STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUMENTHAL JEWISH NURSING & REHAB CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to make available to residents or the public for review a copy of the plan of correction in effect for the most recent complaint survey during two (2) of four (4) days of the standard survey. The findings included: Observation on 6/16/14 at 10:30 AM of the green binder labeled Federal and State survey results located at the front desk revealed survey results from the recertification survey dated 3/1/13 were posted in the binder for review. Record review revealed on 9/12/13 a complaint investigation survey was conducted and a deficiency was cited at the regulatory tag F225 (under resident behavior and facility practices). The plan of correction for the 9/12/13 complaint investigation was not available for review. A second observation on 6/18/14 at 3 PM revealed the survey results with the plan of	F 167	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. There were no residents specifically documented that were affected by this alleged practice. Complaint survey results for 3/1/13 and 9/12/13 were placed in the survey notebook on 6/18/14. All Receptionists were instructed to check the survey notebook daily to ensure a copy of the survey documents is present	7/1/14

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

Electronically Signed | 07/10/2014

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F 167	Continued From page 1 correction following the recertification survey were still not posted in the binder to be reviewed by the residents or public. On 6/18/14 at 3:10 PM the administrator was shown the green binder. An interview at this time revealed she was responsible for ensuring that the results of surveys were posted in the binder. The administrator indicated that she reviewed the binder monthly to ensure that the survey results were posted in the binder for review.	F 167	in the notebook. Receptionists have a master copy of the documents that are required to be kept in the survey notebook in file at the front desk. If survey documents become missing during daily checks, the master copy will be used to replace the missing documents. A log was developed for Receptionists to document their daily checks, noting if documents are present or if they were replaced. Log is maintained by the Receptionist at the front desk. Log will be completed daily for 1 month and then weekly for 3 months. The log will be checked weekly by the Administrator to ensure compliance. Any issues will be discussed with Receptionists for correction. The log will be brought to the Monthly Quality Assurance Committee Meetings for the committee's review and revision if necessary to ensure compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242		7/10/14

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F 242	Continued From page 2 Based on observations, resident interviews, record reviews and staff interviews the facility failed to honor residents ' food choices for two of five sampled residents. (Residents #148 and 64) The findings included: Resident #148 was admitted to the facility on with diagnosis of The Minimum Data Set dated 4/7/14 indicated she had no impairment in cognition or memory. Observations on 6/18/14 at 9:30 AM revealed Resident #148 received her breakfast tray. The tray ticket indicated coffee was one of the beverages of choice and raisin bran cereal was the cereal of choice. There was no dry cereal on her breakfast tray. Interview with Resident # 148 on 6/18/14 at 9:38 AM revealed did not receive coffee for breakfast on 6/18/14. She explained the beverage in her coffee cup was juice. Resident #148 further explained she did not request any, but would get some at an activity at 10:00 AM. She added " this happens a lot." Resident #148 stated her roommate shares her coffee with her since she gets multiple cups of coffee at times. When asked if she would eat the oatmeal or grits, she stated " no " because they were " too thick and were cold. " Continued interview revealed the resident ' s daughter brought in cereal and fruit for her to eat. Interview on 6/19/14 at 9:12 AM with Resident #148 revealed she received coffee in her cup and raisin bran on the breakfast tray. Interview with the resident revealed she had a cereal bowl kept	F 242	Resident #148 and #64 were interviewed by the Dietician to identify food likes and dislikes and any other Dietary concerns. Resident #148 is receiving hot coffee and raisin bran. Resident #64 has not received sausage or voiced other concerns. Current residents were interviewed by the Certified Dietary Manager and/or Dietician for likes and dislikes and their respective tray cards updated when needed. Newly admitted residents are interviewed on day of admission to obtain likes and dislikes and their choices are noted on their tray cards. Dietary Aides, Cooks, Certified Dietary Manager and Dietician were re-educated, by the Administrator regarding the residents right to make choices about aspects of his or her life in the facility that are significant to the resident, including the right to make food choices and the facilities responsibility to honor food choices. A Dining Committee Meeting was convened on June 20th to discuss the resident's right to make choices related to food and dinning, including seating in the dining room and the efficiency of passing trays on each unit. The Dining Committee members include Certified Nursing Assistants, Licensed Nurses, Activities, Social Work, Dietician, Certified Dietary Manager and the Administrator. A meal observation and resident interview audit tool was developed by the Administrator to check the accuracy of trays for likes/dislikes and note any other	

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F 242	Continued From page 3 in her top drawer of her storage bins. After breakfast, she keeps a bowl from her tray and washes it at the sink. Permission was given to view the cereal bowl in her storage unit and one was located in a drawer in the storage unit. Resident #148 stated "Have to do what you can to take care of yourself." Interview on 6/19/14 at 4:40 PM with Registered Dietician #1 revealed she would expect the dietary aides to read the tray ticket, see the highlighted dislikes and ensure they were not served. There was a check the checker system put in place. The person on the end of the line serving the beverages was to check for any dislikes that may have been plated. 2. Resident #64 was interviewed on 6/17/14 at 10:22 AM stating she received foods she did not like on her tray. Observations on 6/18/14 at 9:30 AM revealed Resident #64 received a dislike that was listed on the tray ticket. The tray ticket indicated sausage was a " dislike " and she received a sausage patty for breakfast. Interview at 9:38 AM on 6/18/14 with Resident #64 revealed the coffee was "weak as water" and further stated it was cold. She stated the oatmeal and grits were " thick and gummy " and she would not eat either. The sausage was something she did not like and she would not eat it. Interview with the registered dietician #1 on 6/19/14 at 4:40 PM revealed she would expect the dietary aides to read the tray ticket, see the highlighted dislikes and ensure they were not	F 242	Dietary concerns. This audit will be completed by Dining Committee Members or the Manager on Duty daily, interviewing 10 residents a day for the next 4 weeks. Audit will be reviewed daily by the Dietician and/or Certified Dietary Manager who will update tray cards as needed and address any other Dietary concerns noted. The Administrator will monitor outcomes of the audits weekly to ensure concerns are addressed. After 4 weeks, audit tool will continue to be completed on 20 residents per week for 3 months. The Administrator will develop a report of monitoring outcomes to present to the monthly Quality Assurance Committee for review and revision, if necessary to ensure compliance.	

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F 242	Continued From page 4 served. There was a check the checker system put in place. The person on the end of the line serving the beverages was to check for any dislikes that may have been plated.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain wheelchairs in a clean and sanitary manner for 4 residents on 700 hall (Resident #141, #64, #200 and #5) and failed to maintain walls and baseboards in good repair for Room #308 and 500 hall. Findings included: Observations on 6/17/14 revealed the following: 1. At 9:00AM, Resident #141 ' s wheelchair had dried debris and food spills on bottom of side bars and at leg rest attachment. 2. At 10:15AM, Resident #5 ' s wheelchair had dried spills on lower bar near the breaks. 3. At 10:56AM, Resident #64 ' s wheelchair had dried food crumbs under the wheelchair cushion and Resident #64 stated they (staff) never clean the wheelchairs. They use to clean them on night shift and they never take them out anymore. 4. At 1:50PM, Resident #200 ' s wheelchair had dried food spills on the bottom bars of the wheelchair and on the seat. Observations on 6/19/14 at 2:15PM revealed the	F 253	Wheelchairs for Residents #141, #64, #200 and #5 were cleaned. Right arm of wheelchair for Room 718B has been replaced. Wall repair and sink repair has been completed in Room 308. Baseboard missing in hall nearest to Room 501 has been replaced. All wheelchairs in facility were cleaned and repairs made when applicable. A facility environmental audit was completed to note any walls in need of repair, missing base board and wheelchairs in need of repair. Re-education was provided by the Administrator to the Nursing Assistants, Nurses, Housekeeping Aides and Supervisor, Maintenance Assistant and Maintenance Director regarding the need for the facility to maintain a sanitary, orderly and comfortable interior and the process for completing work orders. The wheelchair cleaning schedule was	7/11/14

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F 253	Continued From page 5 following: 1. Wheelchair in room 718-b with torn right arm rest. 2. Room 308 with torn and peeled sheetrock on wall behind headboard of bed A and torn and peeled sheetrock on wall on left side of bed B. 3. Room 308 had a bathroom sink with support bar under front of sink detached and leaning against wall leaving no support under sink. 4. Baseboard missing at the corner of 500 hall nearest to room 501. During an interview with the ADON (Assistant Director of Nurses) on 6/19/14 at 2:45PM revealed that when wheelchairs needed cleaning that housekeeping is notified to clean the wheelchair, if it a small then any staff can do the cleaning. If it is an item that needs to be repaired, a work order is filled out for maintenance and the work orders are located at each nurse ' s station. An interview with the nurse aide on 600 hall on 6/19/14 at 3:20PM indicated that if any equipment should need repair she would contact maintenance, she was not aware of any work order forms. She further indicated that if equipment needed to be cleaned, she would clean it herself using disinfectant wipes. During an interview with the Maintenance Director on 6/19/14 at 3:30PM revealed that work orders are kept at each nurse ' s station and each housekeeping cart. Maintenance staff check for work orders every hour which are located at each nurse ' s station. If it needs quick attention then it is repaired right then. An interview with the Administrator on 6/19/14 at 4:20PM revealed that she was not sure if there	F 253	updated so that every wheelchair will be cleaned monthly. Maintenance repair requests will be completed by any staff member and placed in the Maintenance box on each unit, when a wheelchair needs cleaning or repair. Maintenance Boxes will be checked daily by Maintenance Assistant and/or Director for repair/cleaning requests. All repair/cleaning requests will be documented in a Maintenance Log and assigned to a Maintenance and/or Housekeeping staff member to complete. Completion of repair/cleaning will be documented by that staff member and checked by Housekeeping Supervisor and/or Maintenance Director for completion and that check documented in the Maintenance Log. The Administrator will review the Maintenance Log and randomly check 10 requests for completion weekly for the next 4 weeks and then 10 requests 2 times a month for 3 months to ensure compliance. Daily room audits will be completed by Management staff to document the need for wall, baseboard repair. A Management Staff member is assigned to each hallway and will make environmental rounds daily, documenting and wall/baseboard issues. Daily audits will be given to the Maintenance Director in morning meeting each day. The Maintenance Director will assign work requests to the Maintenance and/or Housekeeping Department staff for completion and document such in the Maintenance Log. Completion of work request will be documented by the	

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F 253	Continued From page 6 was a wheelchair cleaning schedule or not, she knows wheelchairs are taken out back everyday. The Housekeeping Director indicated on 6/19/14 at 4:25PM that wheelchairs are cleaned as needed. When rooms are cleaned and a wheelchair is noticed to be dirty then the housekeeper takes the wheelchair out back and washes it. At least 2 per day are cleaned.	F 253	assigned staff member in the Maintenance Log. The Maintenance Director will inspect assignments to ensure work is completed as assigned and document inspection on the Maintenance Log. The Administrator will review the Maintenance Log and randomly check 10 assignments weekly for the next 4 weeks and then 10 assignments 2 times a month for 3 months to ensure compliance. The Administrator will develop a report of monitoring outcomes to present to the Monthly Quality Assurance Committee for review and revision, if necessary to ensure compliance.	
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 observations, record review and staff interviews the facility failed to provide assistance during mealtimes for one of three sampled residents that required meal assistance. (Resident # 168) The findings included: Resident #168 was re- admitted on 3/15/12 with diagnosis of Parkinson's and vascular dementia.	F 311	Resident #168 received an Occupational Therapy Screen for assistance with meals. Two different attempts were made and she refused all assistance and interventions, including equipment (built up spoon). Her care plan was updated to reflect her desire to feed herself without assistance or adaptive equipment. Current residents have been assessed for assistance with meals. Any changes have	7/11/14

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F 311	Continued From page 7 Record review revealed Resident #168 had received occupational therapy (OT) March 2014 to April 2014. The discharge summary dated 4/1/14 indicated she did not meet her goals. Resident #168 did not receive therapy to aide in self feeding. The Minimum Data Set (MDS) dated 4/14/14 indicated Resident #168 required limited physical assistance of one staff member for eating. This MDS indicated the resident had short term and long term memory impairment. No weight loss had occurred during this MDS assessment reference dates. The MDS indicated Resident #168 had no behaviors and did not reject care. The updated care plan indicated a problem of " at risk for nutritional decline. " The approaches included staff to encourage the resident to eat in the main dining room and provide assistance with eating as needed. A second problem on the care plan indicated the resident required staff assistance for all activities of daily living, including eating. The care plan did not include behaviors of rejecting care. Resident #168 was observed on 6/16/14 at 1:05 PM eating her lunch with her fingers. Observations revealed the food she ate was cookies. Resident #168 did not use utensils to eat food during this observation. Observations of Resident #168 on 6/17/14 at 8:50 AM revealed she used a spoon and her fingers to eat the eggs for breakfast. Tremors of the right hand were observed. Assistance was not provided by staff with the breakfast. Interview with aide #1 on 6/17/14 at 9:20 AM	F 311	been updated on their care plan and Nursing Assistant care card. New residents will be assessed on admission for ADL assistance, including meal assistance and care plan and care cards updated to reflect any needs. The Director of Nursing has completed re-education with Licensed Nurses and Certified Nursing Assistant regarding the process of obtaining an assessment when a resident is in need of more assistance with ADL's, including meals. The Care Plan Team will discuss each resident's current abilities and any changes or declines at quarterly/significant change reviews to assess the need for assistance with ADL's to include assistance with meals. All completed screens will be brought to daily morning meeting for 4 weeks to monitor results of assessments. The Director of Nursing will review screens and check care plans and Nursing Assistant care cards to ensure any changes have been implemented. A monitoring tool was developed by the Administrator to record screens completed and any changes needed to a residents plan of care to ensure ADL assistance is provided. The Director of Nursing is responsible to complete monitoring tool. After 4 weeks, monitoring by Director of Nursing will continue weekly for 3 months. The Director of Nursing will present the monitoring report at the monthly Quality Assurance Committee Meeting for review	

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F 311	Continued From page 8 revealed she did not provide assistance because the resident would tell you when she does not want any more food to eat. Continuous observation on 6/19/14 from 8:10 AM to 9:10 AM revealed Resident #168 had the breakfast tray set up over the bed and she was eating. Tremors of both hands were observed, with the right being worse than the left. The resident was right handed. Food spillage was noted during the meal observations. Resident #168 held her right hand with the left hand in an attempt to use the spoon and scoop up eggs. The tremors of her hands caused the spoon to bang on the plate. Spillage of the juice was observed with the juice spilling onto the tray, her sheets and into the floor. Aide #1 entered the room at 8:30 AM and encouraged her to drink her juice. At 8:50 AM aide #1 asked Resident #168 if she was finished. Resident #168 answered "yes." At 9:10 AM the tray remained in the room with the dome cover over the food, the spills remained on her bed sheet and floor. During the continuous observations, several staff went by the room and looked into the room, but did not offer feeding assistance to the resident. Observations on 6/19/14 at 1:10 PM revealed Resident #168 was seated in a wheelchair with a lunch tray on the overbed table. She was using her fingers to eat her cake. Tremors of both hands were noted with an inability to control her fork. Resident #168 attempted to use both hands (hand over hand) to use the fork to eat the cake. The resident was unable to do so, and used her fingers to eat the cake. Spillage of food was noted on her clothing and on the floor. Resident #168 did not eat any of the pasta or green beans.	F 311	and revision, if necessary to ensure compliance.	

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F 311	Continued From page 9	F 311		

Interview on 6/19/14 at 2:20 PM with nurse #1 revealed she had noted her Parkinson symptoms and described her shaking as minimal. The nurse explained " She was able to pick her cup up and feed herself. " Nurse #1 explained the most recent observation of Resident #168 during meal times was last Friday for some of the meal. During the interview, nurse #1 explained the resident did have some food spillage with mild tremors. The tremors did not occur all of the time. When asked what nursing could do for the tremors during mealtimes, she replied " a cup with lid (sippy cup) when she was unable to handle drinks without spilling.

Interview with the Rehab manager on 6/19/14 at 2:10 PM revealed Resident #168 had been referred to therapy in February and March of this year. OT began therapy in March, but she was not able to progress with therapy and was discharged. During the interview the Rehab manager explained Resident #168 was not evaluated and treated for eating or drinking problems due to Parkinson's tremors.

Interview with aide #1 on 6/19/14 at 2:00 PM indicated the resident's tremors had become worse over the last month. She explained the resident could feed herself and drink liquids independently and would refuse help with eating.

Interview with aide # 2 on 6/19/14 at 1:55 PM revealed the resident was able to feed herself and drink her fluids. Staff would provide set up for meals.

Interview with MDS nurse #1 on 6/19/14 at 2:29 PM revealed she did not know this resident and had not done any assessments for her. She

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F 311	Continued From page 10 would inform the physician of her tremors and review the chart for possible therapy referral.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff the facility failed to provide treatment as ordered for an advanced pressure sore located on the buttock for 1 of 2 sampled residents reviewed for pressure ulcers. (Resident #15) The findings included: Resident #15 was readmitted to the facility on 12/27/13 with cumulative diagnoses which included diabetes. Review of the Minimum Data Set dated 1/27/14 revealed the resident had some cognitive impairment and required extensive assistance from staff for completion of activities of daily living. Review of the care plan dated 11/18/14 and updated 1/14/14 revealed goals and approaches	F 314	Resident #15 was discharged to the hospital and did not return. Current Treatment Administration Records were audited to identify any treatments not completed or signed for. Licensed Nurses have received re-education regarding the importance of completing treatments as ordered and documenting those treatments on the Treatment Administration Record by the Director of Nursing. Any Nurse identified as having an omission on a treatment administration record was educated and counseled. Licensed Nurses will be required to use shift report to review treatment administration records to ensure all treatments have been completed and documented. Daily treatment	7/11/14

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F 314	Continued From page 11 to address the resident risk for pressure sore development. Review of the medical record revealed the resident developed on 1/9/14 at 2:36 PM a left buttocks abrasion which measured 1.4 centimeters (cm) by 0.8 cm by 0.1 cm. Review of the report of consultation form dated 1/14/14 from the wound center revealed pressure ulcer on the buttocks which was classified as unstagable (Full thickness skin or tissue loss with the depth unknown). The wound center had recommendations for Santyl and Hydrogel QOD (every other day) treatment to the buttocks. Review of the medical record revealed physician orders were obtained to follow the recommendations. Review of the Treatment Administration Record (TAR) revealed 1/14/14 date of a transcription to clean the buttock pressure sore with Normal Saline then apply Santyl and Hydrogel every other day. Reviewed of the TAR revealed the dressings were not documented as done on 1/16/14. Interview on 6/19/14 at 1:30 PM with the director of nurses (DON) and the wound care specialists (WCS) revealed the resident's treatment was scheduled for 3-11 treatments. The wound care specialist indicated he did not remember whether the treatment was done on 1/16/14 were done. The DON indicated that the WCS did not perform all the treatments and the charge nurses would often do the treatments. Further interview with the DON revealed on 1/16/14 the regular charge nurse was absent and Nurse # 10 worked from 7 AM -7 PM and Nurse #11 worked 7 PM -7 AM on	F 314	administration audits will be completed by the Director of Nursing and/or Administrative Nurses for the next 4 weeks. Any omission will be identified, corrected and education/counseling repeated with Nurse responsible. The Director of Nursing will randomly check 10 treatments a week to ensure treatments are completed as signed for. The results of random checks will be documented on a monitoring tool developed by the Director of Nursing. After 4 weeks, weekly treatment administration audits will be completed for the next 3 months. The director of Nursing will review the results of audits and compile a Monitoring Report. The Director of Nursing will present the Monitoring Report to the Monthly Quality Assurance Committee Meeting for the committee's review and revision if necessary to ensure compliance.	

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F 314	Continued From page 12 1/16/14 for coverage. Interview on 6/19/14 at 1:44 PM with Nurse #10 (who worked from 7 AM -7 PM) revealed she did not remember whether or not the dressing changes were performed. An attempt to interview Nurse #11 (who worked 7 PM -7 AM) was unsuccessful. Record review revealed on 1/17/14 the resident was seen by the vascular center and then hospitalized for a right amputation due to peripheral vascular disease. On 6/19/14 approximately 5:15 PM an interview with the DON, administrator and three corporate representatives was held. The DON indicated her expectations were to have treatments provided as ordered.	F 314		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident interview and staff interviews, the facility failed to provide palatable foods during the breakfast meal.. This was evident in 1 of 2 meals observed. Findings included:	F 364	Residents #4, 190, 313, 179, 170, 21, 306, 181, 233, 69, 58 and 167 were interviewed by the Dietician and/or Certified Dietary Manager to identify their food preparation likes and dislikes and any food concerns. Any updates were	7/11/14

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F 364	Continued From page 13 Observation of the kitchen on 6/18/14 at 7:00 AM revealed the dietary staff (dietary aide #2, #3, and #4) were plating the breakfast meal for Resident # 4. On 6/18/14 at 7:05 AM the Day Cook calibrated two thermometers and obtained the following food temperatures from the steam table: Pureed eggs 150 degrees Grits 160 degrees Oatmeal 162 degree Scrambled eggs 140 degrees. The eggs were then placed in the oven to be reheated. Continued observation on 6/18/14 revealed there were twenty six stacked, pre-plated, covered bowls of grits on a tray on top of the toaster. There was dried food debris which resembled the grits on the outer portion of the bowls. . At 7:30 AM the surveyor inquired about the stacked grits. The Dietitian obtained the temperature of the grits at 110 degrees. Observation revealed the grits had gelled and were clumped in portions within the bowl. The trays of four sampled residents (Residents # 4, # 190, #313, and #179) were observed with these pre poured bowls of grits placed on the their food trays and delivered to the unit at 7:35 AM. Interview during the observation with Day Cook revealed she was going to cook more grits and removed 6 of the stacked bowls of grits from the steam table and threw them in the sink. However, at 7:45 AM the dietary aide #2 continued to place the remaining pre poured bowls of grits soiled with food debris on the food trays of four additional residents (Residents # 170, #306, #181, and # 233) and delivered to the unit at 7:45 AM by the Dietitian. An inquiry was made about the food debris on the outsides of the	F 364	recorded on each resident's tray card. Current residents were interviewed by the Certified dietary Manager and/or Dietician to identify their food preparation likes and dislikes and any food concerns. All updates were recorded on each resident's tray card. Dietary Aides, Cooks, Certified Dietary Manager and Dietician were re-educated by the Administrator regarding the requirement that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance, and food that is palatable, attractive and at the proper temperature. The Certified Dietary Manager, Dietician and Dietary Aides #2,3 and 4 were also counseled regarding the content of F354. A Dining Committee Meeting was held on June 20th to review the process of passing trays in timely manner and dining room assignments. The Dining committee members include Nursing Assistants, Licensed Nurses, Activities, Social Work, Dietician, Certified Dietary Manager and the Administrator. Nursing Assistants and Licensed Nurses were re-trained regarding the passing of trays and specific assignments for all meals to ensure meals are provided to residents in timely manner by the Director of Nursing. A meal observation and resident interview audit tool was developed by the Administrator to check the accuracy of trays for likes/dislikes and note any other dietary concerns. The audit tool will be completed by a Dining committee	

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F 364	Continued From page 14 pre poured grits. The Dietitian took a brownish colored cloth and wiped the outside of the bowl that was placed on the tray of another resident (Resident. #21). When asked where the Dietitian obtained the cloth used to remove the food debris, the response was pointing to the crate under the sink. The Dietitian indicated, " That is where the clean cloths are stored. " At 7:50 AM dietary aide #2 continued to use the pre poured bowls on the food trays of three residents (Residents. #69, #58, and #167). Interview on 6/18/14 at 11:50 AM with dietary aide 3 revealed he pre poured the grits into the bowls between 6:50 AM and 6:55 AM because, " The tray line starts at 7:00 AM for breakfast. This is how I usually prepare the bowls with grits. " Interview on 6/18/14 at 2:30 PM with dietary aide #2 indicated he did not wipe the food debris from the bowls containing grits was because he thought someone else would and then responded by stating he did not have a cloth to wipe the food debris. A test tray on the 400 and 500 resident units were conducted on 6/18/14. The food cart left the kitchen at 8:10 AM and was delivered to units 400 and 500 by the Dietitian. The food cart arrived at 8:12 AM and the Dietitian announced the food carts were on the unit. The first tray was served at 8:13 AM by Nursing Assistant (NA # 1) to Resident# 11. The Director of Nurses (DON) and the Director of Clinical Services joined in serving the food trays. Interview on 6/18/14 at 8:20 AM with Resident # 167 after being served the breakfast meal by the Director of Clinical Services, revealed complaints	F 364	member and/or the Manager on Duty interviewing 10 residents per day for the next 4 weeks. The audits will be reviewed daily by the Certified Dietary Manager and/or Dietician who will update tray cards as needed and address any other dietary concerns noted. The Administrator will monitor outcomes of the audits weekly to ensure concerns are addressed. After 4 weeks the audit tool will continue to be completed on 20 residents per week for 3 months. The Administrator will develop a report of monitoring outcomes to present to the Monthly Quality Assurance Meeting for the committee's review and revision if necessary to ensure compliance.	

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F 364	Continued From page 15 that, " This food was terrible. Look at this bowl of grits." The resident picked up pieces of grits with a spoon several times. The grits were observed not moist, but gelled and clumped together. This resident was served one of the twenty six bowls of grits that had been pre poured. The last tray was served on 6/18/14 by NA # 3 at 8:27 AM. A test tray observation was conducted at 8:28 AM in the presence of the Dietitian and the DON. The Dietitian calibrated the thermometer and measured the temperature of the food items. The grits served in a bowl was 106 degrees. The grits were thick in consistency and partially gelled together. The oatmeal in a bowl was 108 degrees and had a dried film on the surface and tasted cool. The oatmeal on the plate under the dome top was 112 degrees. The scrambled eggs were 92 degrees and tasted cool. On 6/19/14 at approximately 5:15 PM interview with the Director of Nurses, the Administrator, the MDS Consultant and the Corporate Consultant was held. The Administrator indicated her expectation was to have food served at the correct temperature and the correct consistency.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		7/11/14

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to failed to air dry kitchenware before stacking , failed to remove cracked kitchenware from stock that are used at meals, failed to have kitchen equipment clean and failed to label and date opened food items in storage. Findings included: The facility has a policy and procedure titled " Cold Food Storage: dated 9/2008 that read in part: Policy: To store foods in a manner that will preserve food quality, prevent food borne illness and avoid cross contamination. Procedure: Step 12. " Label and date refrigerated foods. " Step14. " Keep refrigerator units clean, free of spills and leaks. " The facility has a policy and procedure titled " Frozen Food Storage: dated 9/2008 that read in part: Policy: To store foods in a manner that will preserve food quality, prevent food borne illness and avoid cross contamination. Procedure: Step 6. " Seal, label and date frozen foods. " The facility has a policy and procedure titled " Dry Food Storage: dated 9/2008 that read in part: Policy: To store foods in a manner that will preserve food quality, prevent food borne illness and avoid cross contamination. Procedure: Step #8. " Seal, label and date each package, box, can, etc with the date of receipt or when the	F 371	All unlabeled food items were discarded. The kitchen ware was re-washed and cracked kitchen ware discarded. The kitchen equipment was cleaned. No resident was named in this alleged practice. A walk through was completed by the Administrator to ensure all items not labeled were removed, kitchen equipment and kitchen ware was inspected to ensure cleanliness and that all cracked items were removed. Dietary Aides, Cooks, Certified Dietary Manager and Dietician were re-educated by the Administrator on June 17, 20, 23, 24 and 26. Training included the facility's responsibility to procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary condition. Monitoring tools were created by the Certified Dietary Manager to record cleaning of equipment, removal of damaged kitchen ware and compliance with labeling of food. Dietary Aides and Cooks will clean equipment following the daily schedule and sign for completion on the monitoring tool. Dietary Aides and Cooks will remove any damaged kitchen ware daily, as found and discard. The Dietary Cook is responsible to inspect all	

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F 371	Continued From page 17 item was stored after opening Observations with the Food Service Manager and the Dietitian on 6/16/14 at 9:10 AM of the main kitchen revealed: Walk-In Refrigerator Chicken salad not in an original container was marked as 6/11/14 or 6/12/14 (the writing was unreadable). Sausage links were opened exposed to the air and undated. An 8 pound container of macaroni salad was observed with the top was cut off and covered with a plastic film. The date of the salad was 6/5/14. There was a partially sealed container of beef stock that had been opened, but no date to indicate when it was opened. There were 7 five pound blocks of cheese that were positioned on a shelf directly under the fan without air space. A 5 pound bag of shredded mozzarella cheese was opened and there was no date when this product was opened. Walk-In Freezer: There was a one half bag of French bread sticks opened undated and had a red colored sticky spillage on the outside of the container. A 5 pound bag, one half full of Steak fries, was partially opened and not dated. Ice was noted on the fries. Sliced carrots were opened and not dated when opened. Green beans were open and undated. Second observations of the main kitchen on 6/18/14 at 12:10 PM revealed 82 stacked plate bases were noted to be stored wet. Twenty of these wet bases had food debris caked on them.	F 371	cleaning assignments and kitchen equipment by the end of each shift and sign monitoring tool. The Certified Dietary Manager will inspect all equipment and kitchen ware daily for cleanliness and completion of cleaning assignments and document inspection on monitoring tool. The Administrator will complete random inspections 3 times a week for 4 weeks, inspecting cleanliness of kitchen, equipment and kitchen ware. After 4 weeks, random inspections will continue weekly for 3 months by the Administrator. Dietary aides and Cooks are responsible to properly seal and label all food items stored in coolers, freezers and dry storage. The Dietary Cook is responsible to inspect all coolers, freezers and dry food storage areas daily at the end of their shift. Cooks will document inspection on a monitoring tool to record any issues found, corrections made and ensure compliance with proper labeling of food items daily. The Certified Dietary Manager will inspect 4 times per week for 3 months all cooler, freezers and dry storage areas, and record inspection on the monitoring tool to ensure compliance. The Administrator will complete random audits of food storage areas 3 times a week for 4 weeks and review the monitoring tool at that time to ensure compliance. After 4 weeks, random inspections will continue weekly for 3 months by the Administrator. The Administrator will compile a report of monitoring tool outcomes to present at the Monthly Quality Assurance Meeting for the	

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F 371	Continued From page 18 Three of the three sectional plates had caked on food debris and one of the three sectional plates was cracked. The clean cloths in a crate remained sitting on the floor. The upper and lower ovens had an accumulation of black caked on debris. The dishwasher had an accumulation of brown matter on the handles and in the crevices of the machine. The toaster had a build-up of debris on the sides and top. Observations on 6/18/14 at 12:15 PM in the kosher refrigerator revealed a cucumber that was soft when touched and had black spots. There was a container of cold slaw dressing that was marked opened 4/2/14. Observations on 6/18/14 at 12:20 PM in the Kosher kitchen revealed multiple dried spills of varying colors on the floor of the freezer. The following items were observed undated in the freezer: There were 4 ½ frozen ears of corn opened, unlabeled, and without a date. There was a 1 quart container of broccoli florets that was opened and not dated. There was a 1 quart container of green peppers not in the original container and not labeled when opened. There was a 2 quart container of baby carrots opened and undated. There was a ½ gallon container of frozen lima beans opened and undated. Bread crumbs not in the original container was dated 4/4/14. The Dietary Aide # 6 did not know how long she could keep the product. Continued observation revealed the microwave glass plate was chipped and had food debris on the plate. Inside the hand sink was a sticky build	F 371	committee's review and revision if necessary to ensure compliance.	

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F 371	Continued From page 19	F 371		

up of a dark brown substance. The knife rack had an accumulation of dust and was sticky upon touch.

There was a 2 cup package of uncooked Zita pasta that was opened and undated.

There was a container of Kitchen Bouquet that had dried sticky spills on the bottle. According to the Dietary Aide #6, the expiration date was 7/12/2012.

Record review of the assignment sheet noted as " Sunday Cleaning list " dated 6/8/14 indicated the cleaning assignment revealed the toaster and the pot sink area (where the inside of the sink was noted to have a sticky build-up of a black substance) was initialed as being cleaned by Dietary Aide #5 (who was not available to be interviewed). There was not a Saturday and Sunday sheet for the weekend of 6/14/14 and 6/15/14 to indicate if the toaster or pot sink area had been cleaned.

Interview at 2:45 PM on 6/18/14 with the Dietitian and the Certified Dietary Manager (CDM) was held. The Dietitian indicated that the Saturday and Sunday cleaning was not initialed for all the cleaning for the weekend of 6/14/14 and 6/15/14 so she threw the form in the trash. The Dietitian also indicated that she could not remember who she had assigned to the cleaning task. The Dietitian indicated that the top oven was to be cleaned by the AM Cook and the bottom stove was to be cleaned by the PM Cook. The AM Cook indicated that the top oven was cleaned last week by one of the dietary aides. Dietary Aide #3 joined the conversation and indicated he was assigned to clean the ovens last week only on the front and

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F 371	Continued From page 20 sides. Further interview revealed Dietary Aide #3 indicated he was not requested to clean the inside of the ovens so he did not do so. Continued observations with the Regional Dietitian revealed the inside of the stoves continued to have a built up of black substance and burned substances inside the stoves. There was a build-up of dried spillage inside the door frames observed. Interview with the DON and the Administrator, the MDS Coordinator and the Corporate Consultant was conducted on 6/19/14 at approximately 5:15 PM. The Administrator indicated her expectations were to have a clean kitchen and staff to follow-up and ask questions. The Corporate Consultant indicated her expectation was to have a clean kitchen. The Corporate Consultant also indicated the facility started addressing problems in the kitchen on April 1, 2014.	F 371		