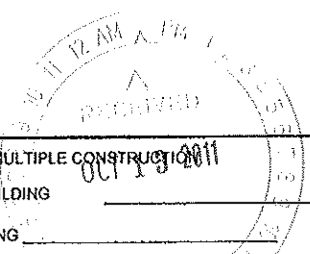

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING ______ B. WING ______	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F-241 1. Residents #64, #45, #14, #4, #3, #21, #105, #40, #18, #57, #97, #80, #96, #9, #8, #76, and #36 were fed and/or served subsequent meals at the same time as the restorative dining residents.	9/23/11
	This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to promote a dignified dining experience for 17 of 23 dependent and independent residents at the same time as the restorative resident in the main dining room (Residents# 21, 40, 18, 14, 64,45,4,3,57,97,80,96,9,8,105,76,and 36). The findings include: During an observation on 9/20/11 at 12:15PM, Residents # 64, #45, #14, #4, #3,#21 #105 and #57were being escorted and seated in the main dining room while three residents were being fed by staff. There were 10 residents seated at various tables awaiting for the meal as staff were feeding the three residents in the front of the main dining room. The main cart for the main dining room did not arrive until 12:40PM. Several staff was observed seated along side one another at the window conversing with one another, while the remaining residents waited to be served. During an observation on 9/22/11 at 12:00PM. There were 23 residents seated in the main dining room. Five restorative residents were being feed by two NA ' s and speech therapy. There was six additional staff along side of the		2. Quality Assurance rounding was conducted within the facility dining room to visualize no other areas of concern identified as related to a dignified dining experience for current dependent and independent residents, as well as restorative dining residents. 3. Current nursing staff was educated on the facility policy and procedure for dining services as to promote a dignified dining experience for dependent and independent residents, as well as restorative dining residents. DON/Designee will conduct Quality Improvement (QI) monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. Dietary Manager will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Completion Date 10-21-11.	9/23/11 10/21/11 10/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth W. Holland
TITLE: Administrator
(X6) DATE: 10/13/2011

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 241	Continued From page 1 wall conversing with one another. The speech therapist was performing her assessment with three of the residents while two other residents were being fed and the other 17 residents watched(Residents#21,#40,#18,#14,#64,#45,#4,#3,#4,#57 ,#97,#80,#96,#9,#8,#105,#76 and #36	F 241		
	The restorative dining meal cart arrived to the dining room at 11:40 AM and it had Resident #9 meal on it until 12:25PM. Resident #9 meal had not been served with the other restorative residents. The remaining residents #21,#40,#18,#14,#64,#45,#4,#3,#4,#57,#97,#80, #96,#8,#105,#76 and #36 was seated at various tables looking at the restorative residents eat. During an interview on 9/22/11 at 12:25PM,RA #1 and RA #2 (restorative aide) stated that generally they feed the restorative residents 1st before they start on the main dining residents. RA #1 stated that some residents sit at least 25-30 minutes before the actual meal was served. RA #2 indicated that Resident #9 family generally feed her, however when the family does not visit staff should be feeding the residents. Resident #9 was one of the residents that was fed 1st. During an interview on 9/22/11 at 12:35PM, NA#1 stated that the family generally feeds Resident#9 and the family was very particular about who fed Resident #9. She added that the family requested that staff wait for when they arrive to feed the resident and that the meal tray should stay on the cart until they arrive. She stated that staff wait			

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F 241	Continued From page 2 until at least 12:40PM before they would feed the resident if family does not show up. She added that the family wants the resident in the dining room early. In addition, the restorative residents were generally fed 1st and the other residents will arrive early after an activity. The observation continued until 1:15PM, Resident #9 family did not come, one staff attempted to feed the resident but did not finish. The administrative staff came in at 1:15PM and began to feed the resident. Resident #9 was seated at the table with the residents that was involved in the restorative program but was not fed. Resident #9 continued to wait until the general population was served. During an interview on 9/23/11 at 9:30AM, Resident #8 was identified by staff as alert and reliable. Resident #8 indicated that there was a wait time of 20 to 30 minutes before the meal came out of the dining room. Resident #8 also indicated they generally had to wait for the other residents to be fed first before there cart got on the dining room. Resident #8 added " I just don ' t understand why we have to wait so long " and pointed to kitchen door. During an interview on 9/23/11 at 3:00PM, the nurse supervisor indicated that she was present in the dining room on 9/22/11 when the restorative residents was being fed, while the other residents observed. The nurse supervisor further stated that generally the restorative residents would be fed 1st and then the remaining residents would receive assistance from the 3 assigned nursing assistants and	F 241		

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F 241	Continued From page 3 administrative staff in the area. She added that she was unaware that Resident #9 tray had remained on the meal cart as long as it did. Resident #9 should have been fed with the other restorative residents. In addition, the dining cart should have also come out at the same times as the restorative cart. Staff should have checked the cart. During a follow-up interview on 9/23/11 at 3:15PM, the administrative staff indicated that she assisted Resident #9 during the meal. She further stated that the new dining process was developed on 9/23/11 to address the meal time delays and meal cart delivery and that typically both carts arrived in the dining room at the same time. In addition, no resident should observe another eat and staff sitting around without assisting. During an interview on 9/23/11 at 3:30PM, the assistant director of nursing indicated that generally the restorative residents eat in an alternate environment. The restorative and main dining cart typically came out at the same time and no resident should be observing another resident eat. The expectation was that staff should offer snacks or fluids during the wait in the dining room. 2. Resident # 80 was observed in the main dining room sitting close to the door chewing his mouth and looking around. When asked if he usually had to wait long for his tray, he indicated, "It's always like this. They feed the Restorative people first and we have to wait a while." Four nursing	F 241		

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F 241	Continued From page 4	F 241		

assistants and a nurse supervisor were observed sitting in the back of the dining room talking and laughing. The meal cart came in the dining room at 12:45 p.m. and all the other residents were served.

During an interview on 9/22/11 at 12:55PM,. with NA # 4, she indicated that she was new in the facility and she did not know anything about the residents, and she was not sure what she needed to do in the dining room. NA # 4 added, "Nobody told me what to do and I was waiting to be told."

During an interview on 9/22/11 at 1:00PM., the dietary manger stated that "normally at 11:45 a.m. the restorative residents are fed and the dining room residents are served immediately after [12:00 noon], but nursing complained that the feeding time was interfering with the aides ' break and they have revised the meal time to feed the dining room residents at 12:15PM." She added that "the carts were ready, but we waiting for the aides to let us know they were ready, because we did not want carts to be sitting in the dining room unattended".

3. Observations were conducted in the main dining room on 09/22/11 at 12:30 PM. Resident # 96 was observed being fed by the Restorative Aide, while all other residents in the dining room were seated without having received a meal tray. An interview with the Restorative Aide was

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F 241	Continued From page 5 conducted on 09/22/11 at 12:35 PM. The Restorative Aide indicated, " We feed the Restorative residents first, then the other residents who come in the dining room get their trays." Resident # 4 (who was verified on 09/22/11 at 9:00 AM by Nurse #1 as being interviewable) was observed in the main dining room on 09/23/11 at 12:50 PM seated at the back of the dining room without having received a meal tray. Resident #4 was observed watching the residents in Restorative Dining being fed. When asked if she usually had to wait long for her tray, she indicated, "It's always like this. They feed the Restorative people first and we have to wait." When asked how the resident felt about waiting for the meal tray while Restorative residents were being fed, the resident indicated, " I don ' t like it, but there is nothing we (the residents) can do about it. It won ' t change. "	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to coordinate discharge services between disciplines for 1 of 2 sampled residents (Resident #78). The findings included:	F 250	1. Resident #78 no longer resides at the facility. 2. Quality Assurance was conducted within the facility for current residents to visualize no other areas of concern identified as related to coordination of discharge services between disciplines. 3. Social Services Director and Interdisciplinary Team were educated on the policy and	10/21/11 10/13/11

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F 250	Continued From page 6 Resident #78 was admitted to the facility on 3/23/11. The resident cumulative diagnoses included coronary artery disease, hypertension, chronic kidney disease, diabetes, parkinson's disease and dementia. The Minimum Data Set(MDS) indicated that Resident #78 had short and long term and cognitively impaired. The resident required extensive assistance with all activities of daily living and limited assistance with eating. Resident #78 was incontinent of bowel and bladder and was admitted for rehabilitation services. Review of Section Q of the Minimum Data Set(MDS) dated 3/30/11, revealed that Resident #78 and/or the family did not participate in the assessment and goal setting for discharge plans. The CAT(care area trigger sheet) dated 3/30/11, revealed under the analysis of findings; the CAA(care area assessment) " caa for return to community because (name) family plans on taking Resident home. Resident #78 continued to work with therapy. The care plan considerations notes indicated home health, upon discharge." The care decision was for this area was documented as no. The care plan dated 4/4/11, did not include and any discharge plans. Review of the facility new admission care review form dated 3/30/11, documented that review of resident/family expectation for discharge outcome and length of stay: likely need LTC(long term care). In addition, the section where the following information was reviewed with the resident and family revealed the family was in to visit and discussed the progression of dementia at length and that Resident #78 would likely need long term placement. Reviewed the increase risks for falls	F 250	procedure for discharge planning as to promote coordination of discharge services between disciplines for facility residents. Administrator will conduct Quality Improvement monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. Administrator will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision. 5. Completion Date 10-21-11.	10/21/11

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F 250	Continued From page 7 and the need for increased supervision and Resident #78 needed to continue with therapy. There was no signature of the resident or family on this form. Review of the physical therapy plan of treatment dated 3/38/11, revealed Resident #78 was referred for treatment for bed mobility, gait training with uses of assistive devices, sitting/standing balance and transfers. The long term outcome included that Resident #78 would ambulate 50 feet with minimum assistance and would be able to perform transfers and bed mobility with controlled gait assistance. The notes sections documented the reason for the referral was Resident #78 was functioning significantly below PLOF and family has goal to return to independent living. During an interview on 9/21/11 at 3:51PM, the family member stated that the family was" mislead" by the facility social worker into thinking that he would assist them with discharge plans for Resident #78 at a local assisted living(name). In addition the family had been informed by the social worker on admission that Resident #78 would participate in rehabilitation services and once therapy was completed the social worker would speak with the family regarding alternate placement. In addition, they were aware of when the Medicare days would end in June. The family members further stated that the social worker and the therapy department had approached the family to discuss alternate placement and what would be done to assist in the transition for alternate placement. The family also stated that the social worker informed them they would be contacting assisting living facilities in the area and	F 250		

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F 250	Continued From page 8 setting up any other services that Resident #78 would need in the transition. The family also stated that when they had inquired with the social worker about the process and progress of the discharge they were told several times that Resident #78 was on the waiting list at the facility. However, after two months of waiting and inquiries, the family contacted the facility and went for a visit/tour of the suggested facility, the facility staff was unaware of Resident #78 placement plans from the facility. The family member indicated after speaking with the potential facility staff, they again followed up with the social worker and were told Resident #78 was still on the waiting list. The family indicated they had not received any written information of the status of the discharge plans. During an interview on 9/22/11 at 3:00PM, the social worker indicated that the social department was responsible for the discharge planning process. He stated that discharge plan discussion began on admission with resident #78 and family with the plan of Resident #78 returning home upon completion of the rehabilitation care. The social worker further indicated that during the discussion the family would be informed of what would be expected during Resident #78 care and therapy. In addition, the SW would contact other agencies and resources as the resident became closer to the discharge date or ending of rehab services. SW stated that weekly conversations had been held with the family regarding the resident's progress and the discharge plans. SW further stated that he had not contacted the assisted living on behalf of Resident #78 because the family had changed their mind about placement and that the resident had begun to	F 250		

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F 250	Continued From page 9	F 250		

Continued From page 9

decline so the family had agreed to transfer the resident from a rehab bed to a long term care bed. The social worker indicated that the discussions were documented in the social work general notes. The social worker reviewed the chart and stated, "I did not document what and who I contacted on behalf of the resident or what and when the conversations took place with the family. He also stated that if he had documented this information it would be in the SW general notes section." In addition, that when referrals were made to other facility for placement he would complete all the paper and the FL2 and the other facility would come and assess the resident.

During an interview on 9/22/11 at 5:45PM, the administrator indicated that the SW was responsible for discussing and preparing residents and family for discharge upon admission. She indicated that the team meets weekly and reviews the resident's condition/progress of the residents and any active alternative plans. The information would be documented on the case management summary weekly, which will include why the decision why discharge/ or not was made. The social worker should be contacting other facilities and resources to facilitate the process for potential discharge with input from the family.

During an interview on 9/23/11 at 11:35AM, the Minimum Data Set coordinator(MDS) indicated that she had completed section Q upon admission regarding discharge plans for Resident #78. The MDS coordinator indicated she did not confer with other disciplines in completing section Q and the MDS. The coordinator indicated that the social worker was responsible for the family

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F 250	Continued From page 10 discussion and she would include the information on the MDS. The coordinator reviewed the information documented in section Q, the case management summary form and admission review form and indicated that additional discussion should have been held with the team, resident and family.	F 250		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide dental exams of a resident with chipped and decayed teeth for one of one sampled resident with dental problems (Resident #25). Findings included: Resident #25 was admitted to the facility on 10/1/09 with diagnoses that included dementia, history of falls, and history of urinary tract infections, chronic back pain, and depression. The latest Minimum Data Set (MDS) dated	F 412	1. Resident #25 received outpatient dental services on 9/25/11. 2. Quality Assurance was conducted within the facility for current residents to visualize no other areas of concern identified as related to provision of dental exams of residents with chipped and decayed teeth. 3. Nursing staff and Interdisciplinary Team were educated on the policy and procedure for dental services as to provide dental exams of residents with chipped and decayed teeth. DON will conduct Quality Improvement (QI) monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. DON will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision. 5. Completion Date 10-21-11.	10/21/11 10/21/11 10/21/11

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F 412	Continued From page 11 08/1/11 revealed the resident had short- and long-term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with activities of daily living including personal hygiene. The MDS also documented that the resident received a therapeutic diet, " mechanical soft. " Section " L Oral/Dental Issues " coded the resident as having obvious or likely cavity or broken natural teeth. On 9/23/11 at 3:03 p.m., Resident #25 was observed lying in her bed. She was observed to have multiple missing teeth on the bottom on both sides of her mouth. Her remaining six front teeth on the bottom appeared to be decayed and chipped with obvious cracking and heavy yellow calculus (tartar). A review of the medical record for Resident #25 revealed no documentation of dental consults or referrals or routine periodic dental examinations. During an interview on 9/23/11 at 10:26 a.m., Nursing Assistant (NA) #4 stated that she was assigned to the resident. Whenever she completed oral care for resident# 25, she noticed that Resident #25 had several frontal lower teeth that appeared decayed. She added that the resident ' s mouth always had an unpleasant odor. NA #4 stated that the resident did not complain of mouth/gum/teeth pain, or showed any signs of mouth pain, but the resident always asked if she could go to the dentist. NA #4 stated that she reported the resident ' s request to Nurse #4 (NURSE was not in the facility and was unable to be reached by telephone on 9/23/11).	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING ______ B. WING ______	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

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F 412	Continued From page 12 On 9/23/11 at 10:45 a.m., the MDS coordinator was interviewed and stated she was unable to find any documentation of dental consults or referrals or routine periodic dental examinations in the complete and thinned medical record for Resident #25. She further indicated that she coded the resident on the MDS as having tooth decay and care-planned for oral care. The MDS coordinator further explained that, " since the resident was not experiencing any pain or discomfort, I did not follow up on a referral for dental consult. " She added, " We [the care plan team members] do not believe the resident could tolerate extractions. " On 09/23/11 at 2:00 p.m. the Director of Nursing stated that " I examined [Resident #25] ' s oral cavity and noted missing teeth, chipped and cracked and decayed teeth. " She added, " The resident needed to be seen by a dentist and the resident will be seen on Sept 25, 2011. On 9/23/11 at 2:30 p.m., the Administrator was interviewed. She stated that if the residents had dental concerns her expectations would be that the nurse would refer the residents to the medical doctor, who would request a dental consult for the residents and a scheduler would schedule the consult. She added that the resident ' s mouth was assessed and Tylenol was given for pain.	F 412		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

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K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 10/13/2011 the smoke doors near room 232 did not release upon activation of the fire alarm when tested on battery power. 42 CFR 483.70 (a)	K 051	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. K51 1. An outside contractor replaced the batteries for the alarm system on 10/25/2011. 2. An audit was completed by the Maintenance Director to ensure that all doors released upon activation of the fire alarm when tested on battery power. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 3. This standard will be monitored by testing the batteries on the alarm system to ensure all doors are released upon activation of the fire alarm. 4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 11/25/2011.	11/25/11
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm	K 061		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth A. Holland
TITLE: Administrator
(X6) DATE: 10/28/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

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K 061	Continued From page 1 will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 10/13/2011 there was a tamper alarm on the accelerator ball valve that is not approved by NFPA. 42 CFR 483.70 (a)	K 061	K061 1. A tamper alarm that is approved by NFPA will be placed on the accelerator ball valve by 11/27/11. 2. An audit was completed by an outside contractor to ensure that Only NFPA approved alarms where in use in the facility. 3 The Maintenance Director will conduct Quality Improvement (QI) monitoring of this 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4 The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.	11/27/11
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A. Based on observation on 10/13/2011 the loading dock out side the kitchen did not have a rail to prevent people from falling off the dock when exiting the kitchen. 42 CFR 483.70 (a)	K 130	K130 1. Steel posts with a safety chain will be installed on the loading dock by 11/27/2011. 2. An audit was completed by the Maintenance director to ensure compliance with K130 throughout the facility. No other issues were noted. 3. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 10//13/2011 there was no emergency light in the main switch gear room. 42 CFR 483.70 (a)	K 147		

Plan of Correction continued from page 2

The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.

11/27/11

K147

1. An emergency light was added In the main switch gear room on 11/2/2011.
2. An audit was completed by an the Maintenance Director to ensure that the facility is in compliance with K147.
3. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.
4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.Date of completion 11/25/2011