

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

PRINTED: 01/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING -----	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217	
(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)
F 000 F 278 SS=B	<p>INITIAL COMMENTS</p> <p>AMENDED SOD ISSUED 01/05/12 A standard health survey was conducted 12/14/11 through 12/16/11. A Life Safety Code survey was conducted on 12/14/11-12/15/11. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct before remedies would be imposed.</p> <p>483.20(g) - U) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a</p>	F 000 F 278	<p>The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>As a part of the facilities' ongoing process improvement program, all audit results will be reported to the Process Improvement Team with additional education as necessary.</p> <p>This "B" deficiency is a level 1 deficiency, which is the least serious. This was not a resident care issue. After analysis it was found that the deficiency occurred due to keystroke error and the expected initial inexperience with the multiple screens associated with new RAI software adopted by the facility October 2011. The adoption of the new software company was the first time in 20 years the facility has changed software vendors. The dates of the MDS's in question were within the first month of utilization of the new software program. As the surveyors noted, the RAI coordinator knew the residents well, and the care plan and rendered care was accurate. The assessments for residents #3, 4, and 21 were completed by one RAI coordinator on one of six units. None of the other units or RAI coordinators was found to have the same issues. Corrections to the assessment documentation on residents #3, 4, and 21 were made. The RAI coordinator was made aware of the inconsistencies and</p>

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

TITLE

(X6) DATE

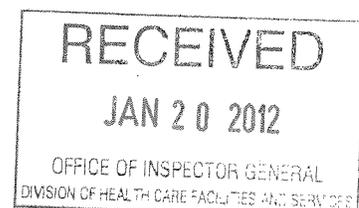
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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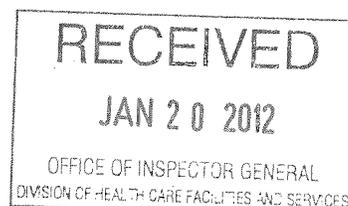
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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to assure the accuracy of the Minimum Data Set (MDS) assessment for three (3) of thirty (30) sampled residents (Resident #3, #4, and #21) accurately reflected the status of the residents. The findings include: 1. The facility admitted Resident #3 on 07/02/04 with diagnoses of Multiple Sclerosis, Paraplegia, Contracture of the lower joint and Osteomyelitis of the ankle/foot. Record review of the MDS quarterly assessment dated 11/14/11 revealed the facility assessed the resident to have no impairment of either his/her upper or lower extremities. 2. The facility admitted resident #4 to the facility on 03/30/07 with diagnoses of Persistent Vegetative State, Intracerebral Hemorrhage, Encephalopathy and Unspecified Quadriplegia. Record review of the MDS quarterly assessment dated 11/16/11 revealed the facility assessed the resident as comatose and always continent of bowel and bladder. 3. The facility admitted Resident #21 on 08/19/11 with diagnoses of Coronary Artery Disease, Hypertension, Heart Failure and Thyroid Disorder.	F 278	F 278 - Continued from page 1 was counseled and re-educated during the survey by the Director of Nursing. All RAI coordinators were given Phase One basic training on the new software in October and November 2011. However, software vendor training will continue through 2012 regarding the nuisances of the new program as we update and complete conversion to the new software system. The conversion to date is not complete, but is on target. As part of this conversion, and as planned from the initial implementation plan, a scrubber program was installed December 23, 2011. This program will identify illogical inconsistencies for the RAI coordinators and would have detected the error related to resident #4. Orientation for the RAI coordinators in usage of the scrubber was 1/12/12 and 1/13/12 by the Director of Nursing. RAI coordinator #1 is rechecking each MDS section before moving to the next section. Systemically, in addition to the utilization of the scrubber software, the Unit Managers will do a final review of the MDS data. These measures should increase data accuracy and collaboration. Residents 3, 4 and 21 were on the same unit. The last MDS of all residents on that unit	



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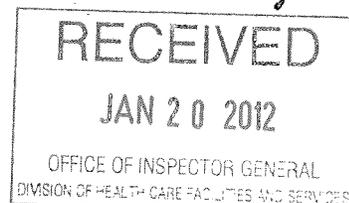
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F 278	Continued From page 2 He/she was under the care of Hospice. Record review of the MDS quarterly assessment dated 11/23/11 revealed the facility assessed the resident as always continent of bowel and bladder. However, the care plan for Resident #21 stated the resident had incontinent episodes. Interview, on 12/16/11 at 1:30PM, with MDS Coordinators #1, #2, #3 and #4 revealed all had been trained on how to complete the MDS based on the assessment. All stated they physically looked at the resident and assessed the resident. MDS Coordinator #1 revealed if an assessment was not accurate, it could affect the resident by not receiving the full care needed. Interview, on 12/16/11 at 3:45PM, with the Director of Nursing revealed a new computer system was being used for the MDS assessments and it had "caused a problem". The specific problem was not stated. It was revealed the last audit for review of the MDS assessments was conducted in October 2010, when the MDS 3.0 was introduced.	F 278	F 278 - Continued from page 2 were audited by the Compliance Officer, LPN, and the RAI Team Leader, LPN. No resident care issues of concern were identified. The Compliance Officer, LPN, will schedule audits monthly for a quarter and then quarterly through 2012. Each audit will consist of the review of four (4) MDS's per unit plus four (4) additional MDS's completed by MDS Coordinator #1. A copy of audit findings will be given to the Process Improvement Analyst, RN, Nurse Administrator, RN, and Director of Nursing, RN for analysis.	1/24/2012
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Medication Administration Policy, it was determined the facility failed to	F 332	F 332 This "E" deficiency is a level 2, meaning no harm to a resident occurred. In the examples given, all medications were the right medication for the right patient at the right dosage. At issue is the time the medications were administered. The concern involved medications that needed to be coordinated with meal times. Resident A's Synthroid time was changed to 6am and Prilosec was	



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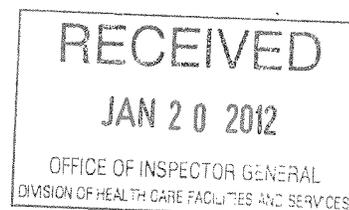
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F 332	<p>Continued From page 3</p> <p>administer medications with a medication error rate of less than five (5) percent. Observation during the medication pass on the 3rd, 4th, 5th, and 7th floors revealed medication errors occurred on three (3) of the four (4) floors, the 3rd, 5th and 7th. Forty (40) medication pass opportunities were observed with four (4) medication errors noted with a medication error rate of 10%. The medication pass observation included two (2) shifts (day and evening) and two (2) nurses and one (1) certified medication tech (CMT).</p> <p>The findings include:</p> <p>Review of facility policy, Medication Administration, (no date) revealed under...preparation for medication administration, section J the policy stated..."medications are administered in accordance with written orders of the attending physician."</p> <p>1. Observation of a medication pass, on 12/15/11 at 8:30AM, on the third floor with LPN #2 revealed Levothyroxine (Synthoid,) 50 meg (one) was administered to unsampled Resident A In addition, the nurse gave Prilosec 20mg (one) at the same time. Observation revealed the breakfast food tray was delivered prior to the medication pass.</p> <p>Review of Resident A's clinical record revealed the most current physician orders was signed on 12/01/11. The physician orders instructed to give Prilosec 20mg thirty (30) minutes prior to breakfast. Review of the Medication Administration Record (MAR) for December 2012 revealed the Prilosec was scheduled for 7:30AM.</p>	F 332	<p>F 332 – continued from page 3</p> <p>changed to HS to decrease the risk of food interactions. Resident B received the Lisinopril after the surveyor voiced concern. The root cause of the noted concern regarding resident C occurred because the facility is implementing home-like medication times on that unit. Resident C's Glyburide administration time was changed to 5:30pm.</p> <p>Potentially this concern could affect any resident. The original trial procedure on home-like medications has been revised. Medications needing to be given at specific times will be identified and the MAR's will be updated by 1/23/2012. The medication administration policy has also been revised. Synthroid will be administered at 6am, PPI's at bedtime and oral hypoglycemic with meals or as ordered by the MD and unless contraindicated. Orders and MAR's will be revised by 1/23/2012.</p> <p>An information sheet explaining the home-like medication procedures was posted on each affected unit and placed in the front of each MAR binder on those units. The updated procedure will be a part of the new orientation essentials. The Essential Agency Information pamphlet was updated to contain information regarding home-like medication procedures on units 6 & 7. LPN #2, LPN #3 and CMT #1 were made aware of the surveyors' concerns and counseled and re-educated during the survey by the Unit Managers and/or Nursing</p>



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F 332	Continued From page 4 In addition, the Synthoid was scheduled to be given at 7:30AM. The clinical record revealed diagnoses of Hypothyroidism and Gastro-esophageal reflux (GERD). Interview with LPN#2, on 12/15/11 at 9:10AM, revealed the Synthoid was to be given on an empty stomach and the Prilosec should have been given prior to the meal. She stated she had been busy and could not administer the medication. She realized the medications were late and she normally gave this resident's medications first. 2. On 12/15/11 at 9:48AM, observation of a medication pass on the 5th floor with LPN #3 revealed Lisinopril 5mg was omitted during the medication pass for Resident B. Review of the clinical record, December 2011's physician orders, revealed Lisinopril 5mg was ordered to be given one time a day. Review of the December 2011 MAR revealed the facility scheduled the Lisinopril 5mg to be given at the 10:00 AM medication pass. Interview with LPN #3, on 12/15/11 at 10:20 AM, revealed the nurse had not given the Lisinopril 5mg during the medication pass. She stated she thought she had given the medication but did not remember pulling the Lisinopril pill packet from the medicine cart and review of the empty pill packets given to the surveyor during the medication pass revealed Lisinopril was not included. 3. On 12/15/11 at 3:48PM, observation during a medication pass on the 7th floor revealed CMT	F 332	F 332 -- Continued from page 4 Administration. On 1/18/2012 and 1/19/2-12, LPN #2, LPN #3, and CMT #1 were observed by the MedCare Pharmacist as they passed early AM medications. Each successfully demonstrated understanding and good technique in administering medications. This situation potentially could affect all residents, therefore the facility identified the need to re-educate nurses and CMT's who administer medications. The Nurse Educator, LPN, Clinical Assistant Director of Nursing, RN, Administrative Assistant Director, RN, 3-11 House Supervisor, RN, 11-7 House Supervisor, LPN, Weekend days RN, and Weekend nights House Supervisor, RN, will hold a Mandatory Skills Event 1/12/2012 through 1/23/2012. During this event nurses and CMT's will be educated/re-educated in home-like medications, and the revised medication administration policies and will be observed administering medications. The Compliance Officer, LPN, Educator/Staff Development, LPN, and/or MedCare Pharmacist will audit four (4) nurses and/or CMT's during medication passes monthly for 3	



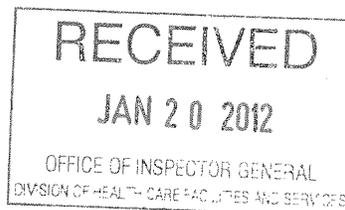
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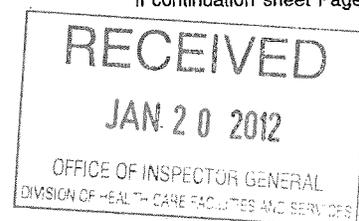
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F 332	<p>Continued From page 5</p> <p>#1 administered glyburide 5mg to Resident C.</p> <p>Review of the December 2011 physician orders revealed the medication Glyburide 5mg was ordered to be given once daily with dinner. Review of the December 2011 MAR also revealed the Glyburide was scheduled to be given with dinner. However, facility staff had hand written late afternoon on the MAR.</p> <p>Interview with CMT#1, on 12/15/11 at 3:56 PM, revealed late afternoon meant from 3PM-7PM. She stated the dinner meal arrived on the floor between 5:30PM and 6:00PM. She stated she should have waited until the dinner meal arrived before giving the Glyburide. The CMT revealed she did not normally work on this floor and the "late afternoon" medication time was not used on the 5th floor.</p> <p>Interview with the 7th floor Nurse Unit Manger, on 12/15/11 at 4:00 PM, revealed the 6th and 7th floor are on a trial period for giving medication on a "Home like Medication Regimen". The pharmacy helped the facility to initiate the program and medication times were changed to: Upon rising, early afternoon, late afternoon, and bedtime. The unit manager stated if the physician ordered the medication for specific times (at dinner), the medication should have been administered at that time. She validated the dinner meal arrived on the 7th floor between 5:30 PM-6:00 PM. The nurse manager stated the Glyburide should have been given at 5:30 PM or 6: PM.</p> <p>Review of the Home-Like Medication Regimen form revealed medication schedule times defined</p>	F 332	<p>Continued from page 5</p> <p>months, then quarterly during 2012. Reports and audit check-off sheets will be given to the Process Improvement Analyst, RN, and Administrative Assistant Director of Nursing, RN, to analyze. The Administrative Assistant Director of Nursing, RN, will continue to evaluate medication error rate in the medication management committee monthly meetings and a report will be given in the Process Improvement quarterly meetings.</p>	1/24/2012



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F 332	Continued From page 6 as: upon rising...6:00 AM-11:00 AM, early afternoon...11:00 AM-3:00PM, late afternoon...3:00 PM-7:00PM, and bedtime...7:00 PM-10:00 PM. Interview with the Director of Nursing, on 12/16/11 at 1:00 PM, revealed the facility was conducting a trial on the 6th and 7th floor where medications were administered using the Home-Like Medication Regimen. The pharmacy initiated the program and medications were scheduled different than the regular scheduled times. However, she indicated if the physician ordered a medication at a specific time, the medication should be given at the ordered time. When asked if the nursing staff was trained on the new Home- Like medication regime, she replied, "yes". However, the facility did not provide any documented evidence the nursing staff was trained prior to implementation of the new medication regimen. Interview with the contract pharmacist, on 12/16/11 at 1:30 PM, revealed the medication Synthroid should be given on an empty stomach, early in the morning. He stated the thyroid releases more hormones in the morning and the resident would need the medication at that time. The Prilosec should be given before meals for better absorption. The glyburide should be given at meals to help decrease stomach upset and side effects. The pharmacist stated the drug manufacturer recommends glyburide be given with meals.	F 332			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE- SANITARY The facility must-	F 371	F 371 This "D" deficiency is a level 2, which is defined as no harm to a resident occurred.		



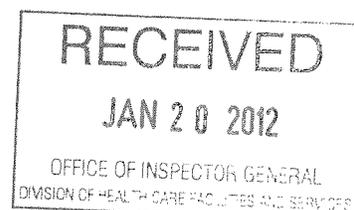
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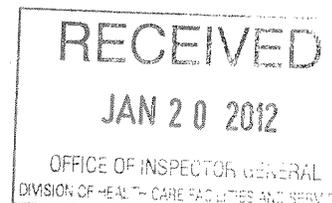
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F 371	<p>Continued From page 7</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to serve food under sanitary conditions. Observation of the breakfast meal on 12/16/11 on the 6th floor revealed two (2) staff members touching food with bare hands for one (1) resident of the thirty (30) sampled residents, (Resident #8) and (3) three of the six (6) unsampled residents (D, E, and F).</p> <p>The findings include:</p> <p>Observation, on 12/16/11 at 7:55AM, revealed Certified Nursing Assistant (CNA) #4 setting up breakfast trays for Resident #8, then unsampled Resident D, followed by unsampled Resident E. CNA #4 was observed to pick up the toast with her bare hands and put butter and jelly on both pieces of the toast for all three (3) residents.</p> <p>Interview with CNA #4, on 12/16/11 at 8:30AM, revealed it was acceptable to touch food with bare hands as long as you washed or sanitized your hands before touching the food. She stated she only touched the residents' food if the resident could not do it for themselves. She indicated she was trained that it was acceptable</p>	F 371	<p>F 371 – Continued from page 7</p> <p>The food trays for residents #8, D, E, and F were served under sanitary conditions. The two staff members who served these trays did wash their hands, per hand washing protocol prior to serving trays. None of the residents' food came in contact with any resident or ill staff member. The unit where residents #8, D, E, and F reside is a person-centered/home-like care unit. This model is not only encouraged by the facility to give the residents the highest quality of life, but also supported by the residents and their families alike.</p> <p>CNA #4 and LPN #11 were re-educated immediately by their Unit Manager.</p> <p>All residents who receive a meal tray could potentially be affected. A proper food handling poster was produced and displayed on 1/12/2012 by the Clinical Assistant Director of Nursing, RN. All employees who potentially handle food must review and sign by 1/23/2012 to assure staff awareness and understanding of the requirement. The Educator/Staff Development LPN will continue to disseminate a sanitary food handling video in orientation and annually. The Compliance Officer, LPN, will observe ten (10) meal tray set-ups on the units. The Administrative Assistant, CMT, will observe ten (10) meal tray set-ups in the dining room. These observations will be done once a month for</p>	



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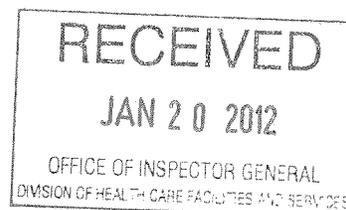
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F 371	Continued From page 8 to do this. Observation, on 12/16/11 at 8:35AM, revealed Licensed Practical Nurse (LPN) #11 setting up unsampled Resident F's breakfast tray. LPN #11 asked the resident if the resident wanted butter and jelly on the toast, then proceeded to pick up the toast with her bare hands and spread jelly on both pieces of toast. Interview with LPN #11, on 12/16/11 at 10:45 AM, revealed touching of food should require using a napkin, or silverware. She went on to say bare hand contact should be avoided with the residents' food. She stated the staff had been inserviced by Staff Development regarding dietary infection control but was unsure of the date because they had so many inservices. LPN #11 stated residents are at risk for getting sick from contamination of the food when staff are touching food with bare hands. Interview with the Director of Nursing, on 12/16/11 at 3:30PM, revealed the Staff Development Nurse had developed a video, about three (3) years ago, on infection control with explicit details of staff not touching residents' food with bare hands. She stated all staff should have viewed it when it was developed and during new employee orientation.	F 371	F 371 – Continued from page 8 2 months, then quarterly in 2012. A copy of audit findings will be given to the Clinical Assistant Director of Nursing, RN, and the Performance Improvement Analyst, RN quarter in 2012.	1/24/2012
F 441 SS=E	483.651 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	This "E" deficiency is a level 2, which means no harm to any resident occurred. The facility does have in place an effective evidence-based Infection Control program that is referenced by State and Federal regulations, CDC, and APIC. Routinely changing the nasal cannula tubing is the responsibility of Respiratory	



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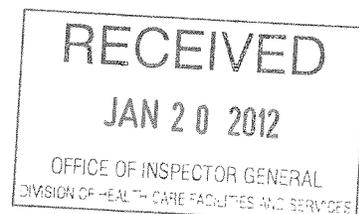
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/16/2011
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F 441	Continued From page 9 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy and review of Center for Disease Control (CDC) recommendations supplied by the facility,	F 441	F 441 – Continued from page 9 Therapist. In addition; nursing changes the nasal cannula if needed. The Unit Manager changed the nasal cannula tubing for resident #8 on 12/15/2011 which was prior to the surveyor making the staff aware. The Respiratory Therapist and the nursing staff were made aware of the concern during the survey and were re-educated by the Unit Manager, LPN, and Administrative Assistant Director of Nursing, RN, on the respiratory change schedule policy. The Respiratory Therapist was again re-educated by the MedSource Plus Director of Operations on 1/10/2012. During the survey, each unit secretary checked all residents with nasal cannula tubing. No other concerns were found. The Respiratory Therapist will complete a monthly equipment change log per unit. A copy will be given to the Director of Nursing. All nurses and CMT's were identified as needing re-education. The Respiratory Equipment Changing Schedule Policy and Procedure will be covered in the Mandatory Nursing/CMT Skills Event on 1/12/2012 through 1/23/2012 given by Educator/Staff Development, LPN, Clinical Assistant Director of Nursing, RN, Administrative Assistant Director of Nursing, RN, 3-11		



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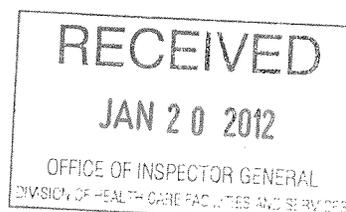
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F 441	<p>Continued From page 10</p> <p>It was determined the facility failed to have an effective infection control program related to oxygen tubing not changed and not washing or sanitizing hands between glove changes for three (3) of thirty (30) sampled residents. Oxygen tubing was outdated by forty-one (41) days for Resident #8 and one (1) staff failed to wash or sanitize hands between glove changes during dressing changes for Residents #3 and #6.</p> <p>The findings include:</p> <p>Review of the facility's policy Respiratory Therapy Supply Change Schedule, revised 03-04, revealed Nasal Cannulas will be changed by Respiratory Therapy one time a month, and as needed when soiled. In addition, the policy stated oxygen supplies are available if at any time the Nursing Staff should need to change a disposable item.</p> <p>Interview with the Director of Nursing (DON), on 12/16/11 at 1:15 PM, revealed nursing staff should "know oxygen tubing dated past one (1) month should be changed. She stated respiratory services are primarily responsible for changing the oxygen tubing. The DON stated the purpose of changing the oxygen supplies once a month was for overall infection control.</p> <p>1. Review of the medical record for Resident #8 revealed the facility admitted the resident on 10/16/09 with Diagnoses including Cardiomegaly and Congestive Heart Failure. The resident was placed on Hosparus on 03/20/10 for Failure to Thrive.</p> <p>Observation, on 12/14/11 at 1:00 PM, revealed</p>	F 441	<p>F 441 – Continued from page 10</p> <p>House Supervisor, RN, 11-7 House Supervisor, LPN, 7a-7p Weekend House Supervisor, RN, and 7p-7a Weekend House Supervisor, RN. The understanding of this policy and procedure will be demonstrated by completion of a 5 question test and a signature of attendance sheet. The Clinical Assistant Director of Nursing, RN, will monitor effectiveness of education/re-education by checking ten (10) nasal cannula tubings monthly in 2012. A copy of findings will be given to the Performance Improvement Analyst, RN quarterly in 2012.</p> <p>Even though the facility feels we have an effective Infection Control program, a policy and procedure change was made during survey in regards to non-sterile dressing changes. The concerns of the surveyors were brought to the attention of the treatment nurse and team. On 12/16/2011 treatment nurse was re-educated by the Infection Control Nurse. The Treatment Nurse, LPN re-educated her staff on 12/16/2011 after revising the procedure on non-sterile dressing changes. Nurses and CMT's performing dressing changes on residents with two or more dressing changes were identified as needing re-education. The new policy and procedure along with a demonstration will be added to the</p>



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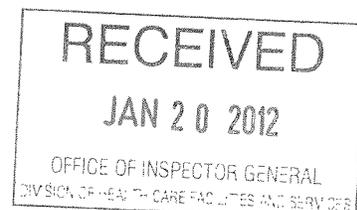
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F 441	<p>Continued From page 11</p> <p>Resident #8 had oxygen infusing per nasal cannula at two liter per minute. The nasal cannula was dated 10/04/11.</p> <p>Continued observation, on 12/14/11 at 3:15 PM and 12/15/11 at 8:45AM, 9:30AM, and 11:25 AM, revealed the same oxygen tubing remained dated for 10/04/11.</p> <p>Observation, on 12/16/11 at 8:00AM, revealed the oxygen tubing had been changed and was now dated 12/15/11.</p> <p>Interview with Licensed Practical Nurse #11, on 12/16/11 at 10:45 AM, revealed nursing could change oxygen supplies when they become soiled, and Respiratory Therapy would change the supplies, including nasal cannulas, on a schedule bases.</p> <p>Interview with the Respiratory Therapist, on 12/16/11 at 10:45 AM, revealed they changed oxygen supplies once a month to decrease the risk of contamination and infection to the residents using the supplies. He stated that he tried to ensure all respiratory supplies were changed monthly but he could have missed one. He stated nursing was trained on how frequently oxygen supplies should be changed and have access to the oxygen supplies on the units.</p> <p>2. Review of the facility policy Hand Hygiene, Revised 03/04, revealed ... Hand Hygiene/Handwashing was expected to be done between care for residents. However, the policy did not address handwashing during dressing</p>	F 441	<p>Continued from page 11</p> <p>Mandatory Nursing Skills Event 1/12/2012 through 1/23/2012. The signature of attendance sheet will exhibit understanding. The Essential Agency Guidelines pamphlet was updated with the new policy and procedure information on 1/18/2012. The Treatment Nurse, LPN, and the Compliance Officer, LPN, will observe six (6) non-sterile dressing changes monthly x 2 months, then quarterly in 2012. The findings will be submitted to the Process Improvement Analyst, RN.</p>	1/24/2012	



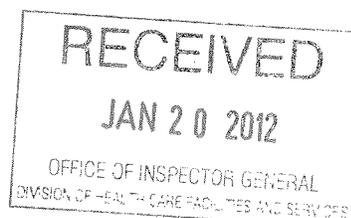
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F 441	<p>Continued From page 12</p> <p>changes or treatments. However, the policy stated to wash hands with soap and water when hands were visibly soiled and at the beginning and end of "dirty" procedures.</p> <p>Review of the Centers for Disease Control (CDC) guidelines revealed hand hygiene was necessary after glove removal because hands could become contaminated through small defects in gloves from the outer surface of gloves used during removal. The CDC guidelines stated hand hygiene should be performed immediately after gloves were removed. The CDC recommends changing gloves when going from dirty to clean areas.</p> <p>Interview, on 12/15/11 at 9:35AM, with the Skin/Wound Nurse revealed a dressing change begins with handwashing. She stated you were to reglove for each dressing and wash hands when finished. She added that each wound would require handwashing prior to the dressing change.</p> <p>Observation, on 12/15/11 at 9:30AM, of the dressing change to the decubiti of Resident #3 revealed Certified Medication Technioian (CMT) #1 changed gloves eight (8) times without washing her hands. CMT #1 washed her hands prior to the procedure and when she completed two dressing changes, one to each side of the buttocks. However, hands were not washed between the glove changes or when she moved from one site to the next.</p> <p>Interview, on 12/16/11 at 9:45AM, with the Fourth Floor Unit Manager revealed she knew what the facility policy on handwashing had stated. Staff</p>	F 441		



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F 441	Continued From page 13 had been trained on the policy. She did not know hands were to be washed between glove changes. In addition, she did not know the CDC guidelines. She stated failure to properly wash hands during dressing changes could result in making the wound worse or contaminating yourself. 3. Review of the medical record for Resident #6 revealed the facility admitted the resident on 11/22/10 with diagnoses including Alzheimer's, Dementia, Right Humeral Fracture, and Chronic Kidney Failure. Observation, on 12/15/11 at 8:45AM, during a dressing change with CMT #2 revealed she did not wash or sanitize her hands after removing soiled gloves and reapplying clean gloves. Interview, on 12/16/11 at 3:50 PM, with the Fifth Floor Unit Manager revealed he/she did not know it was necessary to wash or sanitize hands between glove changes.	F 441		



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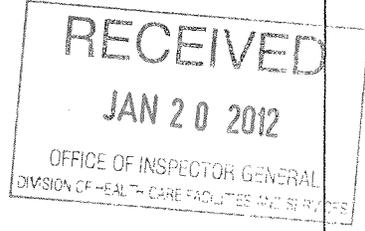
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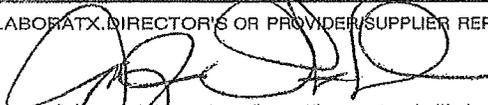
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1973</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Seven (7) stories with a partial basement, Type II, Protected.</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments on each floor, one (1) through seven (7).</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 2001.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system, upgraded in 2001.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was initiated on 12/14/11 and concluded on 12/15/11. Parkway Medical Center was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for two-hundred and fifty-two (252) beds and the census was two-hundred and twenty-six (226) on the days of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K000	<p>The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>As a part of the facilities' ongoing process improvement program, all audit results will be reported to the Process Improvement Team with additional education as necessary.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE (X6) DATE ADMINISTRATOR 1/20/12
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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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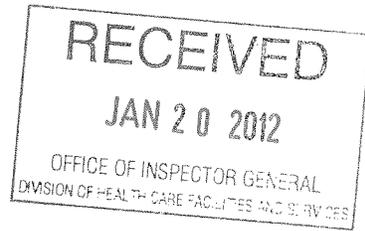
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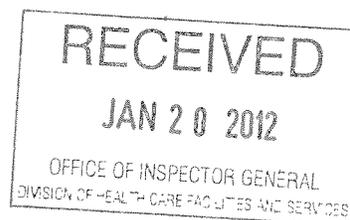
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K000		
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 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 corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect each of the two (2) smoke compartments</p>	K 018	<p>K 018</p> <p>The door knobs for rooms 508, 503, and 218 were repaired and they now latch properly. All resident room door knobs were checked during the survey and only those noted were found to not latch. All resident rooms have the potential to be affected, therefore the Maintenance Assistants will inspect all resident room doors monthly and document on a monthly preventive maintenance form.</p> <p>The Maintenance Supervisor/Director of Facility Management will conduct inspection audits of ten (10) rooms per floor quarterly during 2012.</p> <p>A copy of inspection and audit findings will be given to the Performance Improvement Analyst quarterly.</p>	1/24/2012



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K 018	<p>Continued From page 2</p> <p>on the fifth and second floors, approximately seventy-five (75) residents, staff, and visitors. The facility is licensed for two-hundred and fifty-two (252) beds and the census was two-hundred and twenty-six (226) on the days of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/14/11 between 3:30 PM and 3:35 PM, with the Director of Facility Maintenance and the Maintenance Supervisor revealed the Resident's corridor doors to rooms 508 and 503 did not latch when tested. Further observation, on 12/15/11 at 10:45 AM, with the Director of Facilities Management and Maintenance Supervisor revealed the Resident's corridor door to room 218 did not latch when tested.</p> <p>Interviews, on 12/14/11 between 3:30-PM and 3:35PM, and on 12/15/11 at 10:45 AM, with the Director of Facilities Management and the Maintenance Supervisor revealed a confirmation that the doors would not latch and resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the</p>	K 018		



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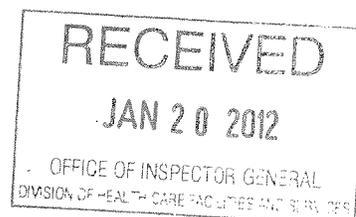
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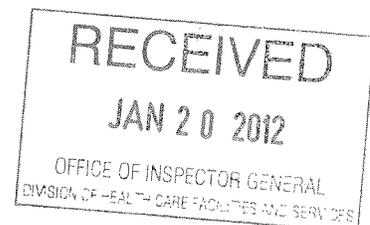
K 018	<p>Continued From page 3</p> <p>passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p>	K 018		
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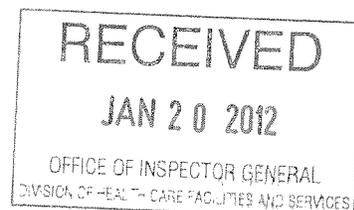
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217	
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K 027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/2-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke. These doors must close all the way and be smoke tight to help prevent smoke from reaching other parts of the building in the event of an emergency. The deficiency had the potential to affect the two (2) smoke compartments on the second floor, approximately thirty-five (35) residents, staff, and visitors. The facility is licensed for two-hundred and fifty-two (252) beds and the census was two-hundred and twenty-six (226) on the days of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/15/11 at 10:15 AM, with the Director of Facility Maintenance and the Maintenance Supervisor revealed the cross-corridor fire doors located on the second floor, closed completely when tested, but had a</p>	K027	<p>K 027</p> <p>A brush astragal was installed on the 2nd floor cross-corridor fire doors to assure the doors are smoke resistant. All other facility cross-corridor fire doors were inspected on 12/15/2011 by Maintenance Supervisor/Director of Facility Manager during the survey and were found to close correctly and not have any gaps. The Maintenance Assistants will inspect all cross-corridor doors monthly to ensure doors are closing properly and resist passage of smoke. The Maintenance Supervisor/Director of Facility Management will conduct inspections of all cross-corridor doors quarterly in 2012. A copy of inspection reports will be given to the Performance Improvement Analyst quarterly.</p>	1/24/2012



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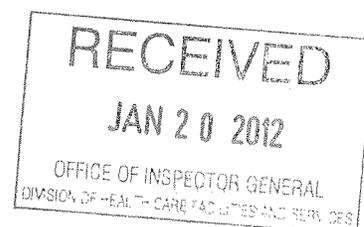
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K 027	Continued From page 5 gap of approximately one-quarter of an inch between the pair of doors and would not resist the passage of smoke. Interview, on 12/15/11 at 10:30 AM, with the Director of Facilities Management and the Maintenance Supervisor revealed they were unaware of the excessive gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD	K 027		
K 056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K056	K 056 A sprinkler head was installed in the 2 nd floor day room closet assuring automatic sprinkler coverage for the closet. Other recently renovated areas were inspected on 12/15/2011 by Maintenance Supervisor/Director of Facility Manager and sprinkler heads were found installed according to code expectations. The facility contractor was made aware on 12/17/2011 by Director of Facility Management of the need to be more vigilant in the future. Maintenance Supervisor/Director of Facility Management will be responsible to assure an assessment for the need for additional sprinkler heads will occur in the event of future renovation projects. The Director of Facility Management will submit a report quarterly to the Performance Improvement Analyst during 2012 to show that areas of renovation were assessed for the need for additional automatic sprinkler coverage.	1/24/2012



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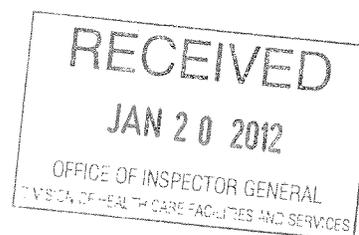
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KD56	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect the two (2) smoke compartments on the second floor, approximately seventy-five (75) residents, staff and visitors. The facility is licensed for two-hundred and fifty-two (252) beds and the census was two-hundred and twenty-six (226) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/15/11 at 10:00 AM, with the Director of Facility Maintenance and Maintenance Supervisor revealed the storage closet located in the second floor Day Room was not protected by automatic sprinkler coverage.</p> <p>Interview, on 12/15/11 at 10:00 AM, with the Director of Facility Maintenance and Maintenance Supervisor revealed the room had recently been remodeled and added a storage closet within the room. The sprinkler system had not been modified to accommodate the newly added room.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in</p>	K 056			



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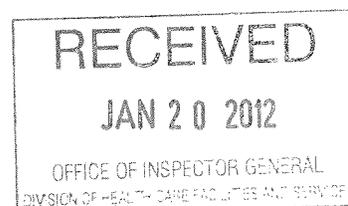
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K 056 K 147 SS=E	<p>Continued From page 7 accordance with Section 9.7.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as 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 two (2) smoke compartments on the seventh, third, second and first floors, residents, staff, and visitors. The facility is licensed for two-hundred and fifty-two (252) beds and the census was two-hundred and twenty-six (226) on the days of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/14/11 at 2:30PM, with the Director of Facility Maintenance revealed a refrigerator plugged into a power strip in Resident Room 707.</p> <p>Interview, on 12/14/11 at 2:30PM, revealed she was unaware of the misuse of a power strip in the Resident's room.</p> <p>Further observations, on 12/15/11 between 9:20 AM and 1:10PM, with the Director of Facility Maintenance and the Maintenance Supervisor revealed:</p>	K056 K 147	<p>K 147</p> <p>The electrical power strip in room 707 was removed. The refrigerator that was plugged into the power strip is now plugged directly into an outlet in the wall. The Maintenance Assistants will do monthly inspections of all resident rooms to assure power strips are not being used for medical equipment or refrigerators. An inservice on the appropriate use of power strips was conducted and video-taped on 1/12/2012 by the Director of Facility Management and mandatory for all staff by 1/23/2012. The Maintenance Supervisor/Director of Facility Management will check ten (10) resident rooms per floor for proper usage of power strips. This will be done quarterly during 2012. A report of inspection findings will be analyzed and submitted to the Performance Improvement Analyst.</p> <p>The third floor Mechanical Room junction box was repaired. Other mechanical room electrical junction boxes were inspected 12/15/2011 by Maintenance Supervisor/Director of Facility Management and cover plates were found to be intact. Maintenance staff and outside contractors were educated by the Director of Facility Management on 12/17/2011 on the importance of cover plates being replaced after work is completed. Maintenance staff and contractors exhibited understanding by signing an acknowledgement form. The Maintenance Supervisor/Director of Facility management will inspect all electrical work to assure all</p>	



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K 147	<p>Continued From page 8</p> <ol style="list-style-type: none"> In the third floor Mechanical Room, an electrical junction box was missing a cover plate, exposing electrical wiring. In the second floor Physical Therapy Room, medical equipment was plugged into a power strip. In the first floor Dining Area, Mechanical Room; chairs were stored in front of electrical switch gear. In the Kitchen, a prep table was located directly in front of electrical panels. <p>Further interviews, on 12/15/11 between 9:20AM and 1:10 PM, with the Director of Facility Maintenance and the Maintenance Supervisor revealed they were not aware of the junction box missing a cover plate in the third floor Mechanical Room, the misuse of a power strip for medical equipment in the second floor Physical Therapy Room, the storage of chairs in front of the electrical switch gear in the Dining area Mechanical Room, and the prep table placed in front of the electrical panels within the Kitchen.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>K 147 – Continued from page 8</p> <p>electrical junction box cover plates are replaced after work is completed. A quarterly report will be submitted to the Performance Improvement Analyst noting inspections and findings in 2012.</p> <p>The electrical power strip was removed in the Physical Therapy room. The medical equipment is now plugged into a wall outlet. Other ancillary work areas were inspected 12/15/2011 by Maintenance Supervisor/Director of Facility Management to ensure that no power strips are being used and that code expectations are being met. An inservice on electrical power strips and limitations of use was conducted and video-taped by the Director of Facility Management on 1/12/2012 and mandatory for all staff by 1/23/2012. The Maintenance Assistants will do monthly inspections of all departments and common areas on each floor to ensure power strips are not being used for medical equipment or refrigerators. The Maintenance Supervisor/Director of Facility Management will do audits of all departments quarterly during 2012 and submit a report of inspections to the Performance Improvement Analyst quarterly.</p> <p>The chairs sitting in front of the electrical switch gear in the mechanical room off the dining area on the first floor were removed. Other similar areas were inspected 12/15/2011 by Maintenance Supervisor/Director of Facility Management throughout the facility to ensure compliance.</p> <p>While doing monthly preventive maintenance inspections, maintenance assistants will inspect the dining storage room and all other similar areas to assure areas in front of electrical switch gears are kept clear.</p>



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K 147	<p>Continued From page 9 110-26. Spaces</p> <p>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.</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147	<p>K 147 – Continued from page 9</p> <p>An inservice on the necessity of keeping the areas in front of all electrical switch gear clear of any and all items was conducted and video-taped on 1/12/2012 by the Director of Facility Management and mandatory for all staff by 1/23/2012. In addition, signs were posted on 12/16/2011 to cue staff not to place anything less than 3 feet in front of the electrical gear box. The Maintenance Supervisor/Director of Facility Management will do inspections of all electrical gear box areas quarterly during 2012 to ensure the policy is being followed. A copy of the inspection report will be submitted to the Performance Improvement Analyst quarterly.</p> <p>The prep table in Nutrition Services was removed from the front of an electrical panel. All other electrical panel areas were inspected 12/15/2011 by Maintenance Supervisor/Director of Facility Management to assure compliance. Monthly while performing preventive maintenance inspections, maintenance assistants will inspect the electrical panel areas in the nutrition service department and throughout the building to ensure all areas in front of electrical panels have a 3 foot clearance. An inservice on the importance of keeping a 3 foot clearance in front of electrical panels clear was conducted and video-taped on 1/12/2012 by the Director of Facility Management and mandatory for all staff by 1/23/2012. The Maintenance Supervisor/Director of Facility Management will inspect all electrical panels quarterly in 2012 to ensure the policy is being followed. A copy of the inspection reports will be given to the Performance Improvement Analyst quarterly.</p>
			1/24/2012

