STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to dress a resident in clothing that was in good repair resulting in skin exposure for one of five sampled residents with cognitive impairment (Resident # 113). The findings included: Resident # 113 was admitted to the facility on 3/22/13. Cumulative diagnoses included: postpoliomyelitis (symptoms include progressive muscle and joint weakness and pain, general fatigue and exhaustion with minimal activity and muscle atrophy) and ataxia. A Quarterly Minimum Data Set (MDS) dated 9/2/13 indicated that Resident #113 was severely impaired in cognition. He required extensive assistance with dressing. On 09/24/2013 at 11:12 AM., Resident # 113 was observed sitting in a wheelchair in the hallway. He wore a red plaid shirt with two missing buttons. His abdominal area was exposed and visible to other residents, visitors and facility staff. On 9/24/13 at 4:30 PM. Resident # 113 was observed sitting in his wheelchair in his room. He was still wearing the red plain shirt with two missing buttons. His abdominal area was	F 241	**PLAN OF CORRECTION TAG #483.15 F-241** The facility will continue to promote care for residents in a manner and environment that maintains each resident's dignity and respect. **For the resident affected** Resident #113 was taken to his room and his shirt was changed. The Unit Manager inspected all garments in the affected resident's closet and removed one other shirt with missing buttons. After two attempts to notify the daughter, the daughter called the unit on 10/02/2013 and was made aware of resident's need for larger shirts. The daughter brought new shirts to the resident. **For residents who have the potential to be affected** Between 9/30/2013 and 10/13/2013, Unit Certified Nursing Assistants, Unit Nurses and Laundry staff inspected all resident closets and removed any clothing needing to be replaced. The Unit Manager and Social Work Staff will notify family of clothing needing repair or replacement. The Staff Development Coordinator will educate the Nursing Staff and Laundry Staff by 10/24/2013 on residents rights to dignity as affected by clothing being in good repair.	10/24/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/13/13

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 241	Continued From page 1 exposed to visitors and facility staff. An attempt was made to interview Resident # 113 regarding the missing buttons on his shirt. Resident # 113 was unable to answer how he felt wearing a shirt with missing buttons. On 9/24/13 at 4:39 PM., NA #1 stated Resident # 113 required assistance with dressing. She stated if clothing was torn or buttons missing, she would ask Resident # 113 if the clothing could be changed. She said Resident # 113 was cooperative with changing his clothing. NA #1 proceeded to change Resident # 113's shirt. On 9/24/13 at 4:47 PM., Nurse #1 stated she expected nursing staff to remove the shirt immediately when they noticed buttons were missing from the shirt. She said the nursing assistant should make the licensed staff aware of the missing buttons and the family would be notified that the shirt needed repair.	F 241	Continued From page 1 The Social Work Staff will purchase clothing for residents if family is unable to purchase. The Activities Director will write an article for the November Newsletter to address Resident Dignity and encourage families to inspect resident clothing for items needing repair or replacement. **System Change** Certified Nursing Assistants will be assigned to monitor resident closets weekly and remove any clothing that is stained or needing repair and give those articles of clothing to the Unit Manager. This duty will be added to the Certified Nursing Assistant Assignment Sheet. When laundry staff finds an article of clothing in need of repair or replacement, they will give it to the Unit Manager so the family can be notified. **Measures put in place to ensure solutions are sustained** The Unit Manager or Charge Nurse began auditing residents as a part of daily rounds for appropriateness of dress for four weeks. The audit will continue every other day for four additional weeks. The audit will continue monthly for seven months. Unit Nurses will also monitor the appropriateness of resident clothing as part of their daily rounds. Results of the monitoring of clothing condition will be documented and reported to the Quality Assurance Performance Improvement Committee for quality review.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to clean two portable shower chair commode plastic buckets in one of five shower rooms (A hall shower room). The findings included: On 9/23/13 at 12:38 PM. during the initial tour, the			

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F 253	Continued From page 2 shower room on A hall was observed. There were two portable shower chair commode buckets noted with flecks of brown material on the sides and bottom of both buckets. On 9/24/13 at 2:06 PM., an observation was conducted of the A hall shower room. There were two portable shower chair commode buckets stacked on the floor. Visible signs of flecks of brown material were noted on the sides and bottom of both buckets. On 9/24/13 at 4:50 PM., Nurse #1 stated the staff member that used the commode buckets would be responsible for cleaning them at the time they became soiled. She further stated cleaning of the buckets would not necessarily be the responsibility of the housekeeping staff. Nurse #1 stated the commode buckets would be removed at once. On 9/24/13 at 5:01 PM., the housekeeping supervisor stated housekeeping staff did not clean commode buckets. She stated she expected her staff to notify the nursing staff if they found soiled commode buckets when they cleaned the shower rooms.	F 253	Continued From page 2 **PLAN OF CORRECTION TAG #483.15 F-253** The facility will continue to provide maintenance and housekeeping services necessary to maintain a sanitary, orderly and comfortable environment. **For area affected and all other areas having the potential to be affected** The facility conducted an onsite inspection of all shower commode buckets and cleaned and sanitized all buckets per facility policy on 9/24/2013. **System Change** The facility has revised the Certified Nursing Assistant assignment sheets to include the areas where commode buckets are used and stored to ensure that they are being cleaned when utilized. The Unit Manager assigns staff responsibility to ensure that equipment such as buckets and storage areas are cleaned at the end of each shift. The Unit Charge Nurse will conduct an inspection of these areas each shift to ensure compliance. Housekeeping will continue to supply cleaning supplies on each nursing unit for staff access and usage.	10/24/2013
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial			

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F 279	Continued From page 3 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a care plan for pressure ulcer for 2 (Residents # 113 & # 132) of 3 sampled residents with pressure ulcer, 1 (Resident # 132) of 1 sampled resident on anticoagulant drug and 1 (Resident # 132) of 2 sampled residents with an indwelling catheter. Findings included: 1a. Resident #132 was originally admitted to the facility on 8/20/13 with multiple diagnoses including diabetes mellitus, heart valve replacement and neurogenic bladder. The admission Minimum Data Set (MDS) assessment dated 9/18/13 indicated that Resident #132 was cognitively intact and had an unstageable pressure ulcer with suspected deep tissue injury. The care area assessment summary (CAAS) for pressure ulcer dated 9/18/13 was reviewed. The summary indicated that the resident has an unstageable wound on left heel and will develop a	F 279	Continued From page 3 **Measures put in place to ensure solutions are sustained.** The facility Housekeeping Supervisor will monitor and inspect weekly for compliance. Compliance reports will be submitted by the Housekeeping Supervisor to the Quality Assurance Performance Improvement Committee for six months. Changes to the Corrective Action Plan will be made if concerns are identified. **PLAN OF CORRECTION TAG #483.20 F-279** The facility will continue to develop a comprehensive plan of care that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs identified in the Comprehensive Assessment for each resident. **For the resident affected** For Resident #113, the Registered Nurse Assessment Nurse developed a pressure ulcer care plan on 9/25/2013. For Resident #132, the Registered Nurse Assessment Nurse developed a pressure ulcer care plan as well as an indwelling catheter care plan and an anticoagulant therapy care plan on 9/26/2013.	10/24/2013

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F 279	Continued From page 4 care plan to resolve unstageable left heel wound and will have no signs and symptoms of infection. . The care plan dated 9/22/13 was reviewed. There was no care plan developed for the unstageable pressure ulcer. The ulcer assessment notes were reviewed. The notes indicated that on 8/25/13 a new ulcer was noted on the left heel. The ulcer was unstageable with suspected deep tissue injury. The ulcer measured 5.4 x 1.5 cm (centimeter) in size. On 9/25/13 at 9:42 AM, Resident # 132 was observed during dressing change. Administrative staff #3 was observed to clean the left heel pressure ulcer with saline wound wash and allevyn adhesive dressing was applied. On 9/26/13 at 8:40 AM, administrative staff #3 was interviewed. She reviewed the care plan and acknowledged that she had missed to develop a care plan for pressure ulcer. 1b. Resident #132 was originally admitted to the facility on 8/20/13 with multiple diagnoses including neurogenic bladder. The admission Minimum Data Set (MDS) assessment dated 9/18/13 indicated that Resident #132 was cognitively intact and had an indwelling catheter. The CAAS for urinary continence and indwelling catheter dated 9/18/13 was reviewed. The summary indicated that Resident # 132 has an indwelling catheter due to her diagnosis of neurogenic bladder. The summary indicated that	F 279	Continued From page 4 **For residents who have the potential to be affected** Care plans for active residents with indwelling catheters, anticoagulant medications, wounds, history of falls, or need for supportive devices were reviewed by the Director of Nursing, the Minimum Data Set Nursing staff and Nurse Consultants on 10/07/2013 to ensure that each resident had a comprehensive care plan with changes made as necessary to meet each resident's needs. **System Change** On 10/7/2013, a new group of reports was developed in the Electronic Medical Records system with a shortcut located under the Reports tab. These reports will be used to audit all designated care plans to ensure appropriate care plans are generated and updated in a timely manner. *See Attachment 1 **Measures put in place to ensure solutions are sustained** The Director of Nursing will monitor monthly and will report results to the Administrator. Results will also be reported to the Quality Assurance Performance Improvement Committee for a period of twelve months.	

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F 279	Continued From page 5 the resident had a chronic urinary tract infection (UTI) and a care plan will be developed to resolve the UTI and to have no complication. Review of the care plan dated 9/22/13 was conducted. There was no care plan developed for the use of the indwelling catheter. On 9/25/13 at 9:42 AM, Resident #132 was observed in bed with an indwelling catheter in place. On 9/26/13 at 8:40 AM, administrative staff #3 was interviewed. She reviewed the care plan and acknowledged that she had missed to develop a care plan for the indwelling catheter. 1c. Resident #132 was originally admitted to the facility on 8/20/13 with multiple diagnoses including deep vein thrombosis (DVT). The admission Minimum Data Set (MDS) assessment dated 9/18/13 indicated that Resident #132 was cognitively intact. The assessment did not indicate that the resident was on anticoagulant medication. Review of the current physician's orders revealed that Resident #132 was on Coumadin (an anticoagulant drug) 15 mgs daily for DVT. The care plan dated 9/22/13 was reviewed. There was no care plan developed for the use of the anticoagulant drug. On 9/26/13 at 8:40 AM, administrative staff #3 was interviewed. She reviewed the care plan and acknowledged that she had missed to develop a	F 279		

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F 279	Continued From page 6 care plan for the use of the anticoagulant drug. 2. Resident # 113 was admitted to the facility 3/22/13. Cumulative diagnoses included: Postpoliomyelitis (symptoms include progressive muscle and joint weakness and pain, general fatigue and exhaustion with minimal activity and muscle atrophy), Ataxia and Diabetes Mellitus. A Quarterly Minimum Data Set (MDS) dated 9/02/13 indicated Resident # 113 was severely impaired in cognition. He required extensive assistance with bed mobility, transfers, toilet use, personal hygiene and dressing. Resident # 113 was totally dependent on staff for bathing. He was frequently incontinent of bladder and bowel. Balance was impaired in that Resident # 113 required staff assistance when moving from a seated to standing position, move on and off the toilet and surface to surface transfers. Skin was noted as no pressure ulcers during the assessment period. A care plan dated 9/2/13 indicated Resident # 113 was at risk for skin breakdown. Approaches included, in part: assess skin condition daily and note changes. Treat as ordered. Keep clean and dry. Pressure relieving device for bed and heel protectors. The care plan did not address the ulcer on the left heel. A nursing skin assessment dated 7/29/13 stated Resident # 113 had a fluid filled area on his left heel. A progress note by the nurse practitioner dated 7/29/13 indicated Resident # 113 had a nickel-sized white intact blister with fluid underneath on the left lateral heel. The	F 279		

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F 279	Continued From page 7 surrounding skin was clean and dry with no redness. The heel blister was discussed with the wound staff (wound care nurse). On 8/5/13, a nursing note indicated the blister filled area noted to left heel was intact. A nursing note dated 8/9/13 at 9:10 PM, revealed the fluid in blister left heel was absorbed and the area remained discolored. A nursing note dated 8/22/13 at 10:16PM. stated, in part, the blister area on left foot appeared larger with a dark purple/black color. A nursing note dated 8/26/13 at 10:53 AM. indicated that bilateral heels were dry with a dark area remaining on the left heel. A nursing note dated 9/23/13 revealed there was an area to left outer heel, unstageable 1.3 cm (centimeters) x 0.5 cm (centimeters), depth unknown. There was loose dark hard brown to black tissue. On 9/24/13 at 4:59 PM., Nurse #1 stated the area on the left heel noted in the nursing notes on 7/29/13 was like a water blister area. The skin was intact at that time. She stated the blister eventually burst. Nurse #1 stated the area was about the size of an egg when the blister burst. She indicated the area had decreased in size and now was an unstageable pressure ulcer with black tissue. On 9/25/13 at 1:59 PM., Nurse #2 stated the left heel fluid filled area was noted on 7/29/13 when Resident # 113's weekly skin check was done.	F 279		

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F 279	Continued From page 8 She stated the area was dark purple in color on 8/22/13 when she performed the weekly skin check. Nurse #2 stated that nursing staff used to leave a note for the wound care nurse when an area was noted on a resident that required an assessment by the wound care nurse. She stated, now, nursing staff would write a physician's order for the wound care nurse when an assessment was needed. Nurse #2 reviewed the medical record for Resident # 113 and indicated there was no documentation in the record from the wound care nurse regarding the assessment and/or progress / decline of the wound area. On 9/25/13 at 2:45 PM., wound care of the left heel was observed for Resident # 113. The area on the left heel measured 1 cm. x 0.8 cm. of black tissue. The surrounding skin was peeled with no redness noted. A foam dressing and clear transparent dressing was applied to the area. On 9/25/13 at 3:44 PM., Administrative staff #1 stated she was not aware that Resident # 113 had a blister on the left heel. She stated the blister area on the left heel should have been documented by the wound care nurse in the ulcer documentation folder. Administrative staff #1 said the blister was a pressure ulcer and should have been care planned as a pressure ulcer area. On 9/26/13 at 8:55 AM., Administrative staff #2 stated when the care plan for Resident # 113 was reviewed, there was no documentation noted in his medical record regarding pressure ulcers during the seven day look-back period (8/27/13-9/2/13). She said the MDS (Minimum Data Set) staff obtained information regarding	F 279		

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F 279	Continued From page 9 skin condition from the wound nurse, the skin condition folder and the ulcer documentation folder.	F 279	Continued From page 9 **PLAN OF CORRECTION TAG #483.10 F-280**	10/24/2013
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to revise and update the care plan for falls for one of three residents reviewed for falls/ accidents (Resident # 113). The findings included: Resident # 113 was admitted to the facility 3/22/13. Cumulative diagnoses included:	F 280	The facility will continue to revise and update the care plan for residents with a history falls or need for supportive devices to include measurable objectives and a timetable to meet a resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessments. **For the resident affected** For resident # 113, the Registered Nurse Assessment Nurse revised the fall care plan on 10/7/2013 and added that Resident #113 will be placed in a highly visible area when out of bed in a wheelchair. **For residents who have the potential to be affected** All care plans for active residents with a history of falls and need for supportive devices were reviewed by the Director of Nursing, the Minimum Data Set Nursing Staff and Nurse Consultants on 10/7/2013 to ensure that each resident has a comprehensive care plan with revisions made to meet each resident's needs.	

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F 280	Continued From page 10 Postpoliomyelitis (symptoms include progressive muscle and joint weakness and pain, general fatigue and exhaustion with minimal activity and muscle atrophy), Ataxia and Diabetes Mellitus. A Quarterly Minimum Data Set (MDS) dated 9/02/13 indicated Resident # 113 was resident severely impaired in cognition. He required extensive assist with bed mobility, transfers, toilet use and locomotion on the unit. Ambulation did not occur during the assessment period. His balance was impaired in that he was only able to move from seated to standing position, move on and off the toilet and perform surface to surface transfers with staff assistance. Impairment was noted on one side for range of motion for upper and lower extremities A care plan dated 9/2/13 indicated Resident # 113 had a potential for falls manifested by history of falls and decline in cognitive status. Approaches included: 9/16/13 nurse aide--encourage to ask for assistance. Call light in reach. Assist with ambulating, transferring, toileting. Do not leave unattended when toileting. Bed should be in lower locked position with mat in place. Check comfort level on routine care rounds. There was no documentation regarding the fall on 8/31/13 or the interventions recommended during the investigation of the fall. A fall assessment done 8/30/13 indicated Resident # 113 had intermittent confusion. He needed assistance with toileting; had no history of falls last 6 months: visual impairment was noted; self propelled his wheelchair and stable blood pressure. He had a score of 10 which indicated medium risk for falls. Interventions included resident, when out of bed in wheelchair, to be in a high visibility area.	F 280	Continued From page 10 **System Change** A new group of reports was developed in the Electronic Medical Records system with a shortcut located under the Reports tab. These reports will be used to audit all designated care plans to ensure appropriate care plans for falls are generated and updated in a timely manner. *See Attachment 1 **Measures put in place to ensure solutions are sustained** The Director of Nursing will print the new Audit Reports weekly for 3 months and then monthly for 9 months to ensure that appropriate care plans are created and updated to meet each resident's medical, nursing, mental and psychosocial needs as identified in the Comprehensive Assessments. Results of these monitoring audits will be reported to the Quality Assurance Performance Improvement Committee for a period of one year.	

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F 280	Continued From page 11	F 280		

An incident report dated 8/31/13 at 4:45 PM. revealed Resident # 113 was found in front of the bathroom door in his room. Resident stated he was going home. He sustained a skin tear and a scrape on top of the right hand. Investigation results stated that Resident # 113 needed to be kept in a highly visible area so he could quickly be assisted when he became restless or tried to get out of his chair.

An occupational therapy note dated 9/2/13 revealed that Resident # 113 had a fall from his wheelchair over the weekend (8/31/13). Occupational therapy ensured that a cushion cover was in place to provide a safe seating surface and reduce likelihood of sliding out of his chair

On 9/26/13 at 7:50 AM., NA #2 stated Resident # 113 had a cushion covered with cloth in his chair in an attempt to prevent him from sliding out of the chair. She also stated she checked on him frequently during her shift. When asked if Resident # 113 used a mat on the floor by his bedside when he was in bed, NA #2 stated he did not use a mat on the floor. An observation of the room at that time revealed there was not a mat in the room/ bathroom.

On 9/26/13 at 8:04 AM., Nurse #2 stated Resident # 113 did not use a mat on the floor beside his bed. She stated, if a mat was used, there would be a physician's order for the mat. Nurse #2 checked the physician's orders and indicated there was not an order for a mat to be used at bedside.

On 9/26/13 at 8:23 AM., Administrative staff #2

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F 280	Continued From page 12 stated the MDS nursing staff was notified of falls daily. If interventions were put in place, they would try to put the intervention on the care plan and remove interventions that were no longer pertinent. Administrative staff #2 stated they had meetings every Wednesday and falls was included in that meeting. The MDS staff tried to keep the care plan updated weekly. She indicated Resident # 113 used a fall mat. An observation of Resident # 113's room was conducted at that time and Administrative staff #2 observed that there was no mat in the room. She said, at some point, he had to have used a mat or it would not have been put on the care plan. Administrative staff #2 stated the use of the cushion implemented by Occupational therapy should have been on the care plan.	F 280	Continued From page 12	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to assess a pressure ulcer frequently enough to monitor for worsening condition that could require new interventions and failed to initiate a treatment	F 314	**PLAN OF CORRECTION TAG #483.25 F-314** The facility will continue to assess all pressure ulcers frequently enough to monitor for worsening conditions and initiate treatment changes as needed in order to promote healing. **For the resident affected** For Resident #144, on 9/25/2013, the Attending Physician assessed the left heel pressure ulcer and venous stasis ulcer located on the right anterior leg. The Attending Physician wrote an order to continue the alginate foam with an additional order to switch to Santyl debriding medication to soften eschar if necessary. The Attending Physician noted that he would reassess the resident on 9/27/2013.	10/24/2013

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F 314	Continued From page 13 change for a pressure ulcer that had become necrotic, when the necrosis was first identified, for 1 (Resident # 144) of 3 sampled residents with pressure ulcers. The findings included: Resident # 144 was admitted on 7/7/13 with diagnoses including anemia, hypertension, peripheral vascular disease, varicose veins, dysthymic disorder and chronic pain syndrome. The Admission Minimum Data Set (MDS) dated 7/16/13 revealed Resident #144 was moderately cognitively impaired and required extensive assistance of two people for turning and repositioning. According to the MDS, Resident #144 was at risk for pressure ulcers but did not have a pressure ulcer, however he did have an open lesion that was not a pressure ulcer. Review of the Care Plan dated 7/16/13 revealed that there was a care plan for the resident ' s open lesions (other than ulcers) which were venous/arterial ulcers. This Care Plan was updated on 7/19/13 with the following interventions: assess skin condition daily and note any change, pressure relieving device to bed, monitor turning/repositioning, provide ulcer care, keep linen clean, dry and wrinkle free, air mattress on bed, float heels. Review of the electronic medical record for Resident #144, from 7/7/13 - 9/26/13, revealed he had a pressure ulcer on his left heel starting on 7/19/13. The wound assessments and physician ' s orders revealed the following: Week of July 14 - 20: 7/19/13 (Friday) initial assessment: unstageable, wound tissue closed and purple, 3.4 x 3.5 (length	F 314	Continued From page 13 **For residents who have the potential to be affected** Shannon Davidson, Certified Wound Care Nurse, conducted wound rounds on 10/02/2013 with the facility treatment nurse and reviewed all ulcers to ensure that the facility has the best possible treatment plan to promote healing of ulcers. The Certified Wound Care Nurse returned again on 10/9/2013 and conducted wound rounds with the treatment nurse to evaluate the healing progress for all wound ulcers in the facility. **System Change** To serve as backup for the facility treatment nurse, by 10/24/2013, the Certified Wound Care Nurse will train all Unit Managers to assess, measure and meet the documentation requirements for ulcers as outlined in F-314. By 10/24/2013, all Unit Managers will have initiated additional training on wound care assessment and wound care documentation. Unit Managers will be required to pass a computerized test hosted by Upstairs Solutions, an online training program.	

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F 314	Continued From page 14 x width in centimeters) 7/19/13 Physician ' s order: float heels, apply skin prep to left heel every shift Week of July 21 - 27: 7/22/13 (Monday) weekly summary: unstageable, wound tissue closed and purple, 3.4 x 3.5. Physician ' s orders for this week revealed no new treatment orders for the left heel pressure ulcer. Week of July 28 - August 3: No documented assessment Physician ' s orders for this week revealed no new treatment orders for the left heel pressure ulcer. Week of August 4 - 10 8/10/13 (Saturday) at 12:38 PM: type of assessment not indicated, stage of wound not indicated, wound described as closed and purple, 3.4 x 3.5. 8/10/13 (Saturday) at 12:59 PM: weekly summary, unstageable - wound bed covered by slough and/or eschar, wound tissue necrotic/eschar and black, healing progress worsened, 3.5 x 4.5 Physician ' s orders for this week revealed no new treatment orders for the left heel pressure ulcer. Week of August 11 - 17: No documented assessment Physician ' s orders for this week revealed no new treatment orders for the left heel pressure ulcer. Week of August 18 - 24:	F 314	Continued From page 14 **Measures put in place to ensure solutions are sustained** Using the Wound Assessment record, the Director of Nursing will conduct weekly audits for three months and then monthly for nine months to ensure that solutions are sustained. The results of the audits will be documented and presented by the Director of Nursing at the Quality Assurance Performance Improvement Committee quarterly meeting for a period of one year. Changes to the corrective action plan will be made to ensure substantial compliance if concerns are identified.	

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F 314	Continued From page 15 8/20/13 (late entry for 8/19/13 [Monday]) weekly summary, unstageable - wound bed covered by slough and/or eschar, wound tissue necrotic/eschar and black, 1.5 x 4, healing progress improving becoming smaller Physician ' s orders for this week revealed no new treatment orders for the left heel pressure ulcer. Week of August 25 - 31: 8/29/13 Physician ' s Order: clean left heel with normal saline, apply hydrocolloid, wrap with stretch gauze, secure with tape two times a week and a needed. 8/30/13 (Friday): weekly summary, unstageable - wound bed covered by slough and/or eschar, wound tissue necrotic/eschar and black, healing progress improving, light serous drainage, 3 x 4, " healing progress improving and becoming smaller " Week of September 1 - 7: 9/6/13: weekly summary, unstageable - wound bed covered by slough and/or eschar, wound tissue necrotic/eschar and grey, 2.5 x 3 9/7/13 Physician ' s Order: clean left heel with normal saline pat dry skin prep to surrounding heel, apply foam to left heel, pad with 4 x 4, wrap with kling (frequency not indicated.) Week of September 8 - 14: 9/16/13(late entry for 9/13/13 [Friday]): weekly summary, stage 3 pressure ulcer, has full thickness of skin loss exposing the subcutaneous tissues - presents as a deep crater, 60% slough, 40% granulation, wound tissue yellow and pink, moderate serosangunious drainage, 4 x 4.5, wound depth not indicated 9/9/13 Physician ' s Order: have Physical	F 314		

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F 314	Continued From page 16 Therapy do debridement of the left heel today. 9/9/13 Physician ' s Order: clean left heel with normal saline, apply foam dressing, secure with transparent dressing and wrap with stretch gauze three times a week and as needed. Week of September 15 - 21: No documented assessment (9/16/13 entry was a late note for 9/13/13) 9/21/13 Physician ' s Order: Clean left heel with normal saline, apply foam dressing with boarders or foam dressing and secure with transparent dressing, wrap with stretch gauze and secure three times a week. Week of September 22 - 28: 9/23/13 (Monday): assessment type not indicated, Stage 3 pressure ulcer, 100% yellow (pale) Necrotic/Eschar, wound tissue yellow, moderate drainage, serosanguineous with some odor, wound culture grew multiple organisms with nothing dominant, sloughing occurring, 4.6 x 4.6, worsened stage 3 pressure ulcer Physician ' s orders for this week revealed no new treatment orders for the left heel pressure ulcer. On 9/25/13 at 2:25 PM, Resident # 144 ' s left heel pressure ulcer was observed during the dressing change. There was a large amount of serosangunious drainage and a mild odor. The wound was 50% granulation tissue and 50% black eschar. The eschar measured 4.4 cm length x 2 cm width and the area with granulation tissue measured 4.4 cm length x 2 cm width x 0.6 cm depth. The overall wound six was 4.4 cm x 4 cm. Interview with Nurse #1, at this time, revealed that the Treatment Nurse was off on leave and floor staff had taken over the dressing	F 314		

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F 314	Continued From page 17 change. She also stated that they had recently stated doing the dressing change daily due to the amount of drainage and that the wound had been cultured on 9/16/13 and showed no growth. Further review of the Treatment Records and Physician ' s Orders for September 2013 revealed Resident # 144 ' s dressing changes were still being documented as being done every 3 days and the need for daily dressing changes had not been included in the Physician ' s Orders. Interview with the Nurse #1 on 9/26/13 at 9:30 AM revealed she had been unaware wound assessments had been missed or undocumented for Resident #144 for 3 of the 12 weeks since the left heel pressure ulcer was first identified. She also stated that she had never seen the measurements or objective wound assessment details for Resident # 144, as the Treatment Nurse was the only staff member who ever used the wound assessment file in the electronic medical record. Nurse #1 acknowledged that it was difficult to objectively track a wound ' s progress and need for treatment changes, without comparison data from week to week, and that wounds could quickly worsen. She added that the Management Team had a weekly meeting where they discuss and track resident ' s progress in various areas including pressure ulcers. She stated however, that the Treatment Nurse did not bring the assessment results or wound measurements to the meeting for review or week to week comparison over time. Nurse #1 provided the notes from the tracking meetings in August. Review of this document with the Nurse #1 revealed that on 8/14/13 the resident ' s left heel was reported as healing, however the Treatment Nurse had not documented an	F 314		

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F 314	Continued From page 18 assessment that week and the assessment prior to that indicated the pressure ulcer had worsened and become necrotic. Nurse #1 was not asked to comment on why there were no new orders for the resident ' s worsening heal ulcer until 8/29/13. The Treatment Nurse was unavailable for interview.	F 314	Continued From page 18	10/24/2013
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the resident's head of bed was elevated when enteral	F 322	**PLAN OF CORRECTION TAG #483.25 F-322** The facility will continue to ensure that a resident who is fed by a gastrostomy tube will receive the appropriate treatment and services to avoid aspiration pneumonia and to restore, if possible, normal eating skills. **For the resident affected** The head of the bed for resident # 13 was immediately elevated to 30 degrees. Resident respiratory status was monitored closely with normal breathing pattern noted. The resident remained afebrile with no changes in respiratory status. Nursing staff was in-serviced on 9/26/2013 by the Unit Manager to ensure resident's tube feeding is paused when the head of the bed is lowered. **For residents who have the potential to be affected** Currently, resident # 13 is the only resident in the building fed by a gastrostomy tube. The measures outlined in this section will also be used for future residents admitted who are fed by a gastrostomy tube.	

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F 322	Continued From page 19 feeding was continuously infusing for 1 (Resident # 133) of 1 sampled resident on enteral feeding. Findings included: The facility's policy on enteral nutrition dated 1/26/11 was reviewed. The policy read in part " position resident in the semi-fowler's position or higher. Residents receiving continuous tube feeding should be kept in semi-fowlers position at all times. " Resident #133 was originally admitted to the facility on 3/23/13 with multiple diagnoses including stroke with dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 9/16/13 indicated that Resident #133 had memory and decision making problems and was on tube feeding. The assessment also indicated that the resident had a diagnosis of pneumonia. The care plan dated 9/17/13 was reviewed. One of the care plan problems was " increase risk for aspiration manifested by recent aspiration pneumonia. " The goal was " nutrition needs will be met, no complications related to tube feeding and will maintain weight. " The approaches included " check for residual per order, check for placement per order, flush tube per order, monitor for complications related to tube placement, assess lung sounds, tubing care per policy and report any changes in tube. " The approaches did not mention how to position the head of bed during care. The doctor's progress notes were reviewed. The notes dated 6/7/13 indicated that Resident #133 was readmitted with diagnosis including pneumonia. The notes dated 7/2/13 revealed that Resident #133 was on IV (intravenous)	F 322	Continued From page 19 **System Change** The words "Elevate head of bed to 30 degrees for residents who receive tube feeding" has been added to the Certified Nursing Assistant assignment sheets. Licensed nurses are responsible for turning the feeding pump off for short periods of time when care is given that requires the head of the bed to be lowered and they are responsible for turning the pump back on when care has been delivered and the head of the bed has been elevated to 30 degrees. **Measures put in place to ensure solutions are sustained** Effective 10/7/2013, the Unit Manager and second shift Charge Nurse will monitor and document weekly for one month, monthly for one quarter and then quarterly for the remainder of the year to ensure that residents with gastronomy tubes are receiving appropriate treatment and services to prevent complications.	

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F 322	Continued From page 20 vancomycin (an antibiotic drug) for recurrent aspiration pneumonia. The notes dated 8/8/13 indicated that Resident #133 was readmitted with diagnoses including Urinary Tract Infection (UTI) and likely aspiration pneumonia. The notes dated 8/25/13 revealed that Resident #133 had a chest x-ray and the report read " right lower lobe pneumonia." Resident #133 was started on Rocephin (an antibiotic drug) 1 gm (gram) IV daily for 7 days. The notes dated 8/26/13 indicated that Resident #133 had increased cough and congestion. On 9/26/13 at 10:25 AM, Resident #133 was observed in bed. The resident's head of the bed was elevated and he was positioned on his back. The tube feeding was continuously infusing at this time. The resident had an indwelling catheter and NA #4 was preparing to provide catheter care to the resident. NA #4 was observed to lower the head of the bed to a flat position while the tube feeding was continuously infusing. When interviewed, NA #4 replied that that there was no problem lowering the head of the bed during care and she normally lowered the head of the bed every time she had to provide care to a resident. She further stated that she was not allowed to turn the tube feeding pump to off/on, she had to call the nurse to do it. On 9/16/13 at 10:30 AM, Nurse #1 was interviewed. She stated that NAs were not allowed to lower the head of the bed to a flat position when the tube feeding was infusing. The NA had to call the nurse to turn the pump to hold before lowering the head of the bed. On 9/26/13 at 11:30 AM, administrative staff #1 was interviewed. She stated that NAs were not	F 322	Continued From page 20 Monitoring will take place on first shift and second shift when Certified Nursing Assistants are performing care. The audit will check to ensure that tube feeding pump is turned off by a Licensed Nurse while care is being rendered and the head of the bed is in a lower position. Results of the audits will be reported at the Quality Assurance Process Improvement meeting quarterly. Any areas of concern will be addressed immediately.	

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F 322	Continued From page 21 allowed to lower the head of the bed to a flat position when tube feeding was infusing. They should call the nurse to turn the pump to hold before lowering the head of the bed. She also acknowledged that Resident #133 had recurrent aspiration pneumonia.	F 322	Continued From page 21	
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 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 record review, staff and pharmacist	F 329	**PLAN OF CORRECTION TAG #483.25 F-329** The facility will ensure that Abnormal Involuntary Movement Scale tests are completed for all residents prescribed antipsychotic medications per facility policy. **For the resident affected** The unit manager completed an Abnormal Involuntary Movement Scale Test for resident # 164 on 9/25/2013. **For residents who have the potential to be affected** The Director of nursing, Minimum Data Set staff and Nurse Consultants audited all records of residents who receive antipsychotic medications to insure that Abnormal Involuntary Movement Scale Tests were completed per the facility's policy. Effective 9/26/2013, all Abnormal Involuntary Movement Scale Tests were in compliance.	10/24/2013

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F 329	Continued From page 22 interviews, the facility failed to monitor the adverse reaction (tardive dyskinesia) for use of antipsychotic drug for 1 (Resident # 164) of 3 sampled residents on antipsychotic medications. Findings included: Resident # 164 was admitted to the facility on 2/15/13 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 8/14/13 indicated that Resident #164 had severe cognitive impairment and was on antipsychotic drug. The care plan dated 8/15/13 was reviewed. One of the problems was " potential for adverse medication side effects related to daily antianxiety and antipsychotic use. " The goal was " no adverse effects due to medication regimen x 3 months. " The approaches included " monitor for side effects every shift, such as daytime lethargy, increase mood swings, crying, decrease appetite, report unusual behavior, report change in physical condition, involve family, make referrals and 1:1 visits. " The doctor's orders were reviewed. On 3/7/13, there was an order for Risperdal (antipsychotic drug) 0.25 mgs (milligrams) by mouth twice a day for bipolar mood disorder/manic depression. On 5/10/13, Risperdal was decreased to 0.25 mgs once a day. Review of the records of Resident #164 revealed that there was no Abnormal Involuntary Movement Scale (AIMS) test done. AIMS test records the occurrence of tardive dyskinesia. The monthly drug regimen review (DRR) notes were reviewed. The DRR revealed that the	F 329	Continued From page 22 **System Change** On 10/07/2013, using the Electronic Medical Record, a report was developed to compare residents who are on antipsychotic medications with Abnormal Involuntary Movement Scale Tests completed. The Director of Nursing will run this comparison report weekly and share results during the weekly TREK meeting (weekly resident progress meeting). *See Attachment 2 **Measures put in place to ensure solutions are sustained** The monitoring and documentation of the Abnormal Involuntary Movement Scale test will be reported to the Quality Assurance Performance Improvement Committee quarterly for one year with changes made as necessary to ensure solutions are sustained.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 329	Continued From page 23 pharmacist had requested for AIMS test to be done for Resident #164 on 3/12/13, 5/14/13, 6/13/13, 7/3/13 and 9/10/13. On 9/25/13 at 10:50 AM, Nurse # 1 was interviewed. She stated that she was responsible for completing the AIMS test for residents on A/B hall. She indicated that the pharmacist normally would request for the AIMS test to be done on residents who were receiving antipsychotic medication. She added that she had received a request for AIMS test for Resident #164 this September, 2013 and she was planning to do it. She also stated that she was not aware that the pharmacist had been requesting for AIMS test since March, 2013. On 9/26/13 at 10:50 AM, the pharmacist was interviewed. She stated that she had been requesting for AIMS test for Resident #164 since March, 2013. She added that she had concerns with A/B hall not responding to her recommendations in a timely manner.	F 329	Continued From page 23	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	**PLAN OF CORRECTION TAG #483.35 F-371** The facility will continue to ensure perishable foods are labeled and dated per facility policy. The Administrator will monitor audits and the Quality Assurance Performance Improvement Committee will review audits completed by the Food Service Director. The audits will be the responsibility of the Food Service Director, the Assistant Food Service Director or the Dietary Shift Supervisor and will be conducted twice daily.	10/24/2013

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F 371	Continued From page 24 by: Based on observations and staff interviews, the facility failed to ensure that hair bonnets were in place for 1 of 6 dietary aides, during meal preparation; failed to label and date 6 bowls containing perishable foods in the reach in cooler and failed to sanitize hands between the handling of dirty then clean dishes. The findings included: 1. On 9/23/13 at 11:30 am, during the initial tour of the kitchen, 6 bowls containing perishable foods were placed in the reach in cooler, without labels or dates. On 9/23/13 at 3:35 PM, the Registered Dietician was interviewed. She stated that everything in the kitchen must be labeled and dated. 2. On 9/25/13 at 11:39 am, one of six dietary aides was observed at the steam table, assisting with lunch, with half of her hair exposed. She wore a hair bonnet over a large bun of braided hair and then left the front portion of hair, from forehead to crown, exposed. On 9/25/13 at 11:50 am, the Dietary Manager was interviewed. She stated that the dietary aide should have her hair entirely covered and removed her from the steam table and instructed her to place two hair bonnets on top of her hair. The Dietary Manager also shared that she didn't realize that the aide left part of her hair exposed, commenting that normally this wasn't a problem. The aide returned to the steam table at 11:53 am with two bonnets in place, covering hair. 3. On 9/25/13 at 11:50 am, the utility aide was	F 371	Continued From page 24 The audits will be completed every shift daily for four weeks then once a week for four weeks; then once a month for the next ten months. Additionally the Food Service Director will conduct random audits throughout the year. Audit changes will be adjusted if concerns identified. Audit results will be submitted to the Quality Assurance Performance Improvement Committee quarterly for one year. In-service meetings regarding labeling and dating perishable foods were completed on 9/26/2013 with 100% attendance. The facility will continue to ensure hair bonnets will be in place during meal preparation per facility policy. On 09/23/ 2013, upon notification that employee 1 of 6 dietary aides was identified to have part of her hair exposed, the Food Service Director removed the Dietary Aid from the serving line and advised the Dietary Aide to put on a second hair bonnet immediately. The Food Service Director provided education to all dietary staff regarding facility policy for hair restraint.	

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F 371	Continued From page 25 the only staff in the dish room and was observed loading the dish washer three times. On one occasion, he loaded the dishwasher with soiled dishes, and allowed the machine to clean them. At the end of the rinse cycle, he was seen re-arranging the clean pots on the dish rack, without cleaning his hands, then returned to a rack of dirty dishes, to start a new clean cycle. On 9/25/13 at 12:05 PM, the Dietary Manager was interviewed. She stated that staff should wash their hands between handling clean and dirty dishes, as well as when the clean dishes are removed from the rack and stored. She mentioned at other times during the shift, she'll have four aides processing dishes. One aide scrapes the dirty dishes, the other aides rinses the dishes, the third aide loads the dishwasher with the fourth aide retrieving the clean dishes. On 9/25/13 at 12:12 PM, the utility aide was interviewed. He stated that his normal routine was to check the pots after the rinse cycle was completed, to make sure they aren't wet. He stacks the pots on the rack to improve air flow for air drying. When he brings the racks to the back of the kitchen, he then washes his hands to unload the clean dishes from the racks.	F 371	Continued From page 25 **System Change** The facility Administrator or Food Service Director will monitor audits completed by the Food Service Director, the Assistant Food Service Director or Shift Supervisor. The daily audits and compliance will be the responsibility of the Food Service Director, Assistant Food Service Director or Shift Supervisor The audits will be completed once daily for one quarter. Additionally the Food Service Director will conduct random audits throughout the year. Audit changes will be adjusted if concerns are identified. **Measures put in place to ensure solutions are sustained** Audit results will be submitted to the Quality Assurance Performance Committee quarterly. Dietary Staff will observe and comply with policies and procedures as outlined in the LSA Dietary Manual Section-Employee Health and Safety stating: "Food service employees must wear suitable and effective hair restraints." In-service meetings regarding hair restraint were completed between 9/26/2013 and 10/02/2013with 100% of the Dietary Staff in attendance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			

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F 428	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews, the facility failed to respond to the pharmacist recommendation for 1 (Resident # 164) of 3 sampled residents on antipsychotic medications. Findings included: Resident # 164 was admitted to the facility on 2/15/13 with multiple diagnoses including Alzheimer ' s disease. The quarterly Minimum Data Set (MDS) assessment dated 8/14/13 indicated that Resident #164 had severe cognitive impairment and was on antipsychotic drug. The care plan dated 8/15/13 was reviewed. One of the problems was " potential for adverse medication side effects related to daily antianxiety and antipsychotic use. " The goal was " no adverse effects due to medication regimen x 3 months. " The approaches included " monitor for side effects every shift, such as daytime lethargy, increase mood swings, crying, decrease appetite, report unusual behavior, report change in physical condition, involve family, make referrals and 1:1 visits. " The doctor ' s orders were reviewed. On 3/7/13, there was an order for Risperdal (antipsychotic drug) 0.25 mgs (milligrams) by mouth twice a day for bipolar mood disorder/manic depression. On 5/10/13, Risperdal was decreased to 0.25 mgs once a day.	F 428	Continued From page 26 The facility will continue to ensure that appropriate infection control measures are adhered to throughout the dishware cleaning process per facility policy. The Food Service Director will ensure that the dishwashing procedure will remain adhered to as a result of incorporating a second staff member responsible for dishwashing. (one employee assigned to clean dishes and one employee assigned to dirty dishes). In-services were completed with 100% compliance 09 26 13-10 02 13 surrounding dishware protocol. **PLAN OF CORRECTION TAG #483.60 F-428** The facility will continue to comply with the Drug Regimen Review at least monthly as directed by the Licensed Pharmacist Consultant. **For the resident affected** The unit manager completed an Abnormal Involuntary Movement Scale Test for resident # 164 on 9/25/2013.	10/24/2013

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F 428	Continued From page 27 Review of the records of Resident #164 revealed that there was no Abnormal Involuntary Movement Scale (AIMS) test done. AIMS test records the occurrence of tardive dyskinesia. The monthly drug regimen review (DRR) notes were reviewed. The DRR revealed that the pharmacist had requested for AIMS test to be done for Resident #164 on 3/12/13, 5/14/13, 6/13/13, 7/3/13 and 9/10/13. On 9/25/13 at 10:50 AM, Nurse # 1 was interviewed. She stated that she was responsible for completing the AIMS test for residents on A/B hall. She indicated that the pharmacist normally would request for the AIMS test to be done on residents who were receiving antipsychotic medication. She added that she had received a request for AIMS test for Resident #164 this September, 2013 and she was planning to do it. She also stated that she was not aware that the pharmacist had been requesting for AIMS test since March, 2013. On 9/26/13 at 10:50 AM, the pharmacist was interviewed. She stated that she had been requesting for AIMS test for Resident #164 since March, 2013. She added that she had concerns with A/B hall not responding to her recommendations in a timely manner.	F 428	Continued From page 27 **For residents who have the potential to be affected** The Director of Nursing will ensure completion of Drug Regimen Review within 3 weeks after given to the Unit Manager. The Pharmacy Consultant conveys urgent requests immediately by telephone and email to the Director of Nursing for immediate response. **System Change** The Pharmacy Consultant was instructed to notify the Director of Nursing and the Administrator by telephone if there is a concern in receiving responses from facility staff in a timely manner after they receive the Drug Regimen Review. **Measures put in place to ensure solutions are sustained** The Drug Regimen Review is now kept on file and initialed and dated as reviewed by the Unit Manager. The Director of Nursing will have the Unit Manager present a copy of the Drug Regimen Review indicating that that it has been completed, initialed and dated.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug			

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F 431	Continued From page 28 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired medication from one of five medication carts (E hall) and failed to maintain refrigerator temperatures between 36-46 degrees for two of three medication refrigerators (C/D hall and E hall medication refrigerators). The findings included:	F 431	Continued From page 28 **PLAN OF CORRECTION TAG #483.60 F-431** The facility will continue to monitor drug expiration dates to ensure replacement of drugs by the date of expiration so that no resident is given an out of date medication. The facility will continue to monitor the temperature of all medication refrigerators per facility policy to ensure proper temperature control. **No resident was affected** No resident had an order for the out of date medication. Refrigerated medications were not compromised by freezing. **For residents who had the potential to be affected** The facility checked all medication carts and refrigerators and did not find any other medications that were expired. It is the expectation of the facility that the expiration dates of medications will be verified by the person administering the medication before the medication is administered. Medication stations are audited monthly by the pharmacy consultant tech and daily by Unit Managers and weekly by 3rd Shift Charge Nurses who look at all medication expiration dates. Medications will be sent back to the pharmacy before the expiration date to be replaced.	10/24/2013

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F 431	Continued From page 29 1. On 9/26/13 at 10:47 AM., an observation of the E hall medication cart revealed a bottle of Q-pap children's acetaminophen liquid with an expiration date of 3/13. On 9/26/13 at 10:47 AM., NA #3 stated the medication should have been discarded. She stated random cart checks were performed monthly and she also checked the expiration date of medications prior to administration. NA #3 stated, to her knowledge, no resident was currently receiving that medication either routinely or as needed (prn). On 9/26/13 at 11:00 AM., Administrative staff #1 stated the medication should have been discarded at the end of March, 2013. 2. On 9/26/13 at 10:30 AM., an observation of the medication refrigerator on C/D hall revealed a temperature of 30 degrees. A sign was observed posted on the refrigerator that stated the temperature should be between 36-46 degrees Fahrenheit. A review of the refrigerator temperature logs documented temperatures below 36 degrees thirty-three (33) times since July 20, 2013. On 9/26/13 at 11:17 AM., the maintenance supervisor stated there had not been any requests to check the medication refrigerators. He stated they only received requests when the temperature for the medication refrigerators was too high and had never been asked to check the refrigerators when the temperature was below 36 degrees. 3. On 9/26/13 at 10:47 AM., an observation of	F 431	Continued From page 29 A new thermostat was installed by maintenance on the Virginia Casey Center medication refrigerator. Maintenance monitors the refrigerator temperature logs weekly for trends or out of range temperatures. Third Shift Charge Nurses check the refrigerator temperatures nightly and record findings on the log. **System Change** On 9/27/2013, maintenance installed a new thermostat on the Virginia Casey Center drug refrigerator. Maintenance staff continued to check the temperatures of drug refrigerators periodically throughout the week to ensure all refrigerators are within the required range. Third Shift Unit Charge nurses on each Unit will check the temperature of drug refrigerators nightly and record findings using the logs provided and notify maintenance the following morning if the temperatures are out of range. The policy related to refrigerator temperatures and corrective action if temperatures are found to be out of range is attached to the temperature log. The expected temperature range between 36 and 46 degrees Fahrenheit is labeled at the top of the daily log and remains posted on each unit drug refrigerator.	

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F 431	Continued From page 30 the medication refrigerator on E hall revealed a temperature of 32 degrees. A review of the refrigerator temperature logs documented temperatures below 36 degrees twenty-eight (28) times since July 20, 2013. On 9/26/13 at 11:17 AM., the maintenance supervisor stated there had not been any requests to check the medication refrigerators. He stated they only received requests when the temperature for the medication refrigerators was too high and had never been asked to check the refrigerators when the temperature was below 36 degrees.	F 431	Continued From page 30 On 9/27/2013, the Unit Managers conducted an in-service of all unit nurses regarding the policy and procedures surrounding drug refrigerator temperatures, correct logging, and notification if out of compliance and the importance of ensuring that drug refrigerators are within expected temperature range. Additionally, Unit Managers will audit all medication refrigerator temperatures daily for 7 days, then weekly for 4 weeks to look for trends or patterns in temperatures and notify maintenance if any concerns are discovered. **Measures put in place to ensure solutions are sustained** Audits will be reported to the quarterly Quality Assurance Performance Improvement Committee meeting for six-months. Any immediate concerns will be addressed on a daily basis.	

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	PLAN OF CORRECTION TAG # K 000 All deficiencies determined during the survey were addressed immediately and corrective actions were taken as follows:	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: 1. laundry room clean side door not closing and latching. 2. soiled linen door on B -hall not latching.	K 029	PLAN OF CORRECTION TAG # K 029 Laundry room door latch was repaired by facility maintenance staff. Soiled linen door latch on B –hall was repaired by facility maintenance staff. System Change Check off of all doors in building closing and latching has been added to Quarterly Safety Round Checklist and to Monthly Fire Drill Record. Repair Orders will be filled out immediately if door fails inspection. Measures put in place to ensure solutions are sustained. All Safety Committee members and monthly fire drill participants will be in serviced on these regulations by 11/15/2013. Results of Quarterly Safety Checklist and Monthly Fire Drill Record will be reported to Quarterly Quality Assurance Performance Improvement Committee.	10/23/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bee Johnson — TITLE: Administrator — (X6) DATE: 11-6-13

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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K 029	Continued From page 1	K 029		
K 038 SS=D	42 CFR 483.70(a) 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: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: delayed egress door going out of therapy, will lock back when wonder guard bracket was used to test door locking system.	K 038	PLAN OF CORRECTION TAG # K 038 The Therapy Room door alarm system was rewired and Maglock power on code alert power supply was changed by Lefler Electronics, Inc, the contractor for alarm, wonder guard and electronic alert systems in the building. System Change No system change warranted Measures put in place to ensure solutions are sustained. Code Alert System is tested and documented monthly. The alarm contractor inspects and tests the system annually.	10/29/2013
K 052 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	PLAN OF CORRECTION TAG # K 052 Lefler Electronics, Inc., the contractor for the fire alarm system, turned the annunciator piezo on and tested alarms. System Change No system change warranted Measures put in place to ensure solutions are sustained. The fire alarm system is tested monthly by maintenance staff and annually by the alarm contractor.	10/29/2013

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: nurse station at A, B Hall. 1. fire alarm panel did not give an audible signal on loss of power. 2. fire alarm panel did not give an audible signal on loss of battery. 3. fire alarm panel did not give an audible signal on loss of telephone connection.	K 052		
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: sprinkler heads in laundry room have excess lent build up on pendent(back of dryer also).	K 062	PLAN OF CORRECTION TAG # K 062 Sprinkler system heads were cleaned by facility maintenance staff. System Change Frequency of cleaning schedule for sprinkler heads in the laundry and dietary departments has been increased to every 2 weeks in Planned Maintenance Work Order software system. Measures put in place to ensure solutions are sustained. Director of Campus Maintenance reviews all completed work orders on a monthly basis. He will report findings to the Quality Assurance Performance Improvement Committee on a quarterly basis.	10/25/2013
K 069 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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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
	345153	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC RD SALISBURY, NC 28144

(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 069	Continued From page 3 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: 1. deep fat fryer in kitchen is not 16 inches from adjacent equipment. Therefore, splash guard must be installed at a minimum of 8 inches in height on fryer.	K 069	PLAN OF CORRECTION TAG # K 069 Splash guard was installed on deep fat fryer in kitchen by facility staff. System Change No system change warranted. Measures put in place to ensure solutions are sustained.	10/28/2013
K 072 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: at time of survey serve hallway had chairs, cleaning carts stored on corridor.	K 072	PLAN OF CORRECTION TAG # K 072 Hallway was cleared of all items by facility Housekeeping staff. System Change Director of Environmental Services is checking hall daily on weekdays to insure that it is clear of any clutter. Weekend Environmental Staff is checking daily on weekends. Measures put in place to ensure solutions are sustained. Safety Committee will also inspect this area monthly and report findings to Quality Assurance Performance Improvement Committee quarterly.	10/23/2013
K 147 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147	Continued From page 4 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: stove in Therapy room is not on electrical lock out system. 42 CFR 483.70(a)	K 147	PLAN OF CORRECTION TAG # K 147 Keyed electrical lockout switch was installed on circuit powering electric stove in Therapy room by facility Maintenance staff. System Change No system change warranted. Measures put in place to ensure solutions are sustained. No sustaining measures warranted.	11/01/2013

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CONSTRUCTION SECTION

PRINTED: 10/28/2013
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
	345153	A. BUILDING 02 - BUILDING 02 B. WING	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:46 pm onward, the following items were noncompliant, specific findings include: door to clean utility door not latching on C -hall. 42 CFR 483.70(a)	K 018	PLAN OF CORRECTION TAG # K 018 Door latch on Clean Utility room on C hall was repaired by facility maintenance staff. System Change Check off of all doors in building closing and latching has been added to Quarterly Safety Round Checklist and to Monthly Fire Drill Record. Repair Orders will be filled out immediately if door fails inspection. Measures put in place to ensure solutions are sustained. All Safety Committee members and monthly fire drill participants will be in serviced on these regulations by 11/15/2013. Results of Quarterly Safety Checklist and Monthly Fire Drill Record will be reported to Quarterly Quality Assurance Performance Improvement Committee.	10/23/2013
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Johnson — TITLE: Administrator — (X6) DATE: 11/6/13

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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K 056	Continued From page 1 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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings include: verify that soiled utility room is sprinkled.	K 056	PLAN OF CORRECTION TAG # K 056 Elite Fire Control, Inc., the contractor for the sprinkler system in the building verified that there is a sprinkler head located in the VCC Soiled Utility Room and replaced the concealed plate with a new one. System Change No system change warranted. Measures put in place to ensure solutions are sustained.	10/29/2013
K 072 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:45 pm onward, the following items were noncompliant, specific findings	K 072	PLAN OF CORRECTION TAG # K 072 Bi-fold doors on closets on C-hall across from clean utility room were removed and replaced with standard 6-panel doors with automatic closers by facility maintenance staff. System Change Plans for changes to or additions of doors to building will be reviewed by Director of Campus Maintenance to ensure compliance with regulations. Measures put in place to ensure solutions are sustained. Director of Campus Maintenance will report planned or completed changes to doorways to the Quality Assurance Performance Improvement Committee quarterly.	10/31/2013

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	345153	A. BUILDING 02 - BUILDING 02 B. WING	10/23/2013

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K 072	Continued From page 2 Include: bi-fold door to closet's on C-hall across from clean utility room project more than 7 inches into corridor. 42.483.70(a)	K 072		