STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING _____ B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON PINES NURSING AND REHABILITATION CENTER	403 CRESTVIEW AVENUE WILSON, NC 27893

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F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide a nutritional supplement, ordered by the physician as an intervention to help prevent further weight loss, for 1 of 4 sampled residents (Resident #90) who experienced significant weight loss in the facility. Findings include: Resident #90 was admitted on 01/13/11 and readmitted on 09/25/12. The resident's documented diagnoses included diabetes, pernicious anemia, chronic kidney disease, hypertension, and history of myocardial infarction. The resident's Weight History documented he weighed 201 pounds on 07/10/12, 199 pounds on 08/31/12, and 188 pounds on 09/25/12. A 09/25/12 physician's order started Resident #90 on Megace appetite stimulant 80 milligrams (mg) twice daily (BID).	F 325	Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Wilson Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. **F325 Avoiding nutritional status decline unless unavoidable** **Corrective Action for Resident Affected** Resident #90, Mighty Shake was corrected in the dietary tray tracker system on 01/17/13 by the dietary manager. Enlive was removed from resident #90 tray card on 01/17/13 by dietary consultant.	02/14/13

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

Peggy W Bullock RN / administrator 2-1-13

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

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F 325	Continued From page 1 Resident #90's 10/02/12 Quarterly Minimum Data Set (MDS) documented he had moderately impaired cognition, required only set-up assistance for eating, was on a therapeutic diet, and experienced a weight loss of 5% or more in the last month or a weight loss of 10% in the last six months (11 pounds or a 5.5% weight loss between 08/31/12 and 09/25/12). The resident's Weight History documented he weighed 181 pounds on 10/24/12. A 10/24/12 Quality Improvement (QI) Weight Review progress note documented the facility would be requesting a nutritional supplement to address Resident #90's continued weight loss. A 10/25/12 physician order began the resident on Mighty Shakes with every meal due to weight loss. The resident's Weight History documented he weighed 182 pounds on 11/06/12. A 11/15/12 registered dietitian (RD) progress note documented Resident #90 was on a regular texture no-added salt (NAS), no-concentrated sweet (NCS) diet with meal consumption averaging 50 - 75%. The note documented the resident was started on Mighty Shakes with meals on 10/25/12, and was already receiving Megace. The RD also reported the resident's weight had begun to stabilize over the past three weeks. The resident's Weight History documented he weighed 185 pounds on 12/13/12.	F 325	**Corrective Action for Resident Potentially Affected** All residents to include resident #90 with ordered nutritional supplements were reviewed by the Director of Nursing on 01/31/13 to ensure residents are receiving supplements per MD ordered. Any identified areas of concern were corrected by the Dietary Consultant and Dietary Manager during the time of review. **Systemic Changes** An in-service was conducted with the dietary staff on 02/01/13 by dietary manager regarding ensuring all items are on the trays per tray card to include ordered nutritional supplements when preparing trays. All newly hired dietary staff will be trained on ensuring all items are on the trays per tray card to include ordered nutritional supplements when preparing trays by the dietary manager during orientation. All certified nursing assistants and license nurses were in serviced on 01/28/13 by administrative nurses to ensure all identified ordered nutritional supplements on the tray card are actually on the meal trays during tray set up and to notify dietary department for any concerns. All newly hired CNAs and license nurses will be trained to ensure all identified ordered nutritional supplements on the tray card are actually on the meal trays during tray set up and to	

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F 325	Continued From page 2 The resident's 12/20/12 Annual MDS documented he had moderately impaired cognition, required only set-up assistance for eating, and was on a therapeutic diet. In a 12/20/12 Dietary Assessment the dietary manager (DM) documented Resident #90's meal intake was still averaging 51 - 75% of meals with weight fluctuation over the past 180 days but with recent weight stabilization. On 01/02/13 "Potential for state of nourishment; less than body requirement characterized by weight loss, inadequate intake, decreased appetite related to : being on a therapeutic diet, cognitive impairment" was identified as problem on Resident #90's care plan. Goals for the problem included, "Will maintain or increase weight." Interventions for the problem included, "Diet as ordered." The resident's Weight History documented he weighed 185 pounds on 01/04/13. At 12:25 PM on 01/14/13 Resident #90 was eating lunch in his room. There was no Mighty Shake on his meal tray. The resident's tray slip documented in the beverage section he was supposed to receive Enlive (a fruit punch-like nutritional supplement) with his lunch meal. However, there was no Enlive on the resident's meal tray. At 12:18 PM on 01/15/13 Resident #90 was eating lunch in his room. There was no Mighty Shake on his meal tray. The resident's tray slip documented in the beverage section he was	F 325	notify dietary department for any concerns by the staff facilitator during orientation. The dietary manager will check residents meals trays against the tray cards at the end of the tray line to include resident #90 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure all items are on the tray per tray card to include ordered nutritional supplements utilizing a tray card monitoring QI tool. All identified areas of concern will be immediately corrected by dietary manager. The Administrator will check the tray card monitoring QI tool weekly for completion. **Quality Assurance** The QI Tray card monitoring QI tool will be reviewed monthly at the QI committee and corrective action initiated as appropriate. The QI committee is the main quality improvement committee. They have regularly scheduled meeting monthly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.	

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F 325	Continued From page 3 supposed to receive Enlive (a fruit punch-like nutritional supplement) with his lunch meal. However, there was no Enlive on the resident's meal tray. At 8:01 AM on 01/16/13 Resident #90 was eating breakfast in his room. There was no Mighty Shake on his meal tray. The resident's tray slip documented in the beverage section he was supposed to receive Enlive (a fruit punch-like nutritional supplement) with his breakfast meal. However, there was no Enlive on the resident's meal tray. At 12:22 PM on 01/16/13 Resident #90 was eating lunch in his room. There was no Mighty Shake on his meal tray. The resident's tray slip documented in the beverage section he was supposed to receive Enlive (a fruit punch-like nutritional supplement) with his lunch meal. However, there was no Enlive on the resident's meal tray. At 1:12 PM on 01/16/13 the DM stated he could find no order for Resident #90 to receive Enlive supplement so he was going to make sure the resident received the Mighty Shakes with his meals as ordered on 10/25/12. At 3:17 PM on 01/16/13 NA #3 stated part of her responsibility at meals was to match the resident tray slips against what was on their meal trays. She reported she was checking the accuracy of the diet prescription, likes/dislikes, and nourishments. NA #1 commented if a resident did not receive the supplement documented on their tray slip, she immediately notified the nurse who made sure the resident did receive the	F 325		

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F 325	Continued From page 4 supplement. At 8:10 AM on 01/17/13 Resident #90 was eating breakfast in his room. There was no Mighty Shake on his meal tray. At 8:52 AM on 01/17/13 the corporate dietary consultant stated the Enlive beverage should not have been entered in the beverage section of the tray slip but in the nourishment section instead. She reported the former DM, who left only a couple of weeks ago, would have been the person who entered supplements into the computer system so they would appear on the tray slips. At 9:12 AM on 01/17/13 the DM stated the facility did not even have the Enlive supplement in stock currently. He reported the dietary department was made aware of new supplements provided at meals by receipt of a dietary communication form, completed when the new physician's order was taken. According to the DM, he was currently matching the tray slips against the meal trays for accuracy at each meal, before the trays/carts left the kitchen. At 9:22 AM on 01/17/13 nursing assistant (NA) #1 stated part of her responsibility at meals was to match the resident tray slips against what was on their meal trays. She reported she was checking the accuracy of the diet prescription, likes/dislikes, and nourishments. NA #1 commented if a resident did not receive the supplement documented on their tray slip, she immediately notified the nurse who made sure the resident did receive the supplement.	F 325		

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F 325	Continued From page 5 At 9:28 AM on 01/17/13 the nurse supervisor stated as far as she knew Resident #90 was still supposed to be receiving Mighty Shakes on his meal trays because there was no physician's order to discontinue them. She reported she was unsure why the resident would have been changed to Enlive, unless the resident or family informed the facility the resident did not like or tolerate milk-based supplements. At 10:12 AM on 01/17/13 Resident #90 stated he used to like the "little shakes in the cartons" that he received with his meals, and chocolate was his very favorite flavor. At 1:38 PM on 01/17/13 the director of nursing (DON) stated the nurse who took a new order for supplements with meals completed a dietary communication form which was sent to the dietary department. Once in dietary, the DON reported the information was put in the computer so it would print out on the tray slips. She commented nutritional supplements were supposed to appear in the nourishment section of the tray slips. According to the DON, the accuracy of the tray slip versus the meal tray was checked by a dietary employee in the kitchen at the end of the tray line, and was checked again when the NAs set up resident meal trays.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	**F329 – Drug regimen is free from unnecessary drugs** **Corrective Action - Affected resident (s)** Resident # 105 was reviewed for gradual dose reduction by the pharmacy consultant on 01/31/13. The Medical Director wrote an order on 1-16-13 to discontinue Risperdal 0.5mg, start Risperdal, ½ of 0.5mg po hs x's 3 days then discontinue.	02/14/13

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F 329	Continued From page 6 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete a gradual dose reduction on an antipsychotic medication as recommended by the consultant pharmacist during four back-to-back medication regimen reviews for 1 of 10 sampled residents (Resident #105) who were reviewed for unnecessary medications. Findings include: Resident #105 was admitted to the facility on 06/8/10 and readmitted on 11/05/10. The resident's documented diagnoses included Alzheimer's dementia and cerebrovascular accident with hemiplegia, and depression. On 09/09/10 in response to the consultant	F 329	**Corrective Action - potential resident (s)** All residents to include resident # 105 who have orders to receive anti-psychotics medications were reviewed on 01/16/13 by the Pharmacy Consultants on to ensure their appropriateness with the GDR. The Medical Director was notified of the pharmacy recommendations and orders received and carried out on 01/30/13 by the nursing supervisors. **Systemic Changes to prevent recurrence** An in-service was performed on 02/01/13 by Director of Nursing regarding ensuring pharmacy recommendations to include recommendations for gradual dose reductions are completed timely and if unable to get recommendations signed by the Primary Physician then to notify the Medical Director. The Director of nursing will review the completion of all residents' pharmacy recommendations to include resident # 105 recommendations and recommendations for gradual dose reductions monthly times 3 months utilizing a Pharmacy recommendation monitoring QI tool. Any identified areas of concern will be immediately corrected by the Director of Nursing.	

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F 329	Continued From page 7 pharmacist's request for a diagnosis to justify the use of Risperdal 0.5 milligrams (mg) three times daily (TID), Resident #105's primary physician checked the block indicating the resident had a dementing illness with associated behavioral symptoms. A 10/13/10 physician's order reduced the resident's Risperdal to 0.5 mg two times daily (BID). On 06/09/11 "Use of psychotropic drugs with the potential for or characterized by side effects of cardiac, neuromuscular, gastrointestinal systems as evidenced by: resident utilizes Celexa and Risperdal as ordered" was identified as a problem on Resident #105's care plan. Interventions to this problem included, "Evaluate effectiveness and side effects of medications for possible reduction/elimination of psychotropic drugs." Resident #105's Quarterly Minimum Data Set (MDS) documented she had short and long term memory impairment, was severely impaired in decision making, exhibited difficulty focusing/concentrating her attention, did not reject care, and received a daily antipsychotic and daily antidepressant. At 10:50 AM on 01/16/13 Nurse #1, Resident #105's nurse on first shift, stated the resident was basically non-verbal, maybe occasionally making some noises. She reported the resident would look around and follow staff members with her eyes, but was really unable to express herself. According to this nurse, when the nursing assistants (NAs) positioned the resident in the bed or chair she remained stationary until they	F 329	**Quality Assurance** The results of the Pharmacy recommendations monitoring QI audit tool will be forwarded to the Quality improvement committee monthly. The QI committee is the main quality improvement committee. They have regularly scheduled meeting monthly which are attended by the Administrator, Director of Nursing, and other nurse managers.	

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F 329	Continued From page 8 returned to reposition her. Nurse #1 stated Resident #105 had not exhibited any behaviors since she worked with her. At 3:17 PM on 01/16/13 NA #3, Resident #105's NA on second shift, stated the resident never exhibited any behaviors or refused any care. She reported the resident was non-verbal except for making occasional moans or grunts. The NA commented the resident never even moved unless the staff was turning and repositioning her. At 3:42 PM on 01/16/13 the consultant pharmacist stated in March of 2012 Resident #105's Risperdal was reduced to 0.5 mg every night (Q HS). However, since the resident was not exhibiting behaviors, she reported pharmacy recommendations were generated on 09/11/12, 10/05/12, 11/14/12, and 12/06/12 to reduce the Risperdal dosage further. The pharmacist reported the resident's primary physician did not respond one way or the other to the recommendations. She stated it was so frustrating to the pharmacists that two of the four recommendations were forwarded directly to the director of nursing (DON) to follow-up on. At 4:10 PM on 01/16/13 Nurse #2, who cared for Resident #105 on second shift, stated the resident never exhibited behaviors, was basically silent, and had to be encouraged sometimes to take her medications, but never refused them. She reported the resident was basically chair and bed bound, and did not move once positioned in either. At 9:28 AM on 01/17/13 a nurse supervisor stated Resident #105 received an antidepressant and	F 329		

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F 329	Continued From page 9 antipsychotic medication. She reported she was unaware of any behaviors that the resident currently presented, but thought there were some behaviors in the past which justified the use of the antipsychotic. However, she commented she could not remember what those behaviors were. At 10:28 AM on 01/17/13 NA #2, who cared for Resident #105 on first shift, stated she never heard the resident talk, but she sometimes mumbled incomprehensively or moaned. She reported the resident never exhibited any behaviors, and could not shift position in the bed or geri-chair unless staff moved her. At 1:38 PM on 01/17/13 the DON stated Resident #105's primary physician would not respond to pharmacist recommendations. She reported when this happened medical records called and reminded the physician's office that a response was needed. However, the DON commented this procedure still did not produce any response from Resident #105's physician. According to the DON, the Administrator also called the office of the resident's primary physician, requesting a meeting to discuss this lack of correspondence, but the physician refused to meet with her. She explained the facility was in the process of preventing this physician from seeing residents in the facility, and reassigning the residents to a more responsive physician. She stated another recourse was to approach the medical director for help in complying with pharmacy requests when the attending physician was not responsive. The DON reported the facility got a new medical director in October 2012. Before the change, the DON commented the old medical director refused to help with a gradual dose reduction in Resident	F 329		

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F 329	Continued From page 10 #105's Risperdal. However, she stated she had not approached the new medical director for help with reducing this resident's antipsychotic medication. The DON reported Resident #105 was not currently exhibiting behaviors, but had in the past. However, she could not remember what those behaviors were.	F 329		

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

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WILSON PINES NURSING AND REHABILITATION CENTER	403 CRESTVIEW AVENUE WILSON, NC 27893

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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 This STANDARD is not met as evidenced by: A. Based on observation on 02/19/2013 the smoke doors at room 502 failed to close smoke tight upon activation of the fire alarm. 42 CFR 483.70 (a)	K 027	**K 027** **Corrective Action** The smoke doors at room 502 was repaired on 02/19/13 to permit it to close smoke tight upon activation of the fire alarm by the Maintenance Supervisor. **Corrective Action for Resident Potentially Affected** All fire doors in facility were examined to ensure there they close properly upon activation of the fire alarm by the Maintenance Director on 02/19/13. **Systemic Changes** An in-service was conducted with the maintenance staff 03/04/13 by the Administrator to ensure understanding of proper procedure for smoke doors to close smoke tight upon activation of the fire alarm. The Maintenance Supervisor will monitor all doors monthly times 3 months to ensure compliance. The Administrator will check the smoke door monitoring QI tool monthly for completion 1 time a month times 3 months. **Quality Assurance** The safety committee will review the auditing tool monthly times 3 months and results will be reviewed by the QI committee times 1 quarter. The QI Committee has regularly scheduled meetings quarterly which are attended by the Administrator, Director of Nursing, other nurse managers, dietary manager, maintenance director and consultants.	04/05/13

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

Regina Bellucci RN LNHA — 3-7-13

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.

cD

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING 01 - MAIN BUILDING 01 MAR 07 2013 B. WING _____	02/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON PINES NURSING AND REHABILITATION CENTER	403 CRESTVIEW AVENUE WILSON, NC 27893

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Wilson Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 0-2/19/2013 the door to the kitchen office had a hasp and pad lock on it. B. Based on observation on 02/19/2013 there was no wiring diagram and component location map under glass near the fire alarm panel. 42 CFR 483.70 (a)	K 038	Wilson Pines Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. **K 038 – NFPA Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1** **Corrective Action** A. The hasp and pad lock on the kitchen office door was removed on 02/19/13. **Corrective Action for Resident Potentially Affected** All doors in facility were examined to ensure there they did not have a hasp and pad lock. This was completed by the Maintenance Director on 02/19/13.	04/05/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy W Bullock RN/LNHA — TITLE — (X6) DATE: 3-7-13

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K 038 continued

Systemic Changes
An in-service was conducted with the maintenance staff 03/04/13 by the Administrator to ensure understanding of proper procedure in utilizing a hasp and pad lock on doors.

The Maintenance Supervisor will monitor all doors monthly times 3 months to ensure compliance. The Administrator will check the door lock monitoring QI tool monthly for completion.

Quality Assurance
The QI door lock monitoring tool will be reviewed monthly by the safety committee 1 time a month times 3 months. The QI committee will review the safety committee QI door lock monitoring tools times 1 quarter. They have regularly scheduled meetings quarterly which are attended by the Administrator, Director of Nursing, other nurse managers, dietary manager, maintenance director and consultants.

Corrective Action
B. A wiring diagram and component location map under glass will be placed near the fire alarm panel by 04/05/13.

Corrective Action for Resident Potentially Affected
N/A

Systemic Changes
An in-service was conducted with the maintenance staff 03/04/13 by the Administrator to ensure understanding of

K 038 Continued

proper procedure in placing a wiring diagram and component location map under glass near the fire alarm panel.

Quality Assurance

The maintenance director will ensure the wiring diagram and component location map under glass near the fire alarm panel is in place weekly times 4 weeks and then quarterly times 3 months utilizing the safety auditing tool. The safety committee will review the auditing tool monthly times 3 months and results will be reviewed by the QI committee times 1 quarter. The QI Committee has regularly scheduled meetings quarterly which are attended by the Administrator, Director of Nursing, other nurse managers, dietary manager, maintenance director and consultants.