters had white liquid leaking from the container.</p> <p>The findings include:</p> <p>Observation on 11/30/10 at 7:00am revealed the kitchen hand washing sink had brown built up substance around the edges of the stainless steel of the sink. Continued observation on 12/01/10 at 10:35am revealed the kitchen sink had a brown build up around the outer edges and caked on the stainless steel sink as well as in the white cracked caulking around the edges of the faucets where there was green and yellow crusty build up. A musty odor could be smelled near the sink.</p> <p>Observation on 11/30/10 at 7:00am revealed the soap dispenser over the sink was loose from the wall.</p> <p>Observation on 12/01/10 revealed hair like particles of grey color were on the outside cover of the vent and on the wall next to the vent. The vent cover was loose and exposed the inner portion of the vent which revealed black particles all along and down the inside.</p> <p>Interview on 12/01/10 at 3:48pm with the Dietary Cook revealed the sink was either cleaned by her or the assistant cook using soap, cleaning detergent or bleach. The Dietary Cook stated that the sink did not get that nasty because people wash their hands in the sink a lot.</p> <p>Interview on 12/01/10 at 4:00pm with the Dietary Manager revealed that everyone is responsible for cleaning the hand sink. The sink was not very clean. Maintenance needed to repair the edges of the sink; it was cracked but was not sure if</p>	F 371	<p>F371 (continued from page 3)</p> <p>All items noted that were not dated were disposed of immediately, including the 5 lb. of pimento cheese and sour cream, two items that had not been opened. This was done by the Dietary Manager.</p> <p>The dumpster that was noted to have liquid draining from it (which was actually liquid that had been spilled from a plastic garbage bag as it was being placed in the dumpster) was cleaned on 12/3/10 by maintenance employees.</p> <p>All residents had the potential of being affected by the items noted in this deficiency.</p> <p>To ensure that these issues do not recur, all kitchen staff have been re-educated on how, when, and why food items must be labeled. This was completed on 12/7/10 by the Dietary Manager and Assist. Manager.</p> <p>Kitchen staff was also retrained on how to clean sinks and the necessity to complete their assignments on the cleaning schedule. This was completed on 12/7/10 by the Dietary Manager.</p> <p>(continued on page 5)</p>	



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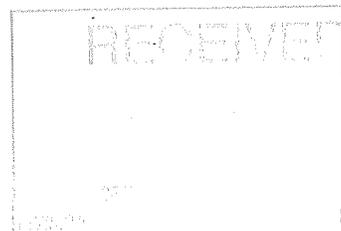
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F 371	Continued From page 4 maintenance knew about the needed repairs to the sink and the soap dispenser. The repair request was not on the maintenance log. The sink had always had a mildew odor. It was dietary's responsibility to ensure the sink was clean and repairs were done. The Dietary Manager stated there was not a policy in place relating to the cleaning of the sink. Observation on 11/30/10 at 7:25am revealed food items from the walk-in refrigerator: Casa Solana salsa, pimento cheese spread in a five pound container, sour cream in a five pound container and bagged salad mix were all opened with no date marked when opened. Observation on 11/30/10 at 7:25am revealed food items from the walk-in freezer that did not have dates after being opened. Cookies, biscuits and peas were all opened with no date indicating when the items had been opened. Interview on 11/30/10 at 8:08am with the Dietary Manager revealed that food not labeled with the dates when the food was opened had the potential to make the residents sick. Observation on 12/01/10 at 10:10am revealed a dumpster had white liquid streaming from the corner edge of the dumpster to approximately six feet out from the dumpster. Interview on 12/01/10 at 4:38pm with the Dietary Manager revealed there was no policy in regards to cleaning the dumpsters.	F 371	F371 (continued from page 4) In order to keep the dumpster area clean the kitchen staff has been educated on how to transport to the dumpster and transfer into the dumpster garbage that is removed from the facility. This was completed on 12/7/10 by the Dietary Manager. Also, the Dietary Manager assures me that it has been our policy to check the dumpster area 2x's per day and clean the area at that time. We will make sure this is placed on the regular cleaning schedule. To monitor and assure these solutions are sustained the Dietary Manager or her designee will do the following: 1. Check sinks no less than weekly to assure they are being properly cleaned and that equipment such as soap dispensers are in good order. 2. Check walk in refrigerator and freezer at least weekly to assure food items are properly stored and dated. 3. Check vents and other areas for cleanliness at least weekly. 4. Check the dumpster area at least weekly to assure that staff have been completing their scheduled cleaning assignments and keeping the dumpster area clean.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	The result of these inspections will be reported to the QA Committee for their review quarterly for 2 quarters.	

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F 441	<p>Continued From page 6</p> <p>Base on observation, interview and record review, it was determined the facility failed to maintain a sanitary environment and ensure proper infection control practices were maintained.</p> <p>The findings include:</p> <p>Record Review of the Infection Control Policy provided by the facility revealed all employees who have direct resident contact are required to wash their hands in accordance with infection control/universal precautions guidelines. Also, the dietary department is responsible for preparing, distributing and serving food under sanitary conditions and disposing of garbage and refuse properly. Consequently, the dietary department is responsible for ensuring that food preparation equipment, dishes, and utensils are effectively sanitized and stored in a protected manner.</p> <p>Observation on 11/30/10 at 12:45pm revealed LPN #3 touched the bread on a resident's meal tray with bare hands.</p> <p>Interview on 11/30/10 at 12:50pm with Licensed Practical Nurse (LPN) #3 revealed touching food with bare hands can be an infection control problem for residents.</p> <p>Observation on 12/01/10 at 8:10am in room 701, bed #2, revealed a resident's indwelling catheter bag was located on the window side of the bed, hanging from the bed frame and lying on the floor without a dignity bag.</p> <p>Interview on 12/02/10 at 8:40am with the Assistant Director of Nursing (ADON) revealed there was a risk for infection when an indwelling</p>	F 441	<p>F441</p> <p>LPN #3 who touched bread on a resident tray was educated on proper food handling procedures by the Assistant Director of Nursing on 12/3/10.</p> <p>Staff caring for the resident in room 701, were re-educated on proper placement of catheter bags and were also re-trained on the need for privacy for those with catheters. They were reminded to always use a dignity cover for catheter bags. This was completed by the Unit Manager on 12/3/10.</p> <p>Resident in room 205 with geriatric chair in disrepair was placed in another geriatric chair with no tears. This was done on 12/7/10 by nursing staff.</p> <p>Un-sampled residents in dining room area noted to have tape holding tab alarms to wheelchairs had the tape removed and alarms were reattached with other methods. This was done on 12/7/10 by the Central Supply Technician.</p> <p>Bed alarm control box in room 205 Was removed and replaced on 12/3/10. This was completed by the Central Supply Technician.</p> <p>(continued on page 7)</p>	1-15-11



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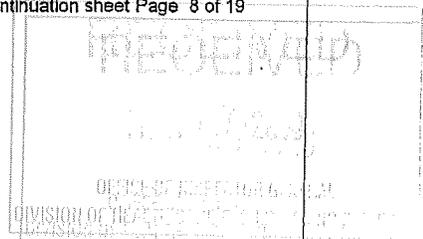
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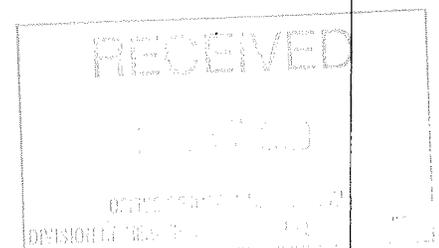
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F 441	<p>Continued From page 7 catheter bag is lying on the floor.</p> <p>Interview on 12/02/10 at 9:40am with the Director of Nursing (DON) revealed the indwelling catheter bag on the floor was a concern because it was an infection control risk. Nursing was responsible for ensuring catheter bags are off the floor and in a dignity bag. The Director of Nursing was ultimately responsible for ensuring nursing is utilizing to infection control practices.</p> <p>Observation during lunch service in the main dining area on 12/01/10 at 11:53am revealed three (3) unsampled residents with tab alarms taped to the handles of the wheelchairs with various types of tape.</p> <p>Observation on 11/30/10 at 5:35pm revealed an unsampled resident in room 205B with a geriatric chair that had cracked blue faux leather taped with white paper tape and foam exposed on the right arm chair rest.</p> <p>Interview on 12/01/10 at 3:15pm with the second shift house supervisor revealed nursing cleaned off the tape on the wheelchairs every couple of weeks or when the tape began to get gooeey. The house supervisor did state that there was a risk for infection because of the bacteria on the tape as the tape could not actually be cleaned appropriately.</p> <p>Interview on 12/01/10 at 3:22pm with Central Supply revealed tab alarms were cleaned on a regular basis by nursing staff. Also, when duct tape was used to attach the alarm to the wheelchair, there was no problem with the tape. If surgical tape or paper tape was used, then there could be a problem because it could not be</p>	F 441	<p>F441 (continued from page 7)</p> <p>To identify other residents who have the potential to be affected by the items in this deficiency we have done the following:</p> <p>Residents have been observed while dining to determine if any staff member touched bread or any other food item with their bare hand, or in any way contaminated food. This was done during breakfast, lunch, and dinner over a two day period, completed on 12/8/10. This was completed by the D.O.N. and her designees. No other residents were identified.</p> <p>Regarding geriatric chairs in disrepair, all residents in geri chairs had their chair inspected on 12/3/10 and none were found to have tears or other structural problems. This was completed by the Housekeeping Director.</p> <p>Resident with tab alarms or sensor alarms were checked to determine if the alarms were taped to wheelchairs or were in any type of disrepair. Those identified had the tape removed immediately and the alarm was secured with a clip. All alarms were intact and in good working order.</p> <p>(continued on page 9)</p>		



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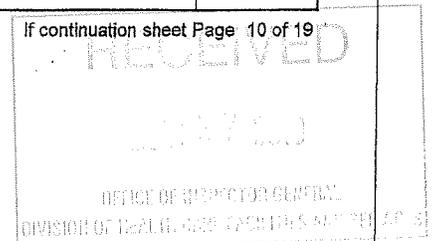
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F 441	<p>Continued From page 8 cleaned, and it could make the resident sick.</p> <p>Interview on 12/02/10 at 8:35am with the Unit Manager for the Blue Unit revealed it was the ADON and DON's responsibility to ensure wheelchairs were cleaned and repaired. The Unit Manager also stated there was no system in place to ensure wheelchairs were being cleaned and repaired.</p> <p>Interview on 12/02/10 at 8:43am with the Maintenance Director, revealed wheelchairs were checked as needed. He also revealed he had no routine system in place to check wheelchairs for repairs.</p> <p>Interview on 12/02/10 at 9:20am, with the ADON revealed she was not sure, but thought nursing was responsible for cleaning the refrigerators in the medication room. The ADON stated the medication rooms are checked quarterly and spot checked for cleanliness. She also stated the medication room refrigerators were to be cleaned routinely and the unit managers were to check to ensure nursing was checking off a list for cleaning and temperatures. She added that there was no system in place for the administrators to ensure the unit managers were checking nursing staff duties.</p> <p>Observation on 11/30/10 at 5:36pm revealed the resident in room 205, Bed A, had silver duct tape around the bed alarm control box with the green electrical board exposed.</p> <p>Interview on 12/01/10 at 3:30pm with Central Supply revealed the sensor alarms were checked routinely for placement and proper function. She stated that she was already aware of the repair</p>	F 441	<p>F441 (continued from page 8)</p> <p>This was completed by the Unit Managers, their designees, and the Central Supply Clerk.</p> <p>All residents had the potential to be affected by the cookie oven, microwave and refrigerator observations.</p> <p>Activity items cited have been removed from use so no other residents can be affected.</p> <p>All residents with catheters have been observed to determine that dignity covers are in place and that the catheter bags are properly placed. This was completed by the D.O.N. on 12/22/10.</p> <p>To ensure these items do not recur we will do the following:</p> <ol style="list-style-type: none"> 1. Meal service will be observed monthly by the D.O.N. or her designee to determine that food is being handled properly without contamination. 2. The D.O.N. or her designee will make rounds at least monthly to ensure that residents with catheters have privacy covers in place over the drainage bags and will assure bags are properly placed. <p>(continued on page 10)</p>	



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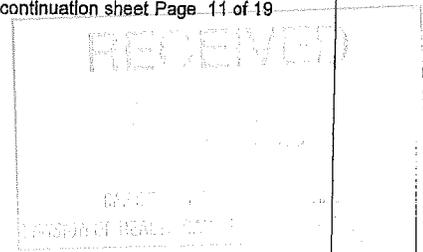
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F 441	<p>Continued From page 9</p> <p>needed for the bed alarm in room 205, Bed A, but revealed that she did not currently have a back piece and two screws for the repair. Furthermore, the alarm could not be cleaned with the back off and it was not acceptable or safe.</p> <p>Interview on 12/01/10 at 3:45pm the Unit Manager on the Blue Unit revealed the bed alarm in room 205, Bed A, should have been repaired, as there was a risk of the bed alarm not working and it could not be cleaned effectively. Furthermore, the third shift nursing staff should be removing tape and cleaning wheelchair arms.</p> <p>Interview on 12/01/10 at 5:00pm with the ADON revealed there was no schedule for checking bed alarms. No system was in place to ensure that the nursing staff was checking bed alarms and cleaning them. Also, she stated she was ultimately responsible for checking to ensure that the third shift house supervisor and the nursing staff were cleaning and checking the bed alarms.</p> <p>Observation on 11/30/10 at 12:35pm revealed the microwave in the blue unit lounge had yellow and brown particle pieces inside and white paper like substance on the round rotating glass tray inside the microwave.</p> <p>Observation on 11/30/10 at 3:45pm revealed the microwave had brown specks all over the inside of the microwave and a red hard substance on the outside of the microwave door.</p> <p>Observation in the main dining area on 11/30/10 at 8:05am and 12/01/10 at 11:53am revealed the microwave had a hard brown food particle substance on the inside of the microwave and a clear film on the outside of the microwave door.</p>	F 441	<p>F441 (continued from page 9)</p> <ol style="list-style-type: none"> 3. Geriatric chairs will be inspected at least monthly by the Housekeeping Supervisor to assure they are clean and in good repair. The D.O.N. will make written assignments for the cleaning of geri chairs and wheelchairs and will keep a log of when they were cleaned and by whom. She will then periodically inspect them to ensure the cleaning was completed. 4. All tab alarms and sensor alarms will be checked at the beginning of each shift by the oncoming nurse who will document that they are in working order and are not attached with tape. The Unit Managers will check periodically to determine that these checks are being completed. 5. Microwaves will be cleaned daily by housekeeping staff. They have been re-educated on proper cleaning procedures by the Housekeeping Supervisor on 12/17/10. They will be checked daily by the Housekeeping Supervisor to ensure they are clean. <p>(continued on page 11)</p>	



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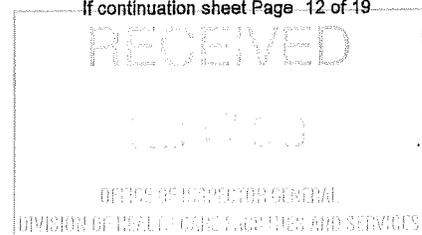
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F 441	<p>Continued From page 10</p> <p>Interview on 12/02/10 at 8:48am with the Housekeeping Director in the Blue Unit Lounge revealed the microwave was dirty and the residents could get unwanted bacteria if the microwaves were dirty.</p> <p>Observation of the Green unit on 11/30/10 at 3:45pm revealed the refrigerator in the lounge had yellow and black build up all along the cracked rim of the refrigerator door. Also, the freezer had white colored ice built up on the inside of the freezer. In addition, a green sterilite pitcher with a brown liquid substance inside the container had no label.</p> <p>Observation on 11/30/10 at 12:35pm on the Blue unit revealed the refrigerator had a buildup of icicles and white ice on the coils inside the freezer. In addition, vanilla ice cream was opened with no date, chicken on a salad, covered in a bowl loosely with plastic wrap, was observed with no date and label.</p> <p>Interview on 11/30/10 at 4:10pm with LPN #7 on the Green Unit revealed that if the black substance from the refrigerator got on the resident's food, it could possibly make the resident sick. The LPN also stated that she was not sure how often the refrigerator was cleaned, but they clean out the old food once a week.</p> <p>Observations on 11/30/10 at 8:10am and on 12/10/10 during lunch service at 11:53am in the main dining room revealed a cookie oven had light brown crumbs in the bottom of the oven and on the rack.</p> <p>Interview on 12/02/10 at 9:50am with the Director</p>	F 441	<p>F441 (continued from page 10)</p> <ol style="list-style-type: none"> 6. Refrigerators will be checked for cleanliness daily by the 11-7 shift supervisor who will log along with temperature checks. If cleaning is needed the supervisor will clean at that time. To ensure this is being completed the Unit Managers will check at least weekly for cleanliness and the D.O.N. or A.D.O.N. will then check the logs and the refrigerators at least monthly to ensure all the checks and cleaning have been performed. 7. The cookie oven will be cleaned after each use and will be stored in the Activity Office when not in use to avoid the unauthorized use. The Activity Director or her assistant will check the oven for cleanliness before its use. 8. No system is being implemented for the cleaning of items such as puzzles and other implements that were in boxes for patient use, since we will no longer make these items available to residents. <p>(continued on page 12)</p>		



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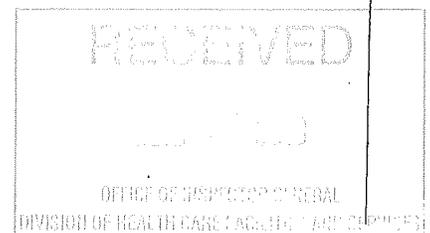
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F 441	<p>Continued From page 11</p> <p>of Activities revealed it was an Infection control issue if the oven was not cleaned. No system currently was in place to ensure the oven was cleaned. She also stated that she did not realize it was the activity department's responsibility, until recently, to clean the oven which was purchased six months ago.</p> <p>Observation on 11/30/10 at 9:20am in the Medication Room on the Blue Unit revealed black spotted smudged areas all along the rubber seal of the refrigerator freezer door. A red sticky substance was on the door of the refrigerator and rust colored spots on the outside of the refrigerator on the right side and around the screws. Unlabeled foods substances were in a clear plastic carton with chicken and mixed vegetables.</p> <p>Observation on 12/01/10 at 9:00am in the Medication Room on the Green Unit revealed the refrigerator had black copious amounts of build up at the base of the refrigerator in the corner extending onto the linoleum floor. The refrigerator seal was torn all along the edges of the broken seal.</p> <p>Observation on 11/30/10 at 3:30pm revealed Resident #31 sitting in the activity area on the Blue Hall handling a round plastic gadget with beads inside. Resident #31 was observed licking his/her fingers and then running his/her fingers around the plastic gadget as though licking a plate. This action was repeated several times.</p> <p>Observation on 11/30/10 at 4:15pm revealed Resident #31 no longer in the activity area on the Blue Hall. The round plastic gadget was observed in the storage cabinet in the activity</p>	F 441	<p>F441 (continued from page 11)</p> <p>To monitor that these solutions are sustained a report shall be submitted to the Administrator at least monthly that will include their findings and observations they have noted when completing their follow up checks. They will also then report their findings to the QA Committee quarterly for two quarters.</p>	



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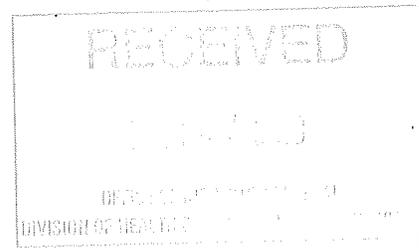
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F 441	<p>Continued From page 12 area.</p> <p>Interview on 11/30/10 at 4:30pm with Certified Nurse Aide (CNA) #2 revealed that when picking up items in the activity room, the items were placed in a box and placed in the storage cabinet. The CNA stated that the staff did not routinely clean the items.</p> <p>Observation on 12/02/10 at 10:00am revealed an unsampled resident sitting at a table in the activity area of Blue Hall with a box of items in front of him/her. The resident was handling items from the box. The box was labeled Ladies' Busy Box and included a hot pad, cookie cutter, cup, spatula, potato masher and other like items.</p> <p>Observation on 12/02/10 at 10:35am revealed the Activity Director cleaning the outside of the Ladies' Busy Box with sani-wipes but did not clean the items on the inside of the box.</p> <p>Interview on 12/02/10 at 11:00am with CNA #1 revealed someone from activities usually puts the activity boxes away. The CNA stated that he/she was unaware of a cleaning process but did state that he/she had seen items being put away without them being cleaned. The CNA also stated that he/she did not want to get anyone in trouble but observed a resident put puzzle pieces in their mouth and then the puzzle pieces were put away without being washed. The CNA stated that by not cleaning these gadgets infections could spread among the residents.</p> <p>Interview on 12/02/10 at 11:10am with LPN #6 revealed that boxes of gadgets were available for residents to use and handle. The LPN stated that there was a Men's Busy Box and a Ladies' Busy</p>	F 441			



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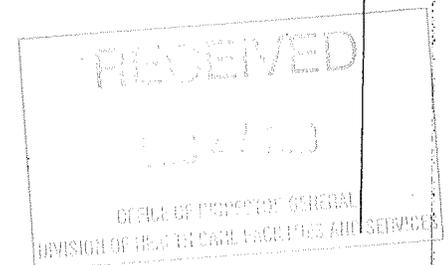
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F 441	Continued From page 13 Box, and both have gadgets for the residents to use. Usually the boxes were set out on the tables for resident use, but when the tables were needed for feeding, the boxes were put away in the corner storage cabinet. CNA #6 stated that to her knowledge the items were not cleaned prior to putting them away. Interview on 12/02/10 at 11:20am with the Activities Director revealed that there were items available for resident use at all times. She stated that she cleaned them when she was there and that it was the nurses' responsibility to clean the items when she was not there. The Activities Director stated she cleaned the items weekly and when they were visibly soiled, but did not keep a cleaning log because she was the only one that did the cleaning. The Activities Director acknowledged that if a resident put an item in their mouth or otherwise got saliva on an item, it probably did not get cleaned since it was not visibly soiled. She stated that due to the cross contamination issues and the items not being cleaned after each use, she could see the need for in-servicing for the staff on cleaning the items in the activity area.	F 441		
F 502 SS=E	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to assure that	F 502	F502 All expired lab specimen containers and the dressing change kit were disposed of immediately. All other specimen containers and dressing kits were checked to assure they were not outdated. This was done immediately by the Unit Manager and completed by 12/3/10. (continued on page 15)	



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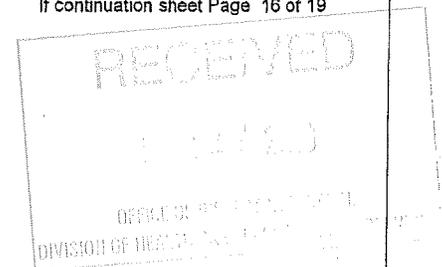
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F 502	<p>Continued From page 14</p> <p>laboratory services were accurate and timely as evidenced by multiple expired specimen containers and vials on two (2) out of two (blue and green) units.</p> <p>The findings include:</p> <p>Observation on 12/01/10 at 9:00am, on the Green Unit, revealed six (6) yellow top SAF fixative ova and parasite stool specimen containers expired on 4/2010 and one (1) had expired on 9/2009. Also, two (2) Star Swab II culture containers expired on 10/21/10.</p> <p>Observation on 11/30/10 at 9:20am, on the Blue Unit, revealed six (6) yellow top vacutainers with the label expiration of 10/2010. One (1) Star Swab culture container expired 10/21/10 and two (2) Star Swab culture containers expired 11/29/10. Four (4) bottles of bact/alert and four (4) bottles of bact/alert SN FA all expired on 08/31/10. Two (2) orange top bottles of Protocol C&S Medium specimen collector and one (1) yellow top bottle of Protocol SAF Fixative specimen collector. Two (2) Churchill Medical Systems incorporated dressing change kit expired 08/20/10.</p> <p>Interview on 11/30/10 at 9:45am with Licensed Practical Nurse (LPN) #6 revealed the nurses were supposed to check the dates and dispose of the items if the dates have expired. Expired lab vacutainers could throw lab values off.</p> <p>Interview on 12/21/10 at 9:20am with the Assistant Director of Nursing revealed that she was not sure, but thought nursing was responsible for the cleaning of the refrigerator and checking medication dates. Cleaning for</p>	F 502	<p>F502 (continued from page 14)</p> <p>Any resident who may have been tested using one of these containers or any resident whose dressing was changed could have been affected by using outdated supplies.</p> <p>To ensure this does not recur the following will be completed. A nurse will be assigned to check all lab and dressing supplies to assure they are not outdated. This will be done monthly, and any supply that will have an expiration date before the next scheduled check will be set aside and disposed of appropriately. This assignment will be made by the Unit Manager. A log will be kept of these checks and reviewed by the Unit Manager. This review begins 1/4/11.</p> <p>To ensure that these plans are sustained the following will occur:</p> <ol style="list-style-type: none"> 1. The Director of Nursing or Assistant Director of Nursing will review the logs monthly to assure the assignment was completed. 2. At least quarterly the D.O.N. or A.D.O.N. will check these supplies to ensure that the checks have been completed timely and properly. <p>(continued on page 16)</p>	J-15-11



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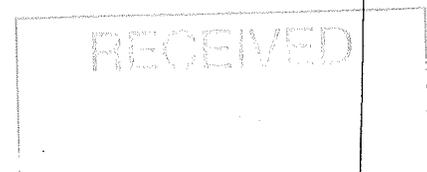
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F 502	Continued From page 15 medication room refrigerators were to be routinely checked as well as the dates of items. The unit managers were checking to ensure nursing was checking, but no system was in place for administrative checks of the unit managers.	F 502	F502 (continued from page 15)	
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews it was determined the facility failed to ensure the closed clinical records were protected from loss, destruction, and unauthorized use. Multiple records were being stored directly on the floor with the door open. The findings include: Review of a policy statement provided by the facility on 12/02/10 revealed it was the responsibility of the Medical Records Director to establish procedures and organize functions relating to the completion, maintenance and	F 516	3. The results of this monitoring will be reported to the QA Committee for their review quarterly for 2 quarters. All of these follow up procedures will begin on January 4, 2011. F516 All medical records noted to be stacked on the floor have been properly boxed for storage. These records and other closed records will be stored in a steel storage pod that has been rented and will be placed adjacent to the garage. This pod is fire and waterproof and will provide a safe place for stored records. This arrangement will be complete by 1/15/11. To protect records from unauthorized use the door to the Medical Records office will be closed when not occupied and will be locked during non-business hours. The Medical Records Clerk had been educated on how to safeguard records. This was done by the Administrator and completed on 12/7/10. (continued on page 17)	1-15-11



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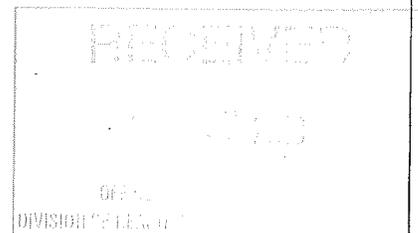
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F 516	<p>Continued From page 16</p> <p>preservation of all medical records at Summerfield Health and Rehab Center. Summerfield Health and Rehab Center will protect the confidentiality of resident information and will safeguard the records against loss, destruction or unauthorized use. The facility will keep confidential all information contained in the resident's record, regardless of the form or storage method of the record.</p> <p>Review of the Medical Records Procedures provided by the facility on 12/02/10 revealed there was no direction as to how to safeguard the clinical record from loss, destruction or unauthorized use.</p> <p>Observations of the medical records office on 11/30/10 at 11:15am, 11:30am, 11:45am, and 12:42pm and on 12/01/10 at 11:25am, 11:45am, 12:10pm, 12:30pm, 12:50pm, 4:50pm, and 5:05pm and on 12/02/10 at 8:00am, 10:45am, and 2:05pm revealed the door to the office was left open with no staff in the office. In addition, there were nineteen (19) stacks, containing approximately twenty (20) or greater records, each sitting directly on the floor of the office and the floor of the entrance area to the office. There were loose papers stacked on top of the stacks of records. There was a small walkway through the stacks of records from the door to the back of the office. The stacks of records were easily accessible from the door of the office. The office was centrally located close to the front office and front entrance of the building. Visitors and staff were noted to pass the office to enter the area leading to the 500 hall where residents resided.</p> <p>Record review on 12/02/10 at 10:45am of eleven (11) random records contained in the nineteen</p>	F 516	<p>F516 (continued from page 16)</p> <p>All residents both current and discharged have the potential to be affected.</p> <p>The door will be kept closed when the office is unoccupied. A part time employee has been hired to work 20 hours in medical records to enhance our ability to file and store records in a proper and timely manner. Medical record staff will be trained on proper handling and storage of medical records. This will be completed by the Administrator on 1/15/11.</p> <p>To ensure that these solutions are sustained the AIT will periodically observe and document findings regarding the proper storage and handling of medical records. This shall be done at least monthly for 6 months and periodically after this time. Findings will be reported to the QA Committee for their review quarterly for 2 quarters.</p>	



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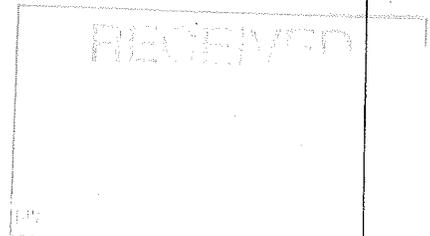
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2010
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216		
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F 516	<p>Continued From page 17 (19) stacks revealed they were closed records.</p> <p>Interview with the Medical Records Director (MRD) on 12/01/10 at 4:50pm revealed the medical records office had run out of storage area. The MRD indicated the Administrator had been made aware of the lack of storage area a couple of months ago. The medical records office received assistance from the light duty employees when they were available. The MRD stated the records on the floor were protected from damage and/or fire as the office door is fire rated and there were sprinklers in the ceiling. The MRD stated that if the sprinklers were to go off, the records would get wet, but the ink would dry out. The MRD further stated there was no policy and procedure for the medical records department.</p> <p>Interview with the Administrator in Training on 12/01/10 at 5:05pm, due to the absence of the Administrator, revealed the Administrator was aware of the medical records office and it had been that way for two months. However, she did not know why it was that way. The only action put in place was a part time person to assist. The facility worked very hard to keep the records in a protected area. An area to protect them from fire, water and insects. She stated she was not sure if the system needed to be revamped; however, she was not really sure what the problem was. In addition, she stated there was no policy and procedure on safeguarding the clinical record.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 12/02/10 at 2:05pm revealed the MRD had no training on Medical Records standards of practice or how to safeguard the clinical record.</p>	F 516			



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K 000	INITIAL COMMENTS	K 000		
K 018 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of resident room doors, according to NFPA standards. The deficiency had the potential to affect one hundred</p>	K 018	<p>K018</p> <p>All doors that were held open with trash cans were closed immediately. Housekeeping and Nursing supervisors observed the doors periodically to assure they were not propped open until staff were educated on this requirement which was completed on 12/17/10.</p> <p>All residents had the potential to be affected by this practice.</p> <p>To ensure this does not recur we are installing magnetic hold open devices that meet code. The rooms cited in the deficiency will be completed by 1/15/11 and the remainder of the doors will be completed by 2/1/11.</p> <p>To monitor that this solution is sustained, the Housekeeping Director will make rounds at least weekly to determine that no doors are improperly blocked open. She will complete a report of her findings and submit to the Administrator monthly for 3 months.</p>	1-15-11

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

TITLE

(X6) DATE

[Signature]

Administrator 12-27-10

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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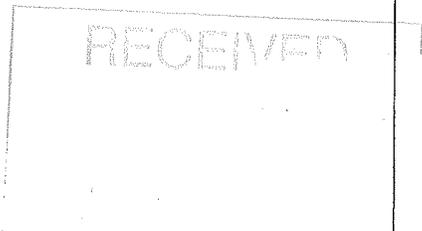
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K 018	Continued From page 1 and fifty four (154) residents and seven (7) of eleven (11) smoke compartments. The findings include: Observation on 12/01/10 at 9:03am revealed a trash can in resident room #205 was positioned so that it prevented the closing of the door. Further observation during the Life Safety Code Survey revealed trash cans preventing the closing of the following doors, #206, #208, #209, #210, #203, #304, #100, #107, #105, #106, #403, #405, #605, #608, #710, #707, #708, #705, #704, #808, and #811. The observation was confirmed with the Maintenance Director, who was present at that time. Interview on 12/01/10 at 9:03am, with the Maintenance Director, revealed the trash cans were being used to hold the doors open, due to the doors wanting to self close. Reference: NFPA 101 (2000 Edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	KO62—continued on page 3	

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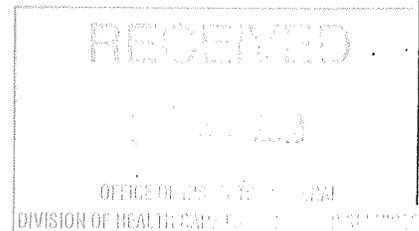
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K 062 SS=F	<p>Continued From page 2</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler control valves where inspected monthly, according to NFPA standards. Sprinkler control valves must be inspected monthly to ensure proper operation of the sprinkler system. The deficiency had the potential to affect nine (9) smoke compartments, all residents and staff.</p> <p>The findings include:</p> <p>Record review of the sprinkler maintenance on 12/01/10 at 11:00am, revealed no documentation of the sprinkler control valves being inspected monthly. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 11/02/10 at 11:00am, with the Maintenance Director, revealed he did check the sprinkler control valves monthly, but had no documentation for it.</p> <p>Reference: NFPA 25 (1998 edition) 9-3.3 Inspection.</p>	K 062	<p>K062 continued from page 2</p> <p>Sprinkler control valves have been inspected monthly to ensure proper operation of the sprinkler system. This item will be added to our TELS System which is a checklist and form of documentation that will be easily available. Documentation of these checks will begin immediately.</p> <p>All residents have the potential to be affected.</p> <p>The documentation of this inspection is being added to our TELS computer documentation program. Until it is added the Maintenance Director will manually document these checks. This begins immediately.</p> <p>To monitor and ensure these solutions are sustained, the Maintenance Director will report the results of these inspections to the QA and Safety Committee for their review quarterly for 2 quarters.</p>	2-15-16



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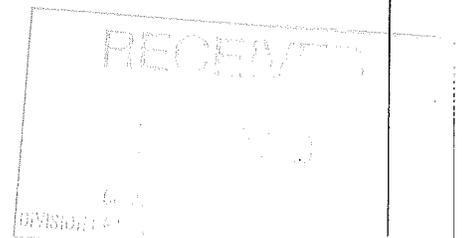
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K 062	Continued From page 3 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification NFPA 101 LIFE SAFETY CODE STANDARD	K 062		
K 066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	K066 Plastic bucket with sand being used as an ashtray was removed from the area immediately. Staff with access to this area have been educated on these smoking policies and requirements. This was completed on 12/21/10. All residents have the potential to be affected by this practice. (Continued on page 5)	12-21-10



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K 066	<p>Continued From page 4</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure residents safety by not following the facility's smoking policy and NFPA standards. The deficiency had the potential to affect nine (9) smoke compartments, all residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 12/01/10 at 10:45am, revealed a plastic bucket filled with sand, being used as an ashtray outside of the Mechanical Room. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 12/01/10 at 10:45am, with the Maintenance Director, revealed he thinks Third Shift used the plastic bucket filled with sand as an ashtray.</p> <p>Review of the facility's smoking policy, revealed the facility was to provide approved non combustible ashtrays at designated smoking areas.</p>	K 066	<p>K066 (continued from page 4)</p> <p>To ensure this does not recur the Maintenance Director will check this area at least weekly to determine that all smoking containers are of the proper type and that smoking materials are being properly disposed of.</p> <p>To monitor this to assure this solution is sustained the Maintenance Director shall document the results of his observations and submit to the Administrator monthly for 3 months.</p>	



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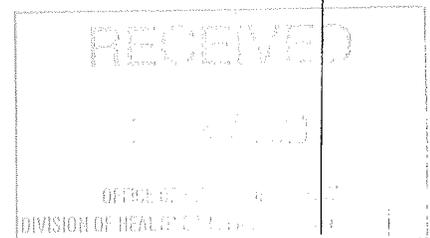
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K 066	Continued From page 5 Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	K147 (continued on page 7)	

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K 147 SS=F	Continued From page 6 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 panels, located in the hallway corridors of the facility, were secured to prevent residents from accessing the electrical panels. Electrical panels must be secured to prevent injuries to the residents. The deficiency had the potential to affect one hundred and thirty (130) residents and six (6) smoke compartments. The findings include: Observation, on 12/01/10 at 9:06am, revealed two (2) electrical panels on the 100 Hall corridor that were not locked. Further observation, during the Life Safety Code survey, revealed one (1) electrical panel on the 200 Hall corridor, one (1) electrical panel on the 300 Hall corridor, one (1) electrical panel on the 600 Hall, one (1) electrical panel on the 700 Hall, and one (1) electrical panel on the 800 Hall were not locked. The observation was confirmed with the Maintenance Director. An interview, on 12/01/10 at 9:06am, with the Maintenance Director, revealed the electrical panels were never locked.	K 147	K147 (continued from page 6) The electrical panels will be locked. The locks are being re-keyed and locks will be available by 1/15/11. Until that time panels are being checked daily by a maintenance employee to assure they are closed and latched. All residents have the potential to be affected. Panels will be locked and maintenance employees will check at least weekly to ensure they are locked. They will document their findings and submit to the Administrator monthly for 3 months. To monitor this solution, the Maintenance Director will report his findings to the Safety Committee monthly for 3 months.	1-15-11



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K 147	Continued From page 7 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 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		

