STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 08/06/18 through 08/08/18. Past-noncompliance was identified at CFR 483.25 at tag F689 at a scope and severity (J). The tags F689 constituted Substandard Quality of Care. Non-noncompliance began on 08/02/18. The facility came back in compliance effective 08/03/18. A Partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation the facility failed to provide adequate supervision and an environment free from accident hazards for 1 of 3 residents reviewed for accident hazards, Resident #1, who exhibited wandering behaviors and wandered unsupervised into the facility's kitchen through an unsecured door and was found in the kitchen's walk-in freezer. When found in the freezer Resident #1 was shivering with a temperature of 98.4 degrees Fahrenheit (F.), a red area to her left forehead, and two broken artificial fingernails. Resident #1	F 689	Past noncompliance: no plan of correction required.	8/23/18

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

Electronically Signed | 08/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 1	F 689		

was sent to the hospital for evaluation.

Findings included:

Resident #1 was admitted to the facility on 7/11/17 with diagnoses of Dementia with Behaviors, Hypertension, and Anxiety. The most recent Minimum Data Set (MDS) assessment dated 7/17/18 revealed Resident #1 was moderately cognitively impaired. She required supervision with all activities of daily living, including walking. Resident #1 did not require mobility aides, such as, a wheelchair or walker. The assessment also revealed Resident #1 had wandering behaviors daily, and verbal and physical behaviors 1 to 3 days a week toward others.

A review of Resident #1's Care Plan dated 7/30/18 revealed she was at risk for elopement due to dementia and at risk for falls due to cognitive loss, impaired balance, and lack of safety awareness. Review of the Care Plan also revealed Resident #1 required supervision for ambulation. The facility documented the Care Plan goal for Resident #1's risk of elopement as not attempting to leave the facility without an escort, and her goal for risk of falls was to have no injury from falls in the review period of 90 days.

A review of Resident #1's Emergency Department Record dated 8/3/18 revealed she had a Computed Tomography (CT) scan of her brain with no acute abnormality. Her temperature on arrival at the Emergency Department was within normal range, 98.7F. Resident #1's condition when she was discharged from the Emergency Department on 8/3/18 at 3:57 am was listed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 2	F 689		

"improved, stable". She was discharged into a family members care.

An interview with Nurse #1 on 8/6/18 at 5:20 am revealed she had last seen Resident #1 at 11:30 pm on 8/2/18. Nurse #1 stated Resident #1 was standing at the nurses' station and had stated, "If (a name) comes tell him I'll be outside in a minute." Nurse #1 stated she walked down the hall to assist another resident and when she returned to the nurses' station at 11:40 pm on 8/2/18 she noticed Resident #1 was not on the unit and she walked up to the front of the building to look for her. Nurse #1 stated she checked two of the three doors to the kitchen and they were locked and the third door was blocked on the inside by large carts. Nurse #1 stated she came back to the unit and initiated a bed to bed search. Nurse #1 stated Nurse #2 notified the Nursing Supervisor they had initiated a search for Resident #1. Nurse #1 stated during the search she checked the kitchen and she found Resident #1 at 12:55 am in the kitchen's walk-in freezer rummaging through the frozen food. She stated the resident told her she bumped her head and there was a red mark under her left eye, on her cheek and she had a broken fingernail on her left fifth finger and another acrylic nail was missing. Nurse #1 stated Resident #1 was a wanderer and frequently wandered at night and required constant supervision. She stated Resident #1 was shivering but her skin was warm to touch. Nurse #1 stated she wrapped Resident #1 in blankets and took her temperature as soon as she moved her back to the nurses' station and her oral temperature was 98.4 degrees F.

An interview with Nurse Aide #1 revealed she was Resident #1's aide on 8/2/18, during the 11:00 pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 3	F 689		

to 7:00 am shift, when she was missing. She stated Resident #1 had a history of wandering. Nurse Aide #1 stated all staff immediately started searching for Resident #1 when Nurse #1 initiated the search. Nurse Aide #1 stated she had seen Resident #1 standing at the nurses' desk around 11:30 pm and she was talking to Nurse #1. She stated Resident #1 had a history of wandering at night and would have behaviors if you tried to redirect her.

The Director of Nursing was interviewed 8/6/18 at 7:30 am and she stated she was called at 12:09 am on 8/3/18 by the Nursing Supervisor regarding Resident #1 being missing. She stated the Nurse Supervisor reported the staff were searching for Resident #1 but had not located her. The Director of Nursing stated she called the Administrator to notify him. She stated she arrived at the building and immediately started to search for Resident #1. The Director of Nursing stated she and the Night Shift Supervisor were going outside to search the grounds at 12:40 am and passed the kitchen. She stated she checked two of the kitchen doors and they were locked and the third door was blocked by large carts on the inside. She stated she was only able to move the unlocked door an inch. She stated she went out the service entrance to look for Resident #1 outside. She stated when she was on her way back into the building she was told someone had found Resident #1 in the freezer. The Director of Nursing stated she went to the unit and the nurse had wrapped Resident #1 in a blanket and her vitals were normal. She stated Resident #1 had a red area under her left eye and some broken fingernails. The Director of Nursing stated all facility doors were checked on 8/3/18 by maintenance to ensure they were functioning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 4	F 689		

properly and the kitchen door that was unlocked was repaired.

On 8/6/18 at 1:55 pm and interview with the kitchen's evening shift Cook revealed she had worked the evening shift on 8/2/18. She stated when she left the kitchen on 8/2/18 she locked the third door behind her and had assumed the staff had locked the second door. The Cook stated she was responsible for locking the kitchen and she should have checked the second door before she left. She stated the first kitchen door was blocked by the tray carts and would be impossible for Resident #1 to open.

The Maintenance Director was interviewed on 8/6/18 at 2:15 pm and stated he had not received a work order for the kitchen door that did not lock properly and the door had not been used in years. He stated the area in front of the door was used to store the tray carts in the kitchen. The Maintenance Director stated he had received a work order to fix the kitchen door on Friday 8/3/18 after Resident #1 was found in the walk-in freezer. He stated he fixed the lock on the door on Friday 8/3/18. The Maintenance Director stated Resident #1 would not have been able to push the door open with the carts behind it. He stated he thought the kitchen staff had accidentally pulled the door closed but did not shut it completely and when Resident #1 closed the door to the kitchen it locked behind her.

During an interview with the Administrator on 8/7/18 at 8:55 am he stated he had checked the doors to the kitchen the night of 8/2/18, before Resident #1 was found in the freezer, and the first door was unlocked but he was only able to open the door about 4 inches due to tray carts being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 5	F 689		

pushed against the door. He stated he tried the second and third door but they were locked. The Administrator stated Cook #1 had stated she had locked the third door to the kitchen but she had assumed the staff had locked the second door to the kitchen when she was interviewed after the incident. The Administrator stated the resident went through the second door and in her confusion turned the dead bolt and locked the door behind her. He stated she must have gone into the freezer and when the door shut behind her she did not know how to open it. The Administrator stated his expectation was the evening Cook would lock the doors and lock the walk-in cooler and freezer when closing the kitchen in the evening. He stated the new process included a checkoff sheet for the evening Cook to sign that they had locked the walk-in cooler and freezer and locked the kitchen doors when the kitchen was closed for the evening.

A second interview with the Administrator on 8/7/18 at 11:30 am revealed Resident #1 was wearing flannel pajamas with long sleeves and long pants when she was found in the walk-in freezer. He stated she had a non-skin sock on one foot and the other sock was found in the freezer.

On 8/7/18 at 3:20 pm a second interview with the evening Cook revealed she was aware the first door to the kitchen was broken and would not lock. She stated the tray carts always blocked the door and it could not be opened from the outside. She stated she did not report the broken door or complete a work order to have it fixed. She stated she didn't report the door because it had been broken since she came to work at the facility on 1/22/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 6	F 689		

An observation on 8/7/18 at 10:03 am of the facility kitchen revealed there were no doors that lead to the outside from the kitchen. The walk-in freezer door was opened and automatically swung shut. The door latched completely. The three kitchen doors were locked and tested by the District Dietary Manager and all locks worked properly.

On 8/7/18 the facility provided the following plan of correction with a compliance date of 8/3/18:

August 6, 2018
Facility respectfully submits the below allegation of compliance for F689 Supervision to Prevent Accidents:
1. On the evening of 8/2/18 at approximately 11:40 pm, Resident #1 was noted to not be in her room. Charge nurse initiated search for resident. When resident was not found on unit, Supervisor was notified and initiated facility wide search. When unable to locate resident on initial search, the Administrator and Director of Nursing were called and responded to the facility to assist with the search. Administrator and Director of Nursing utilized facility search plan. When the DON and Unit Manager went to Kitchen they found the door locked, looked in using flashlights and could not see resident. Retrieved key to kitchen and entered to search dietary department. Upon inspection of the Walk In Freezer, resident was found inside going through items on the stand alone rack. Resident was found at 12:55 am. Resident was assessed and noted to have small mark above her eye, and missing one fake fingernail. Vital signs obtained and noted to have temperature of 98.4. Vital Signs were stable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 7	F 689		

Resident told Director of Nursing that she had seen the flash lights through the window. Physician and daughter were notified. Resident was sent to the ER for evaluation. Resident was subsequently discharged home with daughter from the ER.

Resident with diagnosis of dementia, with a BIMs of 10, is noted to have history of wandering. Has been assessed as an Elopement Risk and had a Wander Guard bracelet on as ordered /care planned. Facility complete a time line of events. Resident had been last seen at nurses station at 11:30 pm, prior to her noted to be missing at 11:40 pm.

2. All resident have potential to be affected. Facility completed a 100% head count of all other residents at time of event. All other residents accounted for Kitchen door was secured by administrator after resident returned to her nursing unit.
Facility conducted a full investigation which included staff interviews. Through investigation and completion of timeline it was determined that resident was missing for approximately and hour and 15 minutes and was in the Walk-in Freezer for approximately 10 minutes. Facility obtained a copy of the Emergency Room Visit report for this resident: Resident arrived at the ER at 1:52 am., temperatures taken during visit were 98.4 and 98.7. She received Tylenol for head ache. Had a head CT which showed no acute abnormality. Noted to have a small abrasion to her left forehead. No other injuries noted. Resident was discharged from the ER with her daughter at 3:57 am in "improved/stable" condition according to the ER notes.
Maintenance Director conducted a full house

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 8	F 689		

audit on 8/3/18 to determine the status of all doors to non-resident areas of the building for appropriate closing and locking mechanisms to ensure safety of all residents from entering these areas.
Facility had conducted a routine Elopement Drill on 8/2/18 on the day shift as part of their Emergency Preparedness Plan. Facility Administrator held an Emergency Preparedness Team Meeting on 8/3/18 to discuss the missing resident event that had transpired.
Dietary Department was educated by Interim Dietary Manager and Administrator on 8/3/18 regarding ensuring the safety of residents to include locking of the kitchen door upon closing of the department at the end of the day.
Education was also provided to 100% of facility staff by the Administrator and Nursing Leadership, regarding monitoring for safety hazards for residents to include ensuring that non secure areas of the facility are locked appropriately. This education was initiated on 8/3/18. No staff shall work until they have received this education. Education also included notifying Maintenance and/or the Administrator immediately for any area of facility noted to be a safety risk for residents. All newly hired staff will have the above education during their orientation to facility.

3. All areas of the facility that are noted to be a safety risk for residents have been added to a daily check sheet, and will be checked daily by Maintenance/Administrator and/or Nursing Supervisor to ensure security is maintained to prevent future incidents. The Kitchen Door will be checked each night by the Nursing Supervisor to ensure that it is closed/locked after the kitchen staff has left. The Dietary Staff will check each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 9	F 689		

door as well as the walk-in Freezer and Refrigerator are locked before leaving for the evening. Dietary will initial the "Kitchen End of Night Check" sheet to verify that all areas are secure before leaving.

4. The results of these audits and monitoring will be reviewed monthly in The Quality Assurance and Performance Improvement Committee, to ensure compliance with the plan. The Administrator is responsible for compliance with this plan of correction.
The alleged date of compliance is 8/3/18.

Validation information:

Validation of the facility's plan of correction was completed on 8/7/18. Interview with the Nurse, Nurse Aide, Director of Nursing, and Administrator validated the time Resident #1 was last seen on 8/2/18 (11:30 pm); when the staff realized Resident #1 was missing (11:40 pm); and when Resident #1 was found (12:55 am on 8/3/18). The staff interviews and medical record revealed Resident #1 had a small mark to her left forehead and had one broken and one missing artificial fingernails, was shivering but had a temperature of 98.4 F. A copy of the 100% head count of all other residents at the time of the event dated 8/3/18 was reviewed. The Administrator was interviewed and stated he secured the kitchen doors after the resident was found. A copy of all staff interviews and the facilities complete investigation were reviewed. The Emergency Department Record dated 8/3/18 revealed Resident #1's arrived at the Emergency department at 1:52 am and a CT of her head revealed no acute abnormality, her temperatures were within normal limits, and she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 689	Continued From page 10 discharged in "improved/stable" condition. A review of the Maintenance Directors audit of all non-resident areas of the building revealed all doors were checked for appropriate closing and locking mechanisms. The kitchen doors and walk-in freezer and cooler were checked for ability to close and lock securely. The education for 100% of staff documentation was checked and multiple staff on all shifts were interviewed regarding procedure for locking of non-secured areas and procedure if they cannot find a resident. A review of the daily check sheet for the Maintenance/Administrator/ and Nursing Supervisor to ensure security is maintained to prevent future incidents was completed. The Kitchen Door sign off by the Nursing Supervisor to ensure it was locked each night was completed. The Dietary "Kitchen End of Night Checklist" check off for the walk-in freezer and cooler and locking the doors to the kitchen were signed off for each night. An interview with the Administrator and copies of the most recent Quality Assurance and Performance Improvement Committee minutes revealed the facility was monitoring completion of the monitoring tools for the kitchen and the Nursing Supervisor to check to ensure the kitchen was secured each night. The facility's date of correction of 8/3/18 was validated.	F 689		