STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. BUILDING _____ B. WING _____	C 11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACGREGOR DOWNS HEALTH AND REHABILITATION	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

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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 reviews and staff interviews, the facility failed to accurately code a wander alarm for 1 of 29 resident assessments reviewed for accuracy of Minimum Data Set (MDS) assessments (Resident #69). The findings included: Resident # 69 was admitted to the facility on 8/31/16. Her diagnoses included Alzheimer's dementia, atrial fibrillation, and hypertension. Review of Resident #69's medical record revealed a physician's order, dated 9/8/17 which ordered the use of a wander alarm. Review of a MDS (Minimum Data Set) assessment dated 2/16/18, coded as a significant change assessment, specified no wander alarms were used during the look back period. Review of the resident's February 2018 Medication Administration Record revealed the battery on the resident's wander alarm was checked nightly. During an observation on 11/2/18 at 1:53 PM revealed Resident # 69 had a wander alarm present on her left wrist. During an interview with the MDS Coordinator on 11/2/18 at 10:19 AM, she stated the February MDS assessment was completed by a staff member who no longer is employed at the facility. She indicated the wander alarm should have been coded on the 2/16/18 MDS assessment. The MDS Coordinator stated she would correct the assessment immediately. An interview was conducted with the Director of	F 641	Please accept this Plan of Correction as MacGregor Downs Health and Rehabilitation's Center's credible allegation of compliance for the alleged deficiency cited. Submission and implementation of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of correction is submitted to meet requirements established by Federal and State laws , which requires an acceptable Plan of Correction as a condition of continued certification. 0641 1)A Wanderalarm was not coded on Section PO200E on the MDS for Resident # 69 on 2/16/18.A modification was completed on the MDS for Resident # 9 with ARD 2/16/18 by the Resident Director of Care Management on 11/2/18 . 2)The District Care Management Director conducted an audit for all current residents with wanderalarms to ensure accuracy of coding section P0200e for the previous 90 days. No Assessments with inaccuracies were identified. 3)The Resident Care Management	11/29/18

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

Electronically Signed | 11/21/2018

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F 641	Continued From page 1 Nursing on 11/2/18 at 11:26 AM, who stated it was her expectation that MDS assessments are completed accurately. She indicated the wander alarm should have been coded on Resident #69's 2/6/18 MDS assessment. During an interview with the Administrator on 11/2/18 at 1:26 PM, who stated it is his expectation that MDS assessments are completed accurately.	F 641	Director provided education to the Administrator, Director of Nursing, and the MDS nurses on accurate coding on Section P200E regarding wanderalarms on the MDS on 11/20/18. 4 The Resident Care Management Director will audit the MDS for any resident assessment that is completed and has a wanderalarm, weekly for four weeks to ensure accuracy of coding , and then monthly for 2 months. The findings will be reviewed at the monthly QAPI meeting for 3 months, or until deemed necessary by the QAPI Committee	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		11/29/18

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F 656	Continued From page 2 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed follow a resident's care plan to obtain labs as ordered by the physician for 1 of 5 residents reviewed for medications. (Resident #57) Findings included: Resident #57 was admitted to the facility on 3/3/17. Her active diagnoses included hypertension and atrial fibrillation. Review of Resident #57's orders revealed on 4/6/18 she was ordered warfarin 2 milligrams by mouth once a day. Review of Resident #57's most recent minimum	F 656	Tag 656 1 .Immediately following discovery of the lab omission on 11/1/2018, a PT/INR was obtained for Resident #57. Result of INR was 1.6. MD was notified regarding delay in obtaining PT/INR. Coumadin has been discontinued to Eliquis 2.5 mg twice a day, and the PT/INR order has been discontinued. 2. Residents on Coumadin with orders for monthly PT/INRs have the potential to be affective by alleged deficient practice therefore all residents on Coumadin, lab orders and results were audited for accuracy and to ensure the residents careplan is followed. Audit was conducted	

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F 656	Continued From page 3 data set assessment dated 9/3/18 revealed she was assessed as severely cognitively impaired. She was also assessed to receive anticoagulant medication therapy. Review of Resident #57's labs revealed the last Prothrombin Time and International Normalized Ratio (PT/INR) lab drawn was on 9/4/18. (This test is used to diagnoses bleeding or clotting disorders as well as monitor therapeutic use of warfarin) Review of the physician orders revealed on 9/18/18 Resident #57 was ordered to have monthly PT/INR labs drawn. The start dated for the order was 10/5/18. Review of Resident #57's care plan dated 10/4/18 revealed she was care planned for anticoagulant therapy. The interventions included to draw labs as ordered. Review of Resident #57's medication administration record for October 2018 revealed she had received warfarin as ordered every day of October 2018. During an interview on 11/01/18 09:27 AM the Assistant Director of Nursing stated she was over all PT/INR labs that are drawn. She further stated if an order was for monthly PT/INR then the lab got drawn each month. She stated if the start date was 10/5/18 the lab would be drawn 10/5/18 or 10/6/18. She further stated after reviewing the lab book that Resident #57's PT/INR lab was not drawn in the month of October 2018 and it should have been based on the physician order. The Assistant Director of Nursing stated she was not aware until the interview that the October 2018	F 656	on 11-1-18 by the Assistant Director of Nursing. No other missing PT/INRs were identified. 3. Nurse Managers, Nurses and Unit Secretaries will be inserviced on the protocol for following up on monthly PT/INR orders as ordered, to assure alleged deficient practice does not reoccur. In-service will include Nurse Managers, Nurses and Unit Secretaries and their responsibility to verify a Physician Order is in place, and check the lab book to determine if monthly PT/INR lab work have been scheduled, and completed. This education will be conducted by the Director of Nursing and or the Assistant Director of Nursing by November 29th, 2018 4. Corrective action will be monitored to ensure alleged deficient practice does not reoccur. The Director of Nursing, Assistant Director of Nursing , and Nurse Managers will audit for the results of orders for monthly PT/INR for those residents on Coumadin. Audits will be conducted twice a week x 4 weeks, then twice a month x 3 months, then monthly x 3 months. Results of the audits will be discussed upon completion with the Resident Care Management Director, who is responsible for Care Plan Development, and in monthly QAPI meetings until substantial compliance is achieved.	

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F 656	Continued From page 4 PT/INR was not drawn as ordered for Resident #57. She concluded she did not know why the October 2018 PT/INR lab draw was not done. During an interview on 11/1/18 at 9:57 AM the Director of Nursing stated it was her expectation that resident care plans were followed. She further stated Resident #57 was care planned to have labs drawn as ordered by the physician and it was not done.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to weigh 1 of 1 residents (Resident #67) reviewed for significant weight change on a monthly basis according to a physician order. Findings included: Review of a Quarterly MDS (Minimum Data Set- a tool used for resident assessments) dated 7/31/18 Resident #67 was originally admitted to the facility 10/13/15 and readmitted 11/19/17. Resident #67 was severely cognitively impaired and displayed no behaviors or rejection of care during the look back period. All activities of daily living, except eating, required extensive to total assistance. Resident #67 had limb impairment in both lower extremities. Active diagnoses included heart failure, weakness, hypothyroidism, atrial	F 658	Tag 658 1. Resident #67 was weighed on 10/16/2018 with a recorded weight of 185 lbs. Previous weight was conducted on 8/13/2018 with a recorded weight of 179lbs. Current order for monthly weight discussed with Resident #67 Physician, Dr. Sharmin, on 10-30-18. Per conversation with Dr. Sharmin, weight order for resident #67 wasn□t intended to be monthly. Order clarification obtained. Monthly weight discontinued. 2. All residents have the potential to be affected by alleged deficient practice; therefore all resident□s charts will be audited for documentation of Physician ordered monthly weights. Audits will be	11/29/18

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F 658	Continued From page 5 fibrillation (an irregular heartbeat), pain and contracture in the left knee, and right and left foot pain. A review of the physician (MD) orders dated 2/21/18 revealed an order for monthly weights. The order was present for the months of March 2018 through October 30, 2018 when an order clarification was received to weigh the resident only when the MD requested a weight. A review of the weight flow sheet revealed weights were completed 2/2/18, 7/31/18, 8/13/18, and 10/16/18. No weights were documented for Resident #67 during the months of March 2018, April 2018, May 2018, June 2018 and September 2018. A review of the care plans, last updated 9/25/18 revealed a care plan focused on hypothyroidism. Interventions read, in part, "Monitor weight as ordered and report to MD as necessary." A care plan last updated 9/25/18 focused on the potential for an alteration in hydration. Stated goals included remaining free of signs and symptoms of fluid excess which included sudden weight gain. Interventions read, in part, "Monitor weight per physician order, Notify physician of weight gain/loss." An additional care plan, initiated 4/26/17, and last updated 10/16/18 read, "(Resident #67) has risk of non-intentional wt. (weight) changes r/t (related to) changes in fluid status/edema and changes in PO (oral) intake AEB (as evidenced by) hx (history of) fluid-related wt. changes and varying PO intake." Stated goals included, "(Resident #67) will have no significant wt. changes r/t PO	F 658	conducted by the Director of Nursing, Assistant Director of Nursing, and Unit Managers. Audits will be completed by 11-29-18. 3. The Restorative Aide will be educated by the Director of Nursing to provide a copy of all recorded monthly weights to the Registered Dietitian and Assistant Director of Nursing. The Dietician will provide the Assistant Director of Nursing, in writing, a list of residents that are lacking monthly weights as ordered by the Physician by the 25th of each month, for follow up. The Assistant Director of Nursing will be educated to provide a copy of all Physician ordered monthly weights to the Director of Nursing for review by the 30th of each month. This education will be conducted by the Director of Nursing and will be completed by 11-30-18. 4. Corrective actions will be monitored to ensure the alleged deficient practice does not reoccur. Monitoring will include auditing the medical records for Physician ordered monthly weights twice a month x 3 months, then monthly x 3 months then randomly until substantial compliance is achieved. These audits will be conducted by the Unit Manager, Assistant Director of Nursing, Director of Nursing and Unit Secretary. Results of the audits will be reviewed in monthly QAPI meetings until substantial compliance is achieved.	

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F 658	Continued From page 6	F 658		

intake through next review." Interventions included, "Monitor significant wt. changes for (Resident #67) through weight committee. Notify MD of significant weight changes for (Resident #67). Obtain weights as ordered (if does not cause pain/discomfort) for (Resident #67) and observe for significant changes."

An interview was conducted with a nursing assistant (NA #2) on 10/31/18 at 2:35PM. She stated Resident #67 was weighed by the Restorative Aid who completed all the weights in the facility. Resident #67 was weighed whenever it was ordered by the doctor, and she a lift scale was used because she was not able to stand.

An interview was conducted with Nurse #1 on 10/31/18 at 2:45PM. She stated she typically cared for Resident #67 and she was weighed by the Restorative Aid. She stated, "In fact, she was on my list to be weighed today. He uses a (lift) scale to weigh her because she's non-ambulatory. If an MD order was written to weigh a resident monthly the resident should be weighed monthly."

An interview was conducted on 10/31/18 at 3:00PM with the Director of Nursing (DON). She stated her expectation was for physician orders to be followed. If weights were ordered monthly they were supposed to be completed monthly. She also stated (Resident #67 had no recorded weights from 2/2018 through 7/2018 because, "There was a point in time where weighing her was uncomfortable. Weights weren't meant to be monthly for her, but there was a doctor's order for monthly weights."

An interview was conducted on 10/31/18 at

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F 658	Continued From page 7 3:25PM with the Restorative Aid. He stated he was responsible for weighing all the residents in the facility according to their physician orders. He received an updated list from the Assistant Director of Nursing (ADON) every morning which contained the names of the residents who needed to be weighed. He also stated he used standing and lift scales, and Resident #67 used a lift scale. He stated, "She doesn't always tolerate getting weighed and if she doesn't I tell the nurse, DON or ADON and go back the next day and try again. I recently weighed (Resident #67) but I don't remember when." An interview was conducted with the ADON on 10/31/18 at 3:35PM. She stated she provided a daily list to the Restorative Aid for residents who required weights. She ran an updated report every morning and added new admits, re-admissions, or anyone else who required a weight. She also conferred with dietary to see if she needed any updated weights. She also stated she expected the resident to be weighed as ordered. She also stated she was not sure why Resident #67 had no weights from 2/2018 through 7/2018, but they were never intended to be ordered monthly, but there was a physician order for monthly weights.	F 658		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		11/29/18

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F 757	Continued From page 8 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor monthly Prothrombin Time and International Normalized Ratio (PT/INR) labs as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications. (Resident #57) Findings included: Resident #57 was admitted to the facility on 3/3/17. Her active diagnoses included hypertension and atrial fibrillation. Review of Resident #57's orders revealed on 4/6/18 she was ordered warfarin 2 milligrams by mouth once a day. Review of Resident #57's most recent minimum data set assessment dated 9/3/18 revealed she was assessed as severely cognitively impaired. She was also assessed to receive anticoagulant medication therapy.	F 757	Tag 757 1 .Immediately following discovery of the lab omission on 11/1/2018, a PT/INR was obtained for Resident #57. Result of INR was 1.6. MD was notified regarding delay in obtaining PT/INR. The MD has since discontinued Coumadin and has changed medication to Eliquis 2.5 mg twice a day 2. Residents on Coumadin with orders for monthly PT/INRs have the potential to be affective by alleged deficient practice therefore all residents on Coumadin, lab orders and results were audited for accuracy. Audit was conducted on 11-1-18 by the Assistant Director of Nursing. No other missing PT/INRs were identified. 3. Nurse Managers, Nurses and Unit Secretaries will be inserviced on the protocol for following up on monthly PT/INR orders as ordered, to assure	

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F 757	Continued From page 9 Review of Resident #57's labs revealed the last PT/INR lab drawn was on 9/4/18. (This test is used to diagnoses bleeding or clotting disorders as well as monitor therapeutic use of warfarin) Review of the physician orders revealed on 9/18/18 Resident #57 was ordered to have monthly PT/INR labs drawn. The start dated for the order was 10/5/18. Review of Resident #57's care plan dated 10/4/18 revealed she was care planned for anticoagulant therapy. The interventions included to draw labs as ordered. Review of Resident #57's medication administration record for October 2018 revealed she had received warfarin as ordered every day of October 2018. During an interview on 11/01/18 09:27 AM the Assistant Director of Nursing stated she was over all PT/INR labs that were drawn. She further stated if an order was for monthly PT/INR then the lab got drawn each month. She stated if the start date was 10/5/18 the lab would be drawn 10/5/18 or 10/6/18. She further stated after reviewing the lab book that Resident #57's PT/INR lab was not drawn in the month of October 2018 and it should have been based on the physician order. The Assistant Director of Nursing stated she was not aware until the interview that the October 2018 PT/INR was not drawn as ordered for Resident #57. She concluded she did not know why the October 2018 PT/INR lab draw was not scheduled and done.	F 757	alleged deficient practice does not reoccur. In-service will include Nurse Managers, Nurses and Unit Secretaries and their responsibility to verify a Physician Order is in place, and check the lab book to determine if monthly PT/INR lab work have been scheduled, and completed. This education will be conducted by the Director of Nursing and or the Assistant Director of Nursing by November 29th, 2018 4. Corrective action will be monitored to ensure alleged deficient practice does not reoccur. The Director of Nursing , Assistant Director of Nursing , and Nurse Managers will audit for the results of orders for monthly PT/INR for those residents on Coumadin. Audits will be conducted twice a week x 4 weeks, then twice a month x 3 months, then monthly x 3 months. Results of the audits will be discussed in monthly QAPI meetings until substantial compliance is achieved.	

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F 757	Continued From page 10 During an interview on 11/1/18 at 9:57 AM the Director of Nursing stated if a lab was ordered to be drawn monthly it was her expectation the lab would be drawn monthly. She further stated Resident #57 was ordered to have monthly PT/INR labs drawn and it was missed in October 2018.	F 757		
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 and staff interviews the facility failed to discard expired food items stored in 1 of 1 walk in refrigerator and failed to maintain the dish machine wash cycle temperature above the minimum temperature of 150 degrees Fahrenheit for 1 of 2 dish machines. The findings included:	F 812	Tag 812 Food storage: 1.Corrective action has been accomplished for the alleged deficient practice in regards to any residents affected. Upon identification of the	11/29/18

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	345168	A. BUILDING _____ B. WING _____	C 11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACGREGOR DOWNS HEALTH AND REHABILITATION	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

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F 812	Continued From page 11 1. An observation of the kitchen's walk-in refrigerator on 10/30/18 at 7:10 AM revealed leftover food items stored in sealed containers. Each container had a label with a storage date and a use by date on it. Observations of these containers of leftover food items revealed the following foods had expired use by dates: a container of leftover turkey had an expiration date of 10/26/18, a container of leftover hot dogs had an expiration date of 10/27/18 and a container of leftover macaroni and cheese had an expiration date of 10/28/18. Kitchen supervisor #1 was interviewed on 10/30/18 at 7:10 AM during the observation. He stated the cooks were responsible to discard the leftover food items on the use by date. During an interview with Food Service Manager #1 on 10/31/18 at 5:30 PM she stated left over foods should be discarded by the use by date which was written on the label. 2. An observation on 11/2/18 at 9:50 AM of the manufacturer label on the dish machine in Pantry #2 revealed the minimum wash temperature was 150 degrees Fahrenheit. On 11/2/18 at 9:50 AM Dietary Aid (DA) #1 was observed washing dishes in the single rack compartment dish machine in Pantry #2. DA #1 washed a rack of beverage glasses for 2 cycles. She stated she always washed the beverage glasses twice. The dish machine wash temperature registered 113 degrees Fahrenheit on the first run and 131 degrees Fahrenheit on the 2nd run. A second rack of beverage glasses was washed for 2 cycles. The first run registered	F 812	deficiency on 10/30/2018,all out of date items noted were discarded immediately by the Kitchen morning supervisor and the Food Service Director so that no residents could have been served the items. 2.On 10/30/18 the noted items were discarded, and the Dietary District Manager and Food Service Director completed inspections of the walk in refrigerator as well as, all other refrigerators and freezers to ensure all food was within State and Federal regulatory guidelines. 3.On 10/30/2018 the Food Service Director began education regarding the importance of labeling and dating and discarding expired items, which will be completed with all full time and part time dietary employees by date of compliance of 11/29/18. The Dietary District Manager implemented a system on 11/02/18 that the AM and PM Dietary Supervisors must complete AM and PM checklists each shift to ensure all food items are labeled, and dated, and discarded. Each day the Food Service Director is to verify that the Dietary AM and PM supervisor checklists are complete and that all items are labeled, and dated, and discarded. 4.To ensure our results are sustained the Food Service Director will verify AM and PM Dietary Supervisor checklists are completed daily for 4 weeks until 12/29/18 and then weekly for the next 4 weeks until 1/29/19. Data will be reviewed and reported to the QAPI Committee monthly	

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F 812	Continued From page 12 131 degrees Fahrenheit and the 2nd run registered 139 degrees Fahrenheit. The 3rd rack of dishes registered 124 degrees Fahrenheit for the wash cycle. DA #1 stated she had previously informed Food Service Manager #1 of the low wash temperature one day last week. During an interview with Food Service Manager #1 on 11/2/18 at 10:05 AM she stated she was aware of the dish machine in Pantry #2 having water problems and she had completed a Maintenance Request form. A review of the Maintenance Request form revealed on 10/9/18 the dish machine in Pantry 2 did not have enough water and the staff were having to add water during the wash cycle. The form also revealed the machine's "wash temperature was only reaching 109 after 3 cycles." The Maintenance Director was interviewed on 11/2/18 at 10:42 AM. He stated when problems with a dish machine were reported he checked to see if he could fix it and if he could not, he called the manufacturer to come and fix the machine. The Maintenance Director stated he had replaced the heating element and the thermocouple but he had no documentation of when that was completed. He stated he would expect the machine to follow manufacturer guidelines. On 11/2/18 at 11:05 the Administrator provided a copy of the Equipment Service History record from the manufacturer from 7/1/18 through 11/2/18. The report revealed this dish machine in Pantry 2 was serviced on 9/27/18 when the machine was not filling so the technician "replaced the chem. Pump tube and water level	F 812	for 3 months until deemed in compliance by the Facility Administrator. Dishwasher Temperature: 1.Corrective action has been accomplished for the alleged deficient practice in regards to any residents affected. Upon identification of the deficiency, use of the dish machine in Pantry 2 was suspended immediately and maintenance was notified. The dishware was cleaned and sanitized in other dish machines in the facility that met Federal and State guidelines. 2.The Dietary District Manager and Food Service Director audited the dish machines in the facility on 10/30/2018 to ensure they were operating within State and Federal Regulatory Guidelines. The Dishwasher Temperature Log has been updated to include instructions to dietary employees if minimum temperatures are not reached.3.On 10/30/18, the Dietary District Manager and Food Service Director began education for all full time and part time dietary staff regarding proper temperature for wash and rinse cycles and will be completed by 11/29/18. Dishwasher temperatures will be checked and recorded on the Dishwasher Temperature Log by the dietary aide during each meal.Dietary will communicate with maintenance utilizing the Maintenance Requests Forms in the event there are issues with the dish machines. The Food Service Director	

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F 812	Continued From page 13 probes. Checked OK."	F 812	and the AM and PM Supervisors will be completing the Manager□s Dishwasher Temperature Tool during each shift to ensure that correct temperatures are reached. The Manager□s Dishwasher Temperature Log will continue daily for 4 weeks until 12/29/18 and then weekly for the next 4 weeks until 1/29/19, or until deemed to be in compliance by the Dietary District Manager. 4. The Maintenance Director and Food Service Director will review the audits weekly for 8 weeks until 1/29/19. Data will be reviewed and reported to the QAPI Committee monthly for 3 months until deemed in compliance by the Facility Administrator.	