STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	C 10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HWY 801 SOUTH ADVANCE, NC 27006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, observations and staff interviews, the facility failed to provide a dignified dining experience for four (4) of seven (7) sampled residents observed during dining. (Resident #80, 104, 26, and 71) The findings are: Observation of the lunch meal in the assistive dining room on 10/24/11 at 12:10 PM revealed residents required assistance with feeding. The meal trays arrived at 12:25 PM and the residents received set-up assistance with their meals. At 12:30 PM, four residents had not yet been served their meal or received feeding assistance while five other residents were being assisted with feeding. At 12:40 PM, the last resident waiting for her meal tray was served her tray with set up by staff. There was a fifteen minute wait for the last resident to receive her meal tray while the other residents were assisted with their meals. A. A review of the medical records revealed Resident #71 was admitted to the facility in 2008 with diagnoses that included Alzheimer's disease and dementia. A review of the most recent significant change Minimum Data Set (MDS) assessment dated 08/12/11 revealed Resident	F 241	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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

John Seyton | Administrator | 11/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 #71 had short and long-term memory problems with severely impaired decision-making skills. The MDS further revealed Resident #71 required one person, extensive physical assistance with eating. Eleven residents were observed on 10/25/11 at 12:12 PM in the assistive dining room. At 12:21 PM, there were four residents being assisted by staff with feeding. At 12:26 PM, Resident #71 was waiting for assistance with feeding. Resident #71 was awake, alert and watching while staff assisted other residents with eating. At 12:34 PM, Resident #71 was assisted by staff with his lunch meal after waiting twenty-two minutes while other residents were being assisted with dining by staff. Another dining observation on 10/25/11 at 5:07 PM revealed nine residents were in the assistive dining room. The meal trays arrived at 5:16 PM. At 5:22 PM, there were a total of seven residents eating. Resident #71 was aware and alert, waiting to be assisted with feeding. Resident #71 was seated at the same table where another resident was assisted with feeding. At 5:47 PM, Resident #71 was the last resident assisted fed by staff. Resident #71 waited twenty-five minutes for feeding assistance while other residents were assisted with feeding. B. Resident #104 was admitted to the facility in 2011 with a diagnosis of dementia. A review of the most recent significant change MDS assessment dated 07/13/11 revealed Resident #104 had short and long-term memory problems with moderately impaired decision-making skills. The MDS further revealed Resident #104 required one person, extensive physical	F 241	F241 A. Residents #'s 80,104,26,and 71 have received their meals timely and assistance with their meals has been delivered in a manner providing a dignified dining experience. B. All residents that require feeding assistance in the Assistive Dining Room have the potential to be affected. The RN Unit Director observed the dining process on 10/28 to be delivered to all residents requiring assistance to be within allowable time frames. C. In-service training was conducted with all C.N.A.'s on 10/31/11 by the RN Staff Development Director. Any in-house staff members who did not receive the training will be trained before returning to work and the training is integrated into orientation new hires and refresher training for all staff. Topics included: Promoting independence with dining, dining etiquette, serving of trays to all residents at each table, providing	

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F 241	Continued From page 2 assistance with eating. A dining observation on 10/25/11 at 8:15 AM in the assistive dining room revealed the meal trays were available on a cart. There were eleven residents waiting for their lunch. At 8:17 AM, a staff member started to assist a resident. At 8:32 AM, there were eight staff members assisting eight residents with feeding. Resident #104 was seated at a table in the middle of the dining room, alert, watching other residents and waiting to be assisted with feeding. At 8:53 AM, Resident #104 was served lunch and assisted with feeding. Resident #104 waited thirty-eight minutes to be assisted with feeding while the other residents received assistance. On 10/25/11 at 12:12 PM, eleven residents were observed waiting for their lunch in the assistive dining room. At 12:21 PM, four residents received feeding assistance from staff while Resident #104 waited. Resident #104 was awake, alert and watching the other staff members feeding the other residents. A restorative nursing assistant explained to Resident #104 that she knew he was hungry and that someone would assist him soon with his meal. At 12:34 PM, Resident #104 was assisted with his lunch meal after waiting twenty-two minutes while the other residents were being assisted with feeding. C. Resident #26 was admitted to the facility in 2011 with a diagnosis of dementia. A review of the most recent quarterly MDS assessment dated 09/14/11 revealed Resident #26 had short and long-term memory problems with moderately impaired decision-making skills. The MDS further revealed Resident #26 required one person,	F 241	assistance with feeding for more than one resident, and proper infection control procedures. The assistive dining room seating has been arranged to encourage compatible dining to help accommodate staff's ability to provide assistance with meals for more than one resident at a time. D. Assistive Dining Room audits will be conducted 5 days a week by the D.O.N. or designee for 4 weeks and then weekly for 2 months. Audits will include observations for tray delivery, assistance with feeding, and any identified dignity issues. Any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be taken as needed. Ongoing compliance will be reviewed at the weekly Quality of Life meetings. E. Completion date 10/31/11	10/31/11

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F 241	Continued From page 3 extensive physical assistance with eating. A dining observation on 10/25/11 at 5:07 PM revealed nine residents were in the assistive dining room. The meal trays arrived at 5:16 PM. At 5:22 PM, seven residents were assisted with feeding while Resident #26 was aware and alert and waited. At 5:36 PM, Resident #26 received assistance with lunch by a staff member after waiting fourteen minutes while other residents were assisted with feeding. D. Resident #80 was admitted to the facility in 2011 with diagnoses that included diabetes and dementia. A review of the most recent quarterly MDS assessment dated 07/23/11 revealed Resident #80 had short and long-term memory problems and moderately impaired decision-making skills. The MDS further revealed Resident #80 required one person, limited physical assistance with eating. A dining observation on 10/25/11 at 8:15 AM in the assistive dining room revealed eleven residents were waiting for lunch and the meal trays were available on a cart. At 8:17 AM, a staff member started to assist one resident with feeding. At 8:32 AM, there were eight staff members assisting eight residents with feeding. Resident #80 was alert, watching and seated at a table in the middle of the dining room. At 8:53 AM, Resident #80 received assistance with the breakfast meal after waiting thirty-eight minutes while other residents received assistance with feeding. Another dining observation on 10/25/11 at 12:12 PM in the assistive dining room revealed eleven	F 241		

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F 241	Continued From page 4 residents were waiting for lunch. At 12:21 PM, four residents received assistance from staff with dining while Resident #80 waited. Resident #80 was observed awake, alert and watching other residents being fed. At 12:34 PM, Resident #80 received assistance with lunch after waiting twenty-two minutes while other residents received feeding assistance from staff. An interview with Nursing Assistant (NA) #4 on 10/27/11 at 9:24 AM revealed he was trained that the staff members could not assist more then one resident at a time, but that he usually fed two residents at a time. An interview with licensed nurse #2 (LN) (unit manager) on 10/27/11 at 9:30 AM revealed she was told by administration that the staff members could only feed one resident at time and that was why all the residents in the assistive dining room were not being assisted with feeding at the same time. LN #2 further revealed that all residents in the assistive dining should have been assisted with feeding at the same time. An interview with the NA #7 (restorative nursing assistant) on 10/27/11 at 9:35 PM revealed she was trained that she could only assist one resident at a time with feeding. An interview with NA #5 on 10/27/11 at 9:41 AM revealed she was trained that only one resident can be assisted with feeding at a time. An interview with LN #1 on 10/27/11 at 9:56 AM revealed the staff was trained to only assist with feeding one resident at a time which was the reason a few residents were not fed until later. LN #1 explained staff would have to feed several	F 241		

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F 241	Continued From page 5 residents at the same time in order for residents to receive assistance with feeding at the same time. An interview with NA #6 on 10/27/11 at 10:12 AM revealed she was instructed to feed one resident at a time, but usually there were 4 to 5 staff members assisting more than resident with feeding as needed. An interview with the Director of Nursing (DON) and the Administrator on 10/27/11 at 10:53 AM revealed they instructed the staff to feed one resident at a time. The DON and the Administrator reported the expected normal routine was for all residents to be assisted with feeding at the same time and there should not be residents waiting to be assisted with feeding while other residents received assistance.	F 241		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide the correct dining table height to maintain independence in eating for one (1) of five (5) sampled residents (Resident #78). The findings are: Resident #78 was admitted to the facility on	F 311		

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F 311	Continued From page 6 8/26/09 with diagnoses which included Dementia. The most recent Minimum Data Set dated 9/7/11 assessed Resident #78 had memory problems and required set up and supervision for eating. The care plan dated 9/7/11 listed interventions of a wheelchair cushion and provision of task segmentation cues for assistance with activities of daily living. Observation during the lunch meal on 10/24/11 revealed Resident #78 seated on a cushion in a wheelchair. The edge of the table was approximately two inches below Resident #78's shoulders. Resident #78 unsuccessfully attempted to reach a sherbet cup with her right hand at 12:40 PM. Nursing Assistant (NA) #1 handed Resident #78 the sherbet cup. Resident #78 consumed 100% of the sherbet holding the cup on her lap. Interview with NA #1 on 10/24/11 at 12:46 PM revealed Resident #78 required assistance with access to food at times because Resident #78 needed to reach up and over the table to get the food. NA #1 explained Resident #78's small stature made it difficult for independent eating and the food "falls on her lap a lot." Observation on 10/25/11at 7:52 AM revealed Resident #78 seated in a wheelchair with the table edge approximately two inches below the shoulders. Upon receipt of the breakfast meal at 8:44 AM, Resident #78 leaned forward, reached up with her right hand and lowered spoonfuls of scrambled eggs which she consumed. Resident #78 reached up and lowered an orange juice glass to her lap and drank 100% of the juice through a straw. After taking several bites of	F 311	F311 A. Resident #78 was provided a more appropriate wheelchair with lower arms by therapy to help achieve dining independence and was reassigned to a lower more accommodating dining table during meal times on 10/26/11. B. All residents who dine seated at a dining table have the potential to be affected by this alleged deficient practice. The rehabilitation department assessed residents dining in the dining room on 10/26/11 and no other residents were observed to have inappropriate wheelchair to table heights and all other residents were observed to be able to self-feed and maintain independence. On 11/15/11, therapy reassessed a random sample of (10) residents and all were determined to remain at appropriate wheelchair to table heights and all were able to maintain independence while dining. C. Residents will be assessed on admission as part of the therapy screen and as needed for proper wheelchair positioning and devices to ensure accommodations are provided to allow for dining independence. Staff in-services	

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F 311	Continued From page 7 raisin bread toast, Resident #78 attempted to reach a water glass and coffee cup which were placed out of reach at the top of the plate. Resident #78 took the empty orange juice glass and attempted to drink from the empty glass at 8:56 AM, 9:01 AM, 9:03 AM and 9:07 AM. Further observation on 10/25/11 at 9:10 AM revealed Resident #78 lowered the empty orange juice glass to her lap, swirled the straw and attempted to drink from the empty glass. Resident #78 unsuccessfully attempted to reach the water glass. Resident #78 attempted to drink out of the empty glass at 9:14 AM. Resident #78 moved the plate against the water glass and coffee cup at 9:18 AM. The coffee cup moved to the left of the plate. Resident #78 reached to the side and lifted the coffee cup spilling part of the coffee on the table. Resident #78 lowered the coffee cup to her mouth and took several sips at 9:20 AM. Interview with NA #2 on 10/25/11 at 9:21 AM revealed Resident #78 would be independent in eating if food were accessible. NA #2 explained the wheelchair was low for the table so nursing staff assisted Resident #78 with access to the meal. NA #2 reported she did not notice Resident #78's difficulty with water and coffee access. Observation of the supper meal on 10/25/11 at 5:19 PM revealed Resident #78 seated by NA #3 at a different table. Resident #78's shoulders were approximately one inch below the table's edge. Interview with NA #3 on 10/25/11 at 5:52 PM	F 311	were provided on 10/31/31 on dining independence, proper wheelchair to dining table height, and notifying therapy when any resident does not exhibit proper wheelchair height to promote independence with dining. Any in-house staff members who did not receive the in-service training will be trained before returning to work. This training has been integrated into the standard orientation for new hires and refresher training for all staff. D. Dining room audits will be conducted 5 x per week by the D.O.N./designee for 4 weeks and then weekly x 2 months for resident wheelchair positioning and dining independence. Any issues will be reported immediately to the therapy department for review. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality of Life meeting. E. Completion date: 10/31/11	10/31/11

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F 311	Continued From page 8 revealed she seated Resident #78 at this table because the table was the "shortest in the room" and made certain to sit next to her. NA #3 explained Resident # 78 could not reach all of the food so required staff assistance even at this table. Interview with Licensed Nurse #1 on 10/26/11 at 9:12 AM upon observation of Resident #78 at the breakfast meal revealed Resident #78's position at the table was not correct and the table was too high for independent access to the meal. LN #1 reported an over the bed table had been attempted in the past to provide a correct table height but Resident #78 wanted to eat at a dining table. LN #1 did not know if other measures such as a higher cushion or transfer to a dining chair were tried. Interview with LN #2, unit manager, on 10/26/11 at 9:27 AM revealed Resident #78's wheelchair was too low for the dining room table and not correct. LN #2 explained she was not aware of Resident #78's low position at the dining table. Interview with the Director of Nursing (DON) on 10/26/11 at 9:34 AM revealed Resident #78's height at the dining table was low and incorrect. The DON explained an over the bed table attempt in the past was not successful because Resident #78 liked to be like the rest of the residents and sit at a table. Interview with LN #2 and observation of Resident #78 on 10/26/11 at 10:29 AM revealed Resident #78 seated on a higher cushion in the wheelchair and proper height at the dining table. LN #2 reported the change in cushion provided the	F 311		

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F 311	Continued From page 9 correct height at the table for Resident #78.	F 311		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review, the facility failed to provide a serving of ground sausage and mashed potatoes, according to the menu, for 27 residents receiving a mechanical soft diet and 9 residents receiving a pureed consistency diet and failed to prepare pureed and mechanical soft foods to a consistency according to the recipe. The findings are: 1. An observation of the breakfast meal tray line occurred on 10/25/11 at 8:10 AM. The tray line was observed with ground sausage served from a #30 scoop (approximately 2 tablespoons) to residents on a mechanical soft diet. Review of the therapeutic spreadsheet which included the menu, documented the serving size of ground sausage for residents on a mechanical soft diet should have been a #12 scoop or approximately 5 tablespoons. Additionally, an observation of the lunch meal tray	F 363	F363 A. All residents including the 27 noted in this 2567 with mechanically altered diet orders and 9 noted to be on pureed consistency diets are receiving their meals daily to a consistency and proper portioning according to the diet orders beginning 10/28/11. B. All residents with diet orders have the potential to be affected by this alleged deficient practice and resident meals have been monitored beginning 11/3/11 at tray line service to assure proper consistency and portioning with no exceptions noted as of 11/16/11. C. All dietary staff were in-serviced on 10/28/11 by the Dietary Director on proper food handling, use of appropriate portioning tools, and mechanical soft and pureed consistency diets. The corporate dietician followed up with an all dietary staff in-service on 11/15/11 on preparation and service of mechanically altered foods and reviewed proper procedures for preparing mechanically altered foods with the Dietary Director and Cook.	

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F 363	Continued From page 10 line occurred on 10/25/11 at 12:15 PM. The tray line was observed with mashed potatoes served from a #12 scoop (1/3 cup) to residents on a pureed diet. Review of the therapeutic spread sheet which included the menu, documented the serving size of mashed potatoes for residents on a pureed diet should have been a #8 scoop or ½ cup serving. An interview with the dietary manager on 10/25/11 at 12:35 PM revealed that several residents complained of receiving too much food at a resident council meeting a few months back. Two of those residents were still residents in the facility and the remaining residents had since been discharged. As a result of these complaints, he instructed his department to start providing smaller portions of food. The dietary manager further stated that he had not discussed the smaller servings with the consultant dietitian. The dietary manager stated he knew he had to serve portions of food according to the menu, but he was also trying to honor the requests of the residents. An interview with the consultant dietitian on 10/25/11 at 1:15 PM revealed that she visited the facility monthly and completed a general sanitation inspection, checked tray line temperatures at lunch, observed dining for residents who required assistance with dining in the main dining room, ate lunch and monitored the dietary department for palatable foods and food temperatures. During her visits she had not observed concerns with the lunch meal; occasionally, she would request that dietary staff reheat pureed consistency foods. She confirmed that she was not aware that portions of foods	F 363	D. Diet consistencies and food portion audits will be conducted 5 x per week by the Dietary Director/designee for 4 weeks and then weekly x 2 months. Any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be taken as needed. Ongoing compliance will be reviewed at the weekly Quality of Life meetings. E. Completion date 11/3/11	11/3/11

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F 363	Continued From page 11 were served smaller than the menu required. She expected the dietary manager to inform her of these changes and stated that a physician's order should be obtained for residents who wanted smaller portions. An interview was conducted with dietary staff #1 on 10/25/11 at 1:25 PM. She confirmed that she prepared the breakfast and lunch meals on 10/25/11. The interview revealed that she received training on serving sizes, and she provided the serving sizes according to her training. She stated that she did not refer to the menu or the therapeutic diet spreadsheet for guidance on the serving sizes. 2. An observation of the lunch meal tray line occurred on 10/25/11 at 12:15 PM. Residents on a pureed diet were observed served pureed beef and pureed green beans of a soupy, loose consistency, without form, which poured onto the resident's plate. Residents on a mechanical soft diet were observed served chunks of beef approximately one fourth to one eighth inch in diameter. Review of the therapeutic spreadsheet which included the menu and the recipe revealed residents on a mechanical soft diet were to receive a beef patty of a ground meat consistency. During an interview with the dietary manager on 10/25/11 at 12:35 PM, he confirmed that the pureed green beans and the pureed beef consistency was too loose and needed to be thicker to hold form; he was observed to add a thickening agent to each food item. He further stated that residents on a mechanical soft diet complained about receiving ground meat	F 363		

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	345543	A. BUILDING _____ B. WING _____	C 10/27/2011

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F 363	Continued From page 12 according to their diet. To accommodate their requests, he stated that he started providing ground meat for breakfast to residents on a mechanical soft diet, chopped meat for lunch to residents on a mechanical soft diet and ground meat for lunch to residents on a mechanical ground meat diet. He also stated that there were no residents currently on a mechanical ground meat diet. The dietary manager added that he monitored the tray line, but had not noticed a concern with the consistency of the pureed or mechanical soft foods. An interview with the consultant dietitian on 10/25/11 at 1:15 PM revealed that she visited the facility monthly and completed a general sanitation inspection, checked tray line temperatures at lunch, observed dining for residents who required assistance with dining in the main dining room, ate lunch and monitored the dietary department for palatable foods and food temperatures. During her visits she had not observed concerns with the lunch meal; occasionally, she would request that dietary staff reheat pureed consistency foods. She confirmed that she was not aware of the changes made to the consistency of the mechanical soft foods. She also had not noticed a concern with the consistency of the pureed foods during her lunch observations. She stated that pureed foods should be of a pudding-like consistency according to the menu. An interview was conducted with dietary staff #1 on 10/25/11 at 1:25 PM. She stated that she did not use a recipe to prepare pureed or mechanical soft foods, but instead she prepared these items according to what she remembered from her	F 363		

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F 363	Continued From page 13 training.	F 363		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to 1) monitor and maintain potentially hazardous foods at least 135 degrees Fahrenheit on the breakfast tray line and 2) reheat potentially hazardous foods to 165 degrees Fahrenheit. Shelled eggs were served at temperatures of 110 and 114 degrees Fahrenheit and reheated to 140 degrees. The findings are: An observation of the breakfast meal tray line occurred on 10/25/11 at 8:10 AM. During the observation, temperature monitoring occurred at 8:18 AM by dietary staff #1 and the dietary manager. The temperature of all foods on the breakfast tray line was monitored, except for the shelled fried eggs and shelled scrambled eggs. Shelled fried eggs and scrambled eggs were observed plated, uncovered and stored in a	F 371	F371 A. All residents affected by this alleged deficient practice are receiving foods at properly prepared and served temperatures and the facility procures, stores, prepares, distributes, and serves all resident meals under sanitary conditions with auditing of these services beginning on 11/3/11. B. All residents have the potential to be affected by this alleged deficient practice and meal line procedures have been monitored beginning 11/3/11 to assure that foods are being served at proper temperatures and under sanitary conditions. C. All dietary staff were in-serviced on 10/28/11 by the Dietary Director on proper food handling, end point cooking temperatures of special order items, and holding temperatures of special order items. The corporate dietician followed up with an all dietary staff in-service on 11/15/11 on preparing and serving hot TCS (Time/Temperature controlled for safety) foods and in-service handouts were provided.	

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F 371	Continued From page 14 warmer with the temperature setting on 150 degrees Fahrenheit. At 8:25 AM and 8:30 AM on 10/25/11 fried eggs were plated for residents and placed on a cart for delivery; temperature monitoring revealed the fried eggs were 110 degrees Fahrenheit. Dietary staff #1 stated during the observation that she did not check the temperature of the shelled eggs after the eggs were cooked. She confirmed that this was the first temperature monitoring of the shelled eggs. At this time, the dietary manager stated that hot foods should be served at a temperature of at least 135 degrees Fahrenheit, but he instructed his staff to serve hot foods at 140 degrees Fahrenheit. At 8:34 AM on 10/25/11 shelled scrambled eggs were plated for a resident and placed on a cart for delivery; temperature monitoring revealed the shelled scrambled eggs were 112 degrees Fahrenheit. The dietary manager stated at 8:40 AM on 10/25/11 that the scrambled eggs should be served at a temperature of 135 degrees Fahrenheit. The dietary manager conducted temperature monitoring of two fried eggs in the warmer at 8:42 AM; the temperature of the fried eggs was 120 degrees Fahrenheit. He was observed to reheat the fried eggs in the microwave to a temperature of 140 degrees Fahrenheit, covered the eggs with an insulated dome lid and returned the eggs to the warmer still set on 150 degrees. He provided no explanation as to why the warmer temperature was not increased or why the eggs were not reheated to 165 degrees Fahrenheit. At 9:08 AM on 10/25/11, a fried egg that was reheated to 140 degrees Fahrenheit was plated	F 371	D. Monitoring of food end point cooking temperatures, holding temperatures and tray line temperatures and serving of foods under sanitary conditions will be conducted 5 x per week by the Dietary Director/designee for 4 weeks and then weekly x 2 months. Any issues identified will be reported immediately to the D.O.N. or Administrator and corrective action will be taken as needed. Ongoing compliance will be reviewed at the weekly Quality of Life meetings. E. Completion date: 11/3/11	11/3/11

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F 371	Continued From page 15 for a resident and placed on the cart for service. Temperature monitoring of the egg revealed it was 114 degrees Fahrenheit. An interview with the consultant dietitian on 10/25/11 at 1:15 PM revealed that she visited the facility monthly for lunch and completed a general sanitation inspection, checked tray line temperatures at lunch, observed dining for residents who required assistance with dining in the main dining room, ate lunch and monitored the dietary department for palatable foods and food temperatures. During her visits she had not observed concerns with the lunch meal; occasionally, she would request that dietary staff reheat pureed consistency foods. She confirmed that shelled eggs should be cooked initially to 155 degrees Fahrenheit and held at least 135 degrees Fahrenheit for the meal service. If the eggs were reheated, she stated the eggs should be reheated to 165 degrees Fahrenheit, but the egg's quality would not be good. She stated the eggs should have been re-cooked instead of reheated. She also stated that once the eggs held in the warmer were identified less than 135 degrees, the warmer temperature could have been increased. An interview with dietary staff #1 on 10/25/11 at 1:25 PM revealed that it was not her practice to check the temperature of shelled eggs when the eggs were prepared as fried or scrambled eggs. She stated that the fried eggs and the scrambled eggs were prepared at 7:40 AM on 10/25/11 for residents who request them at breakfast and placed in the warmer until the meal service. She stated she did not adjust or notice the temperature setting on the warmer, she stated	F 371		

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F 371	Continued From page 16 the temperature was already set.	F 371		