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	345460	A. BUILDING _____ B. WING _____	C 09/27/2018

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GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews the facility failed to accurately code the Minimum Data Set (MDS) that a resident was receiving dialysis for 1 of 2 residents reviewed for dialysis services (Resident #11). Findings include: Resident #11 was originally admitted to the facility on 11/3/2017 with diagnoses that included End Stage Renal Disease (ESRD). The resident's Admission Minimum Data Set (MDS) dated for 11/10/17 and the Significant Change MDS dated for 9/1/18 specified the resident had intact cognition, with no behaviors or rejection of care. Resident #11's Admission MDS dated for 11/10/17 specified that the resident was receiving dialysis services. Review of Section O of the Significant Change MDS dated for 9/1/18 did not specify that Resident #11 was receiving dialysis services. Review of Resident #11's Physician's orders from his most recent readmission to the facility on 8/25/18 revealed that there was no order written for him to receive dialysis on Monday, Wednesday and Friday until 9/27/18. During an interview with the MDS Coordinator on 9/27/18 at 11:35 AM she stated that not indicating the resident received dialysis services on the	F 641	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F641 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #11 Significant Change MDS ARD 9/1/18 was incorrectly coded as No for Question O0100J, Dialysis, under Special Treatments, Procedures, and Programs in Section O. The MDS was modified on 10/1/18 to correctly code dialysis. F641 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current dialysis residents□ MDS will be reviewed to ensure Question O0100J, Dialysis under	10/21/18

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

Electronically Signed | 10/17/2018

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F 641	Continued From page 1 Significant Change MDS dated for 9/1/18 was an error and that it must have been overlooked while completing the assessment. During an interview with the Administrator, Director of Nursing, and the Regional Nurse Consultant on 9/27/18 at 5:32 PM they stated that it was their expectation for the MDS to be accurate for each resident.	F 641	Special Treatments, Procedures, and Programs in Section O is correctly coded according to the documentation from the residents medical records. Any issues identified as being coded incorrectly, will be modified by the MDSC. F641 Measures to be put in place or systemic changes made to ensure practice will not re-occur: Education will be provided to MDSC by the MDSC Regional Consultant on the RAI requirements for coding Question O0100J, Dialysis under Special Treatments, Procedures, and Programs in Section O. All new MDSC employees will be educated during orientation on proper coding of Question O0100J, Dialysis under Special Treatments, Procedures, and Programs in Section O. The MDS Consultant or designee will audit 5 residents MDS to ensure Question O0100J, Dialysis under Special Treatments, Procedures, and Programs in Section O, is correctly coded according to the documentation from the residents medical records once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. F641 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.	

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to update the care plan when a resident transitioned from weekly to monthly weights for 1 of 5 residents (Resident #52) reviewed for nutrition. Findings included:	F 657	F657 How corrective action will be accomplished for those residents found to have been affected the deficient practice: The facility Failed to update the care plan when a resident transitioned from weekly to monthly weights for resident #52. Care	10/21/18

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F 657	Continued From page 3 Resident #52 was admitted to the facility on 8/17/16 with diagnoses that included, in part, end stage renal disease and non-Alzheimer's dementia. A review of Resident #52's comprehensive Minimum Data Set (MDS) assessment dated 7/11/18 revealed the resident had moderately impaired cognition and had weight loss of ten percent or more in the previous six months. A review of the care plan updated 8/1/18 revealed a problem of, "At risk for weight fluctuation." A care plan intervention dated 12/9/16 included weekly weights. A review of the medical record revealed weights were recorded monthly for July, August and September. An interview was completed with MDS Nurse #1 on 9/27/18 at 9:24 AM. She stated Resident #52 was no longer on weekly weights but was weighed monthly. She said care plans were updated after the MDS assessments were completed or when there was a physician's order. MDS Nurse #1 stated she was not sure why the weekly weights were on Resident #52's care plan but that it should have been removed and thought it was an oversight that the intervention remained on the care plan. A follow up interview was completed with MDS Nurse #1 on 9/27/18 at 9:50 AM. She reported Resident #52 was switched to monthly weights on 7/11/18. An interview was completed with the Director of Nursing (DON) on 9/27/18 at 2:55 PM. She said	F 657	plan for Resident #52 was updated on 9/27/2018. How the facility will identify other residents having the potential to be affected by the same deficient practice: Director of Nursing will educate Unit Manager and Unit Coordinator on updating residents care plan when transitioning from weekly to monthly weights. All current residents care plans will be reviewed to validate updated when transitioned from weekly weights to monthly weights. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of Nursing or designee will audit all residents that transition from weekly to monthly weights for care plan update weekly X 4 weeks, Bi-weekly X 2, and monthly X 1. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.	

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F 657	Continued From page 4 the facility typically did not have orders written for weights. She stated the interdisciplinary team met weekly and discussed residents who had lost weight and determined how often a resident was weighed. The DON reported that Resident #52 was placed on weekly weights because of weight loss but was transitioned back to monthly weights on 7/11/18 after her weight stabilized. The DON said she expected the care plan be updated when the frequency of weights was changed.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide wound care as ordered for one of one sampled residents with arterial wounds. Resident #353 The findings included: Resident #353 was admitted to the facility on 7/25/18 with diagnoses that included gangrene, above the knee amputation, osteomyelitis, diabetes type 2 and pressure ulcers. The admission Minimum Data Set (MDS) dated 7/25/18 indicated Resident #323 had no short or	F 684	F684 How corrective action will be accomplished for those residents found to have been affected the deficient practice: Facility failed to provide wound care as ordered for Resident #353. Wound care was provided on 09/24/2018 How the facility will identify other residents having the potential to be affected by the same deficient practice: Staff Development nurse will educate all	10/21/18

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F 684	Continued From page 5 long-term memory impairment, had no behavior issues, required extensive assistance for all activities of daily living except eating, which was with supervision of one staff member. The MDS assessed the resident as having no venous or arterial wounds. Review of a wound note dated 7/26/18 revealed blackened areas on the resident ' s left toes and lateral foot. Physician order dated 7/26/18 to apply Betadine to areas on the left foot every day. The care plan dated 7/30/18 included a problem of impaired skin integrity with risk for further impairment. The interventions included providing wound care as ordered. Review of a nurse ' s note dated 8/7/18 revealed a doppler study (checks for blood flow) to the left leg was ordered. The results showed a lack of blood flow in the left leg. Review of a nurse ' s note dated 9/17/18 revealed the resident was able to communicate his needs but presented with confusion during conversation Review of a wound progress note dated 9/21/18 revealed the resident ' s wounds were assessed by the wound nurse. The type of wound was "Arterial," the location was "Lateral Left Foot" and "Left Toes" and the progress was "Deteriorating." Record review of the Medication Administration Record and the Treatment Record revealed Nurse # 6 had initialed the treatment was	F 684	Licensed nurses on providing wound care as ordered. Any Licensed Nurse that has not been educated will not be allowed to work until education is completed. All new nurses will receive education on providing wound care as ordered during orientation. All current residents with wound care orders will be observed to validate wound care provided as ordered. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of Nursing or designee will audit 5 residents with wound care orders to validate wound care provided as ordered 3 X weekly X 2 weeks, weekly X 2, and monthly X 1. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.	

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F 684	Continued From page 6	F 684		

provided on 9/22/18 and 9/23/18. There were no nurse ' s notes for 9/22/18 or 9/23/18 to indicate the resident refused the treatment.

Observation on 9/24/18 at 10:44 AM revealed Resident #353 was lying in bed with a dressing that wrapped around his left foot and ankle. The date on the tape on the bottom of his foot was 9/21/18.

An attempt to interview the resident during the observation on 9/24/18 at 10:44 AM revealed he did not answer questions appropriately, and spoke in disconnected sentences.

Observations on 9/24/18 at 3:50 PM revealed the dressing on the left foot had a date of 9/24/18.

Interview on 9/25/18 at 3:13 PM with the treatment nurse revealed she had changed the dressing on 9/24/18, and did not notice the date on the old dressing when it was removed.

Observations on 9/27/18 at 11:00 PM revealed the treatment nurse provided the wound care for Resident #353. Observations of the left foot revealed all of the resident ' s toes were black with crusty areas, the outer and inner lateral areas of the foot had black eschar (dried, thick and necrotic skin). The treatment nurse cleansed the areas with wound cleanser, applied Betadine, placed 4x4 gauze between the resident ' s toes and wrapped the foot and ankle with a gauze wrap. A piece of tape was dated with 9/27/18 and placed on the outer gauze dressing.

Interview with Nurse # 6 on 9/27/18 at 1:09 PM revealed she worked on 9/22/18 and 9/23/18 and would have provided wound care on first shift for

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F 684	Continued From page 7 Resident #353. She explained the electronic chart would show the treatments that were to be done. The left foot wound would have been provided by her on those dates. Nurse # 6 was asked about the date on the dressing was 9/21/18 indicating the dressing had not been changed. She explained did not remember if she did the treatment or not. She may have documented and then forgot to do the treatment or he may have refused and then she forgot to document his refusal. Further interview revealed if the resident refused the treatment, she would document the refusal in the nurse ' s notes and call the NP (Nurse Practitioner). Interview with the Director of Nursing on 9/27/18 at 2:52 PM revealed she would expect the nurses to do treatments as ordered. Further explanation provided revealed she would expect a resident ' s refusal to be documented in the chart.	F 684		
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 and resident interviews, physician and nurse practitioner (NP) interview the facility failed to supervise a cognitively impaired resident to prevent wandering from the facility and smoking off	F 689	F689 How corrective action will be accomplished for those residents found to have been affected the deficient practice:	10/21/18

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F 689	Continued From page 8 campus without staff ' s presence The failure of the facility to supervise this resident while smoking and walking around the outside of the facility resulted in no injury, but placed the resident at a high likelihood for injury or accident. Immediate jeopardy began on 6/12/18 when Resident #16 who had impaired cognition, poor safety awareness, and was wheelchair bound was found 440 feet off the facility premises. Immediate jeopardy was removed on 9/27/18 at 5:00 PM after validation of the credible allegation of removal of the immediate jeopardy. The facility remains out of compliance at a lower scope and severity D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring. Findings included: Resident #16 was readmitted to the facility on 3/20/17 with diagnoses of stroke, acute respiratory failure with hypoxia, dysphagia, dementia without behavior disturbances, psychosis, and inability to walk. Review of the Minimum Data Set (MDS), a quarterly review, dated 3/7/18 indicated he had short and long-term memory impairment. His Brief Interview for Mental Status (BIMS) was a score of 7, which indicated moderate impairment with memory. There were no behaviors of wandering exhibited during the 7 days of review for the assessment. Resident #16 required extensive assistance of one staff person for bed mobility and transfers. He required supervision of one staff person for locomotion on/off the unit. The MDS indicated Resident #16 had impairment of functional movement on one side of his body affecting his upper and lower extremity. The "Wandering Risk Assessment" dated 3/20/18	F 689	Facility failed to supervise a cognitively impaired resident to prevent wandering from the facility and smoking off campus without staff□s presence on 06/12/2018. Resident #16 had a wander prevention device placed on 07/23/2018. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 09/27/2018 All current residents with diagnosis of Dementia/Alzheimer□s were assessed by Director of Nursing or designee for impaired safety awareness, independent mobility and risk for leaving facility unattended. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team occurred to accurately assess safety of the resident, that have been deemed at risk, based off diagnosis of Alzheimer□s/Dementia, impaired safety awareness, independent mobility and risk for leaving facility unattended. List of residents deemed unsafe to leave facility unattended will be kept on each unit in patient information notebooks and their care plans will be updated accordingly. All new admissions with diagnosis of Dementia/Alzheimer□s will be assessed by Director of Nursing or designee for impaired safety awareness, independent mobility and risk for leaving facility unattended. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team occurred to accurately assess safety of the resident,	

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F 689	Continued From page 9 indicated the resident was forgetful/short attention span, exhibits fear/anxiety, early dementia, and received antipsychotics and antidepressants. This assessment did not indicate he had made attempts to exit or expressed desire to leave the facility. The care plan dated 3/20/18 included problems of: - Exhibiting adverse behavioral symptoms as evidenced by poor safety awareness, physical aggression, agitation, anxiety crying due to psychosis, refusing medications, wants to go to the hospital, receives antipsychotic. - Communication problem related to intracranial bleed. At times he cannot say what he wants to and is not able to understand what is said to him. The interventions included for staff to allow him time to process information and form a response, anticipate and meet needs. - Impaired cognitive function/dementia and impaired thought processes related to stroke. Interventions included for staff to ask yes/no question, keep the resident ' s routine consistent, and provide consistent care givers as much as possible in order to decrease confusion. - Actual fall with high risk for future falls related to unaware of safety needs, paralysis, poor communication/comprehension and gait/balance problems, use of psychotropic/narcotic medications. The facility "Campus Free Smoking Plan", with a revised date of 5/18/2018 included the following: All new admissions that smoke and any other resident who begins smoking while at the center will receive a patient smoking acknowledgement form. The resident is expected to read,	F 689	that have been deemed at risk, based off diagnosis of Alzheimer□s/Dementia, impaired safety awareness, independent mobility and risk for leaving facility unattended. List of residents deemed unsafe to leave facility unattended will be kept on each unit in patient information notebooks and their care plans will be updated accordingly. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of Nursing or designee will audit all new admissions with diagnosis of Dementia/Alzheimer□s to validate that assessment done for impaired safety awareness, independent mobility and risk for leaving facility unattended, including discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team and that List of residents deemed unsafe to leave facility unattended is kept on each unit in patient information notebooks and their care plans will be updated accordingly. Audits will be weekly for one month, bi-weekly for 1 month, and monthly for one month. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X2 for further problem resolution if needed.	

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F 689	Continued From page 10	F 689		

understand and sign the acknowledgement. These residents are educated on where the established smoking area is off of Guilford Healthcare property. Any resident whom is found to be noncompliant with this will be reeducated and notified that any further noncompliance may result in potential discharge." A revised smoking acknowledgement form was not available for review for Resident #16.
Review of the "Patient Smoking Acknowledgement" form signed by Resident #16 on 8/31/16 did not include the smoking was to be off the facility property. The form did not include where the resident was to smoke off the facility property. The form indicated the Administrator may choose or may not choose to designate areas outside of the building for any smoking activities. Assessments of residents were to be completed if the resident smoked on the facility grounds.
Review of nurse ' s note dated 5/25/18 at 11:24 AM revealed the resident "continued" to go outside of the facility to smoke. He had refused all of the morning medications for that shift.
Psychiatric progress note dated 5/29/18 included diagnoses of dementia, mood disorder and anxiety. The Nurse Practitioner (NP) documented changes in his mood as irritable, threatening gestures with balled up fist towards roommate. The resident was refusing his medications on a daily basis. He had poor insight, judgement, concentration and short- term memory. Long term memory was fair. He was oriented to person and surroundings. His thought process was disorganized. The Depakote (for mood disorder) was increased to treat his mood.
Review of the nurse ' s note dated 5/29/18 at 1:54 PM revealed the resident continued to smoke outside "near sidewalk."

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Interview with Nursing Assistant (NA) #5 on 9/29/18 at 9:09 AM revealed she knew the resident and was aware of his behaviors. She said his memory was poor, and it had always been poor. He would make comments that he wanted to go to the super store. Further interview revealed she had no knowledge Resident #16 had gone to a super store. He would not tell staff if he was going outside the facility. She had knowledge of him smoking, and he would smoke cigarette butts. During the interview the NA#5 thought the resident could go outside to smoke.
Interview on 9/26/18 at 1:15 PM with Resident #5 revealed he had been outside with Resident #16 when he was smoking. He explained Resident #16 had his own cigarettes and lighter.
Review of the nurse ' s note dated 6/2/18 at 3:27 PM revealed the resident was "having some concerns with right leg being contracted." The charge nurse educated the resident as to the reason for having contraction to right leg. Resident understood and continued to go outside to smoke on sidewalk.
Review of a nurse ' s note dated 6/9/18 revealed the resident was observed smoking outside of the facility on the sidewalk smoking cigarettes. It was unknown at that time how he was able to get cigarettes. Educated the resident about smoking and importance of his health. Staff will continue to monitor for any behavior and health changes.
An interview with Nurse #4 on 9/26/18 at 4:30 PM revealed she had worked with Resident #16 when he went out to smoke on second shift. She explained he would go to the facility sign on the sidewalk to smoke. She explained he had not signed out to go smoke and she had educated him so many times about signing out. She had noted changes in his behavior during May and June. During the interview, Nurse #4 was not

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aware of any other interventions for the resident ' s non-compliance with not signing out to leave the facility.
Interview with the Director of Nursing (DON) on 9/26/18 at 12:45 PM revealed they did not do assessments of residents for safe smoking. The residents were aware on admission the facility was a nonsmoking facility. If the residents wanted to smoke, they were to go off the facility property. She explained Resident #16 was able to make his own decisions and could smoke independently. Further interview revealed the facility was a no smoking facility, assessments were not completed due to residents were supposed to smoke off the facility ' s property. She did not know where he obtained the cigarettes or lighter. She explained the resident must have "bummed" one from another resident. She explained she did not know if he had his own smoking materials and she had not checked his room to see if he did. When the DON was asked what the criteria for not allowing a resident to smoke due to safety reasons, she did not have an answer. She further explained Resident #16 had a change in cognition around July 2018. The change in his cognition was described as "being fixated" on things, ie his leg and not being able to stand. The care plan was discussed regarding his impaired cognition, impaired thought processes related to a stroke and actual fall with high risk for future falls related to unaware of safety needs, paralysis, poor communication/comprehension and gait balance problems. The DON indicated those care plan problems were accurate when they were created. Continued interview revealed the resident had gone to a super store down the street in his wheelchair previously, and he would sign himself out of the facility. When asked when the last time

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he signed himself out and went to a store, a definite date and time was not provided. The DON explained recently Resident #16 had attempted to go to a store, and an employee brought him back because he did not sign himself out. The employee saw him down the block from the facility in the church parking lot.

Review of a nurse ' s note dated 6/12/18 at 1:30 PM revealed Resident #16 was found "wondering" (sic) "near a church parking lot headed to a super store on MLK (Martin Luther King) Drive. He stated, ' I to buy my own batteries, I do not want to use ya ' ll batteries. ' Front office staff safely escorted resident back to ... facility without any injuries. Notified NP (Nurse Practitioner) whom recommended resident not to go out of facility until further evaluation .... Educated (the resident) importance on the safety of resident/policy for leaving (facility) unattended ..."

Interview with business office staff #2 on 9/26/18 at 3:30 PM revealed she was walking back from the church on 6/12/18. During the interview, she explained she did not remember the time, but she saw Resident #16 at the corner next to the church parking lot. The business office staff #2 explained she asked Resident #16 if he had signed out before leaving the facility and he replied "He did not remember if he signed out." Further interview revealed she asked the resident to return to the facility to sign out and he went back to the facility.

Interview with the receptionist on 9/27/18 at 9:50 AM revealed she was working on 6/12/18 and was at the front desk beside the front door of the facility. She explained Resident #16 was out of

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the facility and waving at people. She saw him go to the sidewalk next to the facility sign, and then up the sidewalk beside the highway. She further explained he had gone to the end of the block and a staff person brought him back to the facility. During the interview she was not aware Resident #16 was not safe to be outside alone.

Interview with the DON on 9/26/18 at 4:45 PM revealed she had evaluated the resident after the 6/12/18 incident and found him to be able to make his own decisions. She explained she did not document or use an assessment form for her evaluation. Further interview revealed she had no explanation for misunderstanding what the NP had intended for the type of evaluation (by a psychiatrist).

Review of the MDS, quarterly 6/19/18 indicated he had short and long- term memory impairment with a BIMs of 10. The MDS indicated Resident #16 had behaviors of verbal and physical aggression towards others and no wandering behaviors were included. Resident #16 was assessed as having no changes in activities of daily living except for eating.

Review of the care plan dated 6/26/18 did not include problems of smoking or elopement risk. There were no changes to the care plan for additional problems related to behaviors or cognition.

Review of the MDS, an annual, dated 7/1/18 indicated he had short and long- term memory impairment with a BIMS of 2 (severe impairment). This assessment had included behaviors of physical and verbal aggressiveness towards others, and no wandering behaviors were included.

Review of the Care Area Assessments (CAA ' s) dated 7/9/18 included the following "Analysis of

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Findings" included no new diagnoses, a new score of 2 out of 15 with the BIMs interview. Areas of consideration were due to frequent lack of reorientation, reminders to help make sense of things, and hearing or vision impairment may have an impact on ability to process information (directions, reminders environmental cues).
Review of the updated care plan of 7/16/18 revealed no changes in the problems or interventions were made in the areas of cognition, behaviors, safety awareness, fall risk, smoking or wandering.
Interview with the MDS nurse on 9/27/18 at 9:00 AM revealed Resident #16 had disorganized thinking, inattention, short term memory with answers to interview questions that were not appropriate and he never remembered the year. The MDS ' s dated 6/1/18, 6/19/18 and 7/1/18 were reviewed with the MDS nurse. She verified he continued to have disorganized thinking, inattention, short term memory impairment. The MDS nurse explained the MDS dated 7/1/18 indicated his long- term memory had become more impaired. After reading the note of 6/12/18, the MDS nurse explained she would consider that incident as wandering. She had no knowledge of him going to a super store. She considered he was not able to make safety decisions and he could not walk but thought he could and wanted to walk. During interview, the MDS nurse explained Resident #16 ' s cognition assessment would vary depending on his mood and who was asking him the questions in the interview.
Follow up interview with the MDS nurse on 9/27/18 at 2:00 PM revealed the 7/1/18 was accurate regarding wandering due to the timeframe of the assessment reference date.

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Review of a nurse ' s note written by the Director of Nursing, dated 7/23/18 at 2:45 PM revealed the resident continued with poor decision-making abilities. "Leaving center without signing out. We have spoke (sic) to resident before and continues to be non-complaint (sic). Resident with recent acute change in cognition. Will place wander guard at this time."

Review of a nurse ' s note dated 8/20/18 at 10:07 PM revealed the resident tried to hit writer in face with fist. He was trying to cut off wander guard with toenail clipper.

Review of the physician orders for 5/2018, 6/2018 and 7/2018 included Seroquel 50 milligrams (mg), Give 1 tablet by mouth two times a day related to unspecified psychosis not due to a substance or known physiological condition. Resident #16 continued to receive Seroquel through September 27, 2018.
Interview with the Social Worker on 9/26/18 at 11:45 AM revealed the resident had short term memory problems. He could remember things "at the moment" but then would forget what was said to him. He would forget to sign out to go outside. A wander guard was placed on the resident due to not being compliant about signing out. She had no knowledge of his smoking outside or attempting to go to a super store and was found up the road at the church parking lot.
Review of the sign out log for Resident #16 revealed he was last signed out on 2/3/18 at 4:30 PM by a staff member and was signed back in at 7:30 PM by the same staff member. The resident had not signed himself out since 8/27/17.
The smoking area for the residents was viewed

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with the DON on 9/26/18 at 1:00 PM. A resident was in the driveway of the facility. Two residents were on a sidewalk leading to the sidewalk by the roadway. The DON instructed the resident in the driveway to go to the sidewalk past the facility sign. When asked if that was facility property, she said she would have to check.
Interview with the Administrator on 9/26/18 at 1:10 PM revealed the facility was a no smoking facility. Further interview revealed assessments for safe smoking were not completed on residents and they were to smoke off the facility property. The wander guard was placed on the resident due to his noncompliance with signing out of the facility. During the interview, she explained the DON had assessed Resident #16 as being safe to go outside without supervision after the 6/12/18 incident.
On 9/26/18 at 3:00 PM, the surveyor, accompanied by the therapy manager, measured the distance using his rolling measuring device for distances. The distance from the threshold of the front door to the facility sign was 180 feet. The distance from the threshold of the front door to the corner of the block was 440 feet.
The distance measured by the surveyor via car, from the end of the facility driveway to the point where the sidewalk ended, was 0.3 of a mile. The final destination to the super store was 0.5 miles from the facility driveway. This route was in the opposite direction Resident #16 was taking when he said he was going to a super store. Resident #16 turned left and proceeded up the sidewalk away from the facility. The route to the super store would have been a right turn, go down an incline using the sidewalk for 0.3 of a mile. After the sidewalk ended, a resident in a wheelchair would have had to go down a steep hill on a two- lane highway without the use of a

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sidewalk for 0.2 of a mile, cross to the left on the two-lane highway to enter the Walmart parking lot.
Interview with the NP on 9/26/18 at 3:15 PM revealed she would expect a psychiatric evaluation to be completed before the resident went outside after the incident on 6/12/18. Interview revealed the resident had a change in cognition over the last month. He could not remember to sign himself out and was more fixated on his leg and being able to walk again. She was not involved in smoking assessments and explained the resident had been able to sign himself out or tell the staff he was going outside. The resident was able to go outside and smoke independently prior to his change in cognition in the last month.
Interview with the NP on 9/26/18 at 3:30 PM revealed she had written a progress note indicating Resident #16 had attempted to get on a public transportation bus. She explained "staff" had informed her, but she did not have details about the incident.
Interview with the primary physician on 9/26/18 at 4:10 PM revealed Resident #16 was getting forgetful. He had a stroke with right sided hemiparesis and moved about in a wheelchair. The resident ' s usual behavior was to ask if he could walk and why could he not walk again. The resident attempted to leave the facility and due to the safety issue, the resident should not be outside unaccompanied. He explained the mental status decline had occurred in the last 3-4 months. As far as smoking, the physician explained that would be a safety concern in his opinion. During the time of his mental status change, he would not consider Resident #16 to be safe smoking. He would expect the nursing staff to accompany Resident #16 outside. The

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resident had "safety issues, would not know consequences and could get lost. He was forgetful and that could impact his life/safety." On 9/26/17 at 5:00 PM the Administrator and DON were informed of the immediate jeopardy. The facility provided a credible allegation of the removal of the immediate jeopardy on 9/27/18. The credible allegation included:

The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. This plan of correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center ' s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

Deficit practice is evident by, 06/12/2018, resident # 16, 1 of 5 smokers, left facility unattended without signing out or informing staff. Facility failed to provide supervision to ensure safety of resident # 16. Resident #16 left from the facility unattended from the front lobby door. Resident #16 was a smoker and left the center unattended to smoke unsupervised without signing out. Resident #16 had not been assessed as cognitively impaired with poor safety awareness until 07/23/2018 when resident #16 attempted to leave center without signing out again. At that time a wander prevention device was placed on resident #16, and continues to be in place.

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Facility failed to determine he was at risk, related to his impaired cognition and poor decision making skills, and being independently mobile in wheelchair. Facility could have prevented this by determining the resident could have been at risk based on his impaired cognition and poor decision making skills, and independently mobile in wheelchair. All doors are locked 24 hours per day with the exception of the front door. The front door was locked from 8pm to 6am.
Root cause analysis: The facility failed to establish a set of criteria for determining which residents are appropriate to leave the center unattended.

Facility Action
· 06/12/2018 resident # 16 Power of Attorney was notified that he left facility without signing out. Nurse Practitioner was notified. Recommended resident #16 not go out of facility until further evaluation. Director of Nursing evaluated resident on 6/12 and deemed safe to continue to leave facility unattended and provided reeducation on signing out when he leaves the center. This evaluation was not placed in the medical record. Resident was evaluated by psychiatrist on 7/25/2018. The psychiatrist recommendation was to implement slight increase to Seroquel to reduce baseline impaired reality, perseverations and distress, will continue to monitor patient response.
· Resident left center on 6/12/2018 to go to Walmart to get certain batteries as he did not want center ' s batteries. The receptionist saw resident move toward the facility sign at which time he continued down the sidewalk toward the church. The receptionist recalls a front office staff member bringing patient back to center. Upon return to facility resident #16 was assessed

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by the Licensed Nurse for any injuries, none were noted.
On 6/20/2018 it was identified the resident continued to leave the center to smoke off the property unattended and failed to sign out. Resident was reeducated on sign in/out when leaving to smoke. The center is non-smoking therefore a smoking assessment was not completed to deem the resident safe or not. Director of nursing used nursing judgement and knowledge of patient for two years. The resident knew where he was going and why he wanted to leave the center. The resident demonstrated capability of making good judgement such as not leaving the center in poor weather conditions, not leaving the center for long periods of time and wearing proper attire. He demonstrated ability to retain information as evidenced by resident frequently coming to Director of Nursing and Administrator to apologize for leaving the center without signing out.

· On 7/23/2018 resident #16 attempted to leave facility unattended. Nurse Practitioner and Power of attorney were notified. Wandering assessment completed and wander prevention device placed on resident.
· Education with all facility staff was completed on 09/27/2018 to ensure 100% coverage of the front door for any resident attempting to leave the facility between the hours of 8am and 8pm, doors locked between 8pm and 8am. In-service will emphasize the importance of monitoring to make sure all cognitively impaired residents do not exit the center. Facility will utilize a single check in/out book for all residents that enter and leave the facility. All visitors will receive a visitor pass. Visitor passes must be worn during visit and returned to the front desk upon

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Doctor/NP, and Interdisciplinary team will occur on 9/27/2018 to accurately assess safety of the resident, that have been deemed at risk, based off diagnosis of Alzheimer ' s/Dementia, impaired safety awareness, independent mobility and risk for leaving facility unattended. List of residents deemed unsafe to leave facility unattended will be kept on each unit in patient information notebooks and their care plans will be updated accordingly.

· Front door lock times changed on 09/27/2018 to 8p to 8am.
· On 09/27/2018 and ongoing, facility receptionist remained posted in the front lobby to monitor for any attempts by any resident to exit the facility. The hours of this were 8AM-8PM. From 8PM to 8AM the doors remain locked and any person has to be badged out by a staff member.
· To open doors, a person must be badged out by a staff member. Badging members out of the building has been in process since November 2017. Receptionist to nurse verification will be required for any resident that signs out that is leaving unattended. Between the hours of 8:00PM and 8:00AM a clinical staff member will then make the determination as to let a resident out unattended or not using a list of residents deemed unsafe to leave facility unattended will be kept on each unit in patient information notebooks.

· Education started on 09/26/2018 by Administrator or designee. New hires will be educated during general orientation.
1) All facility staff will be in-serviced, by the Administrator or their designee, on resident check in/out procedures. Facility will utilize a single

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check in/out book for all residents that enter and leave the facility. All visitors will receive a visitor pass. Visitor passes must be worn during visit and returned to the front desk upon exiting the building. Any person to be a visitor in the building will be required to have a pass. Those that do not have passes will be residents. Receptionist to nurse verification will be required for any resident that signs out that is leaving unattended. Between the hours of 8:00PM and 8:00AM a clinical staff member will then make the determination as to let a resident out unattended or not.

2) No Nurse, C.N.A, weekend manager on duty, front office staff and receptionist will be allowed to work unless they have completed the required in-servicing.

· Any new potential admissions will be notified by facility representative that center is a non-smoking campus. Any current smoker who is later deemed incapable of leaving the center unsupervised will be supervised and their care plans will be updated accordingly.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

· All new admissions will be audited by the Director of Nursing or designee for diagnosis of Dementia/Alzheimer ' s and impaired safety awareness, independent mobility, smoking and risk for leaving facility unattended. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team will occur to accurately assess safety of the resident, that have been deemed at risk, based off diagnosis of Alzheimer ' s/Dementia, impaired safety awareness,

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independent mobility, smoking and risk for leaving facility unattended. List of residents deemed unsafe to leave facility unattended will be kept on each unit in patient information notebooks and their care plans will be updated accordingly . QA committee met 9/27/2018 on 100% coverage of the front door for any resident attempting to leave the facility between the hours of 8am and 8pm, doors locked between 8pm and 8am. Facility will utilize a single check in/out book for all residents that enter and leave the facility. All visitors will receive a visitor pass. Visitor passes must be worn during visit and returned to the front desk upon exiting the building. Any person to be a visitor in the building will be required to have a pass. Those that do not have passes will be residents. Receptionist to nurse verification will be required for any resident that signs out that is leaving unattended. Between the hours of 8:00PM and 8:00AM a clinical staff member will then make the determination as to let a resident out unattended or not using a list of residents deemed unsafe to leave facility unattended will be kept on each unit in patient information notebooks. All current residents with diagnosis of Dementia/Alzheimer ' s were assessed by Director of Nursing or designee for impaired safety awareness, independent mobility and risk for leaving facility unattended. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team will occur on 9/27/2018 to accurately assess safety of the resident, that have been deemed at risk, based off diagnosis of Alzheimer ' s/Dementia, impaired safety awareness, independent mobility and risk for leaving facility unattended. Audits will be weekly for one months, bi-weekly for 2 weeks, and monthly for one month. Determination included discussion with Responsible Party,

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F 689	Continued From page 26 Medical Doctor/NP, and Interdisciplinary team. Audits will be reviewed in quarterly quality assurance process improvement meeting X ' s 2 quarters. The title of the person responsible for implementing the acceptable plan of correction. · Administrator approved that the above is accurate and complete as of 09/27/2018. Validation of the credible allegation for removal of the immediate jeopardy was conducted on 9/27/18 at 5:00 PM. Validation included review of the audits of residents, record review for a sample of 4 residents identified as not safe to be unaccompanied off the facility premise, review of the assessments, care plan updates, notification of physician of the assessments, review of the inservice information provided to all staff and follow up interviews with various staff members.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to monitor and assess dialysis access sites for 1 of 2 residents (Resident #11) reviewed for dialysis (a treatment used to mechanically remove fluid, electrolytes,	F 698	F698 How corrective action will be accomplished for those residents found to have been affected the deficient practice:	10/21/18

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F 698	Continued From page 27 and waste products from the blood). Findings included: Resident #11 was originally admitted to the facility on 11/3/2017 with diagnoses that included End Stage Renal Disease (ESRD). The resident's Significant Change Minimum Data Set (MDS) dated for 9/1/18 specified the resident had intact cognition, with no behaviors or rejection of care. Review of Resident #11's active care plan as of 9/26/18 revealed the following: Problem: " The resident needs dialysis related to renal failure Goal: " The resident will have no signs and symptoms of complications from dialysis through the review date. Interventions: " Do not draw blood or take blood pressure in arm with graft (A man-made tube that is inserted into your arm to connect an artery to a vein. It is completely under the skin and is used for dialysis access) " Lab work as ordered " Observe for/document/report as needed any signs and symptoms of infection to access site: Redness, Swelling, warmth or drainage Review of Resident #11's Physician's orders from his most recent readmission to the facility on 8/25/18 revealed the following orders placed on 9/27/18: " Dialysis Monday, Wednesday, and Friday every shift related to ESRD " Monitor perma-cath (an external dialysis access site that has two tubes, one venous and	F 698	Facility failed to monitor and assess dialysis access site for Resident # 11. Current order for resident #11 reads to Monitor Dialysis access site to right thigh AV shunt for s/s of bleeding/infection every shift. Document any unusual findings and notify MD/RP in progress notes every shift and Palpate for the presence of the thrill and Auscultate Bruit every shift over Right thigh AV shunt. How the facility will identify other residents having the potential to be affected by the same deficient practice: Staff Development nurse will educate all Licensed nurses on 1) 3 types of Hemodialysis access 2) Assess the access sites for signs of infection (Redness, swelling, warmth, pain, and discharge) 3) Assess the Fistula or Graft (these are sometimes referred to as a shunt) for Thrill and Bruit as MD ordered. No BP□s, IV□s or venipuncture taken in the arm with the access. Any Licensed Nurse that has not been educated will not be allowed to work until education is completed. All new nurses will receive education on 1) 3 types of Hemodialysis access 2) Assess the access sites for signs of infection (Redness, swelling, warmth, pain, and discharge) 3) Assess the Fistula or Graft (these are sometimes referred to as a shunt) for Thrill and Bruit as MD ordered. No BP□s, IV□s or venipuncture taken in the arm with the access during orientation.	

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F 698	Continued From page 28 one arterial) to right upper thigh every shift related to ESRD Review of Skills Competency Validation Records for Nurse #2, Nurse #6, and Nurse #7 revealed dialysis protocol was completed in yearly training. During an interview with Resident #11 on 9/25/18 at 9:25 AM he stated that no staff had assessed his dialysis graft (right upper leg) since had been admitted to the facility. During an interview on 9/27/18 at 11:00 AM with Nurse #1 when asked if she routinely worked with Resident #11, she stated that she did. When Nurse #1 was asked if she knew where the dialysis site was and what type of dialysis access Resident #11's had, she did not know. During an interview on 9/27/18 at 11:12 AM with Nurse #7 was asked if she knew where the dialysis site was and what type of dialysis access Resident #11 had, she stated that he had a right upper leg perma-cath. She stated that documentation was only done if there was a problem with the site. When asked what would be looked for with a perma-cath, she stated that it was assessed for bleeding after dialysis and for signs of infection every shift. When asked what would be assessed for a resident with a graft, she stated that it would be assessed for the same thing, as well as for a bruit (auscultate the access site with a stethoscope to detect a "swishing" sound that indicated patency) and thrill (feel for a vibration in the access site that indicated arterial and venous blood flow and patency). When asked which arm the graft mentioned in the resident's care plan to not use for blood draws or	F 698	All current Dialysis residents have current orders to Monitor Dialysis access site to (site) for s/s of bleeding/infection every shift. Document any unusual findings and notify MD/RP in progress notes every shift and Palpate for the presence of the thrill and Auscultate Bruit every shift over (Site) (if indicated based off type of site). Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of Nursing or designee will audit all new/readmit Dialysis resident□s orders for Monitor Dialysis access site to (site) for s/s of bleeding/infection every shift. Document any unusual findings and notify MD/RP in progress notes every shift and Palpate for the presence of the thrill and Auscultate Bruit every shift over (Site) (if indicated based off type of site) weekly X 4 weeks, Bi-weekly X 2, and monthly X 1. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.	

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take blood pressures from was, she stated she was not sure.

During an interview with Dialysis Nurse #1 on 9/27/18 at 1:32 PM she stated that Resident #11 had a well-established right upper leg graft that had been there for a long time and had not had a perma-cath access in the past year while she had him as a patient. When asked how nurses assess this type of access site she stated that after dialysis it is very important to assess for bleeding, and routinely needed to be assessed for a bruit and thrill, as well as any signs and symptoms of infection.

During a second interview with on 9/27/18 at 4:10 PM, when Nurse #6 was asked again if she knew where the dialysis site was and what type of dialysis access Resident #11 had, she stated that he had a right upper thigh perma-cath. When asked what she assessed Resident #11's perma-cath for, she stated she looked at the dressing, and for signs and symptoms of infection. When asked what would be assessed for a resident with a graft, she stated that it would be assessed for a bruit and thrill. When asked which arm the graft mentioned in the resident's care plan to not use for blood draws or take blood pressures from was, she stated she was not sure.

During a second interview with on 9/27/18 at 4:14 PM with Nurse #2 when asked if she routinely worked with Resident #11, she stated that she did. When she was asked if she knew where the dialysis site was and what type of dialysis access Resident #11 had, she stated that he had a right upper thigh porta-cath (an implanted device, accessed through the skin by a needle for patients who need frequent or continuous

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administration of chemotherapy). When asked what she assessed Resident #11's porta-cath for, she stated she looked at the dressing, for signs and symptoms of infection and would contact the doctor for any problems. When asked what would be assessed for a resident with a graft, she stated she would observe for a bruit and thrill. When asked which arm the graft mentioned in the Resident #11's care plan to not use for blood draws or take blood pressures from was, she stated she did not know.

During an observation and interview with the Director of Nursing (DON) on 9/27/18 at 4:25 PM she stated that the resident had a right upper leg perma-cath that was used for his dialysis treatments. She stated that the nurses documented by exception, and only if there were issues with the site. She was asked by this surveyor to join her in Resident #11's room to observe his dialysis access site. Resident #11 revealed his right upper leg graft to the DON and to this surveyor. The DON stated that the access was not a perma-cath, that is was graft. When asked how staff should assess this type of access site, she stated it should be observed for a bruit and thrill, and for bleeding after dialysis treatments.

During an interview with the Administrator, Regional Nurse Consultant, and the DON on 9/27/18 at 5:32 PM, the DON stated that it was her expectation that the nursing staff knew the difference between each dialysis access types, how to accurately assess them, and document their findings.

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F 812	Continued From page 31	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to store opened foods in sealed containers, failed to discard food by the manufacturer use by date and failed to maintain clean kitchen equipment and walls. This was evident in 2 of 2 kitchen observations. The facility additionally failed to use a method to maintain cold food temperatures of protein-based sandwiches prepared with mayonnaise for bagged lunches provided to residents on dialysis. This was evident for 1 of 2 residents reviewed for dialysis (Resident #69). Findings Included:	F 812	F812 How corrective action will be accomplished for those residents found to have been affected: The facility failed to store, and discard foods found in the dry storage room and walk in refrigerator. The facility failed to appropriately clean cooking equipment and wall of dish washing area. Facility failed to properly package dialysis lunch for transport. On 9/24/18, a partial case of graham cracker crumbs found uncovered and exposed to air and a partial case of puree pasta mix found uncovered and exposed	10/21/18

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F 812	Continued From page 32 1. An observation of the kitchen on 9/24/18 at 10:00 am with the Registered Dietitian (RD) revealed the following: a. The dry storage room had a partial case of puree pasta mix and a partial case of graham cracker crumbs that were open and exposed to the air. The puree pasta mix had a manufacturer use by date of 6/8/18. b. The top convection oven had an accumulation of black food particles on the bottom of the oven. c. The hood filters above the cooking equipment had an accumulation of dust and grease. An interview with the RD on 9/24/18 10:25 am revealed the puree pasta mix and graham cracker crumbs were not stored correctly. She stated the puree pasta mix should have been discarded by the use by date. She explained the convection oven was scheduled for deep cleaning on Thursdays, but food spills should be cleaned daily. The RD stated an outside service company cleaned the hood vents and she believed they were scheduled to come to the facility in October. 2. An observation of the kitchen on 9/26/18 at 11:40 am with the Dietary Manager (DM) revealed the following: a. The walk-in freezer had partial cases of carrots, sweet potato fries and chicken tenders that were open and exposed to the air. b. The lower portion of the wall around the dish machine was heavily stained with a dark black substance. An interview with the DM on 9/26/18 at 11:55 am revealed the open food products in the walk-in freezer should be sealed, labeled and dated. She added the lower portion of the wall around the	F 812	to air and expired in the dry storage room were immediately removed and discarded at the time of observation. On 9/24/18, the convection oven found with accumulation of black food particles was immediately deep cleaned at the time of observation. On 9/24/18, the hood filters above the cooking equipment found with an accumulation of dust and grease were immediately removed and cleaned at the time of observation. On 9/26/18, the partial cases of carrots, sweet potato fries and chicken tenders that were found open and exposed to air were immediately removed and discarded at the time of observation. On 9/26/18, the lower portion of the wall around the dish machine that was found heavily stained with a dark black sub stance was immediately cleaned at the time of observation. On 9/25/18, the staff were immediately in serviced on the procedure of sending dialysis lunches including placing them in an insulated cooler bag with an ice pack. F812 How the facility will identify other residents having the potential to be affected by the same deficient practice: All Dining Services employees were in-serviced regarding proper procedures for discarding expired food items, labeling and dating items and storing food items when received, cleaning procedure for cooking equipment (9/24/18) All Dining Services employees were	

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F 812	Continued From page 33 dish machine should be clean. 3. An interview with Resident #69 on 9/25/18 at 9:26 am revealed he went to dialysis at approximately 10:00 am on Tuesdays, Thursdays and Saturdays. He stated the facility packed a bag lunch for him on those days that was often a chicken salad sandwich. Resident #69 added the lunch was packed in a plastic bag. Review of a quarterly minimum data set (MDS) dated 8/16/18 for Resident #69 revealed his cognition was intact. An interview with Dietary Aide #1 on 9/26/18 at 10:02 am revealed she typically packed a chicken salad sandwich for dialysis bagged lunches. An observation on 9/26/18 at 10:32 am of Resident #69 revealed he was on his way to dialysis. He had a plastic bag in the back of his power chair that contained a chicken salad sandwich and a carton of cranberry juice. There was no ice or ice pack observed in the bag. An interview with the DM on 9/26/18 at 11:55 am revealed the dialysis lunches were supposed to be placed in an insulated cooler bag with an ice pack. An interview on 9/26/18 at 4:23 pm with Dietary Aide #2 revealed when residents went to dialysis the kitchen packed them a sandwich, juice and a cookie for their lunch. She stated there was a choice of sandwiches the residents could choose from and the lunch was packed in a plastic bag. A phone interview on 9/27/18 at 9:29 am with a dialysis center representative revealed the facility	F 812	in-serviced regarding proper procedure for storing foods in refrigerated/freezer storage (9/26/18) All Dining Services employees were in-serviced regarding proper procedure for sending and storing dialysis lunch bags (9/25/18) F812 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A sanitation inspection will be conducted by Corporate Registered Dietician weekly x 4 weeks, twice-monthly x 1 month, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened. F812 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed.	

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sent a bag lunch with the residents. She stated the residents kept the lunch with them and ate it when they were ready. She added the dialysis center was not responsible for the food the facility provided to the residents.

An interview on 9/27/18 at 6:04 pm with the Administrator revealed it was her expectation that foods were stored correctly, and expired foods were discarded. She stated she expected the kitchen equipment and the kitchen walls to be clean. The Administrator added she expected the staff to use cooler totes for the packed dialysis lunches.