

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

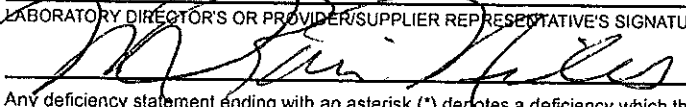
APR 09 2013  
ACCEPTED  
PRINTED: 03/15/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/01/2013
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NAME OF PROVIDER OR SUPPLIER  BLUMENTHAL JEWISH NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455
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(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
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F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations staff and family interviews and medical record reviews the facility failed to provide mouth care for dependent residents. This was evident for 2 of 2 residents observed for mouth care. (Resident # 140 and # 61). Findings include: 1. Resident # 140 was admitted to the facility on 11/09/11 with cumulative diagnoses of pharyngeal dysphasia, general muscle weakness and dementia. According to the minimum data set dated 02/14/13 Resident # 140 had impaired cognitive skills for daily decision making. She required extensive assistance of one staff person for personal hygiene. The Care Plan updated 02/06/13 indicated "I require staff assistance for all ADLs (activities of daily living) related to impaired cognition secondary to dementia." The interventions included "one person to assist me with bathing, encourage participation in ADL as much as possible and praise efforts. Provide assist (assistance) with ADLs, ensure resident ' s teeth is brushed AM and PM daily." A telephone interview with a family member on 02/25/13 at 11:08 AM revealed his concern that the resident's teeth were not being cleaned after</p>	F 312	<p>Submission of the response to the Statement of Deficiencies by the undersigned does not constitute as admission that deficiencies existed, were correctly cited, and/or require correction.</p> <p>Resident #140 &amp; #61 received mouth Care timely. Care Plan revised for resident #140 and #61 for mouth care to be done after each meal, hour of sleep and as needed.</p> <p>Administrative Nurses and/or designee completed an audit to identify dependent/hospice residents whom require mouth care. Which include oral care after meals, at hour of sleep and as needed. Care Plans have been reviewed to ensure they reflect oral hygiene needs.</p> <p>The Staff Development Nurse and/or designee has completed re-education to nursing staff on providing oral hygiene after meals, at HS and as needed for dependent/hospice residents. All new hires will receive education at orientation on mouth care for dependent/hospice residents.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3/25/13
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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 312	Continued From page 1 she ate. He indicated he has visited her several times and he has had to ask the staff to clean her teeth. Once he asked them, they (nursing assistants (NA) cleaned her teeth. He stated "I should not have to ask them to clean her teeth. It bothers me when I come to visit her and she has food in her teeth." Resident # 140 was very particular about having clean teeth when she was able to care for herself." An observation was conducted on 02/26/13 at 11:12 AM of Resident # 140 sitting in the dayroom. The resident smiled and her teeth were noted to have small pieces of matter that resembled toast and meat. An accumulation of white matter was noted on the top of her teeth next to her gum line. This was noted on several of her upper and lower teeth. She also had black particles noted in between her teeth on the bottom and top of her teeth. This resembled chewed meat products. A review of the resident's diet revealed the resident received sausage gravy, toast and margarine on her breakfast meal tray on 02/26/13. An observation was conducted on 02/26/13 at 2:40 PM of Resident # 140 sitting in her room. The resident was noted to have white and brown chewed particles in her mouth; resembling chewed meat and bread. An accumulation of white matter was noted on the top of her upper and lower teeth next to her gum line. A review of her lunch meal menu revealed the resident received meatloaf and a dinner roll with margarine for lunch. An observation was conducted on 02/28/13 at 10:00 AM of Resident # 140 sitting in the day room. The resident smiled and her teeth were noted with an accumulation of white matter on the	F 312	F 312 Hospice service care will be in addition to the care delivered by the facility. Hospice services are invited to all care plans on hospice residents. Any changes in the plan of care, the Care Plan will be updated at that time and staff educated on expectation of care. Hospice care plan will reflect care provided by hospice service for ADL's. Facility staff will provide oral care for dependent/hospice residents after each meal, hour of sleep and as needed. Care Plans have been updated to reflect oral hygiene for hospice/dependent residents. Current nursing staff has been educated on providing care which included oral care for hospice residents. All new hires will be educated on mouth care at orientation on hospice/dependent residents.  The Director of Nursing and/or designee will monitor mouth care to ensure no visible matter or food particles on teeth or gum lines. The auditing tool used is "System Check for Denture /Oral Care ". A minimum of 2 meals or at hour of sleep will be monitored for 6 dependent residents, five times a week, for four weeks. Then a minimum of 2 meals or at an hour of sleep will be monitored for 6 dependent residents, three times a week, for four weeks. Then, a minimum of 2 meals or at an hour of sleep will be monitored for 6 dependent residents, weekly, for four weeks. Then, a minimum of 2 meals or at an hour of sleep will be monitored for 6 dependent residents, monthly for four months.	A113

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F 312	<p>Continued From page 2</p> <p>top of her upper and lower teeth next to her gum line. The resident was also noted with chewed brown and white matter in between her teeth. Chewed brown and white matter resembled food particles.</p> <p>A review of Resident # 140's breakfast menu revealed she was served sausage gravy and toast and butter for breakfast.</p> <p>A review of the speech therapy 2012 notes revealed the resident had swallowing difficulty due to impaired cognition. Findings of the swallow study revealed moderate oral residue noted after resident swallows and maximum cues required while eating for the resident to swallow her food. The recommendation of the speech therapist was a mechanical soft diet with thin liquids with maximum cueing for swallowing.</p> <p>An interview with (nursing assistant) NA # 1 at 10:17 AM on 02/28/13 revealed Resident #140 was gotten up and ADLs were provided by the night staff. The NA indicated she brought her to the dining room for breakfast and brought her back to her room after she finished her meals. The staff assisted the resident to brush her teeth when they did her morning care.</p> <p>An interview with the Administrator, Administrator in Training (AIT) and director of nursing (DON) on 02/28/13 at 4:15 PM revealed the DON's expectation was that the NAs were to provide mouth care to all dependent residents after each meal.</p> <p>An interview on 03/01/13 at 8:55 AM with the AIT revealed the AIT spoke with NA # 1 and she had done the resident's mouth care after breakfast but the nurse had given the resident her medications with applesauce and that was on her teeth and in her mouth.</p>	F 312	<p>Any nursing staff in violation of this regulation will be retrained immediately, with further disciplinary action for repeated occurrences.</p> <p>The DON will complete a summary of monitoring efforts and present at the next scheduled Quality Assurance Meeting. The Committee will review the information and revise the action plan as necessary to ensure continued compliance.</p>	

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F 312	<p>Continued From page 3</p> <p>2. Resident # 61 was admitted to the facility on 12/09/10 with cumulative diagnoses of Alzheimer's disease, generalized anxiety and depression psychosis. Resident # 61 was admitted to Hospice Care on 04/12/12. According to the minimum data set (MDS) dated 10/25/12 the resident had impaired cognition. She was dependent on the staff and required extensive assistance of two staff members for activities of daily living (ADLs).</p> <p>A review of the care plan updated on 02/04/13 for self care deficit revealed the resident required assistance with ADL related to weakness/impaired cognition secondary to dementia with interventions to provide assistance with ADLs.</p> <p>An observation was conducted on 02/26/13 at 10:00 AM of Resident # 61 laying in bed after AM care had just been completed. The resident had black particles in between her top teeth, and an accumulation of white matter on the gum line of her top and bottom teeth.</p> <p>An observation was conducted on 02/26/13 at 3:08 PM of Resident # 61 lying in bed, with yellowish, white matter noted to teeth. Particles of white food matter were noted on the gum line and in between the resident's upper and lower teeth.</p> <p>An interview with NA #2 on 02/28/13 at 10:05 AM revealed the resident had dentures; they were to be cleaned on second shift. They (staff) were to remove them every night and soak them and day staff placed them in her mouth in the morning. Her mouth was to be swabbed out after each</p>	F 312		

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F 312	Continued From page 4 meal. The NA stated that was not done this morning because Hospice was caring for her this morning. NA #2 stated, after looking in the resident's mouth, "she does have food particles on her teeth, I will clean them now."  An interview with the Administrator, Administrator in Training (AIT) and director of nursing (DON) on 02/28/13 at 4:15 PM revealed the DON's expectation were that the NAs were to provide mouth care to all dependent residents after each meal.	F 312			
F 371 SS=D	483.35(j) 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 1 of 2 Kitchen/Food Service observations and staff interviews, the facility failed to store dry goods in a sanitary manner by not dating foods in the dry storage area with an opened or expiration date, not labeling opened dry goods with a product label, and not discarding one canned food item. Findings include:  Observations of the Kitchen/Food Service Department were conducted on 02/25/13 at 6:50	F 371	No resident was named in this alleged deficit practice.		

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F 371	<p>Continued From page 5</p> <p>PM in the Main Kitchen. In the dry storage area the following food items were observed without being labeled and without a date to indicate when the food item had been opened: 1) Two sixteen ounce boxes of cornstarch 2) Two sixteen ounce bags of potato chips, observed half full 3) Two bags of cake mix 4) One bag of cornbread mix 5) One bag of cream soup 6) Two opened bags of jello and 7) One five pound bag of elbow macaroni. All items were observed previously opened and wrapped in plastic wrap, and did not have opened or expiration dates, nor a product label. Also observed in the dry storage room on the canned goods rack, was one institutional size can of northern beans which was dented on one side at the bottom of the can.</p> <p>Review of the facility Dry Food Storage Policy dated September 2008 read: Policy: To store foods in a manner that will preserve food quality, prevent food borne illness and avoid cross-contamination. Procedure: 1. Train employees regarding proper food storage procedures. 7. Designate and label and area for cans with dents or compromised seals to prevent service prior to return or disposal 8. Seal, label and date each package, box, can, etc. with the date of receipt or when the item was stored after opening.</p> <p>A staff interview was conducted on 2/28/13 at 9:30 AM with the Registered Dietitian (RD). When asked what the normal procedure for storing the dry goods was, the RD indicated, "The routine would be to put the date the item was opened."</p> <p>A Follow-Up observation was conducted in the Kitchen dry storage area on 2/28/13 at 9:45 AM.</p>	F 371	<p>The dry goods were immediately disposed of by the Registered Dietician.</p> <p>The dented can was removed from the can rack by the dietary staff and was placed in the designated area for dented cans for return to the distributor.</p> <p>Registered Dietician and Food Service Director provided re-education to the dietary staff on proper labeling &amp; dating of opened dry goods. Printed labels were also initiated, and cooks and preparation aides were in-serviced on proper usage.</p> <p>Food Service Director provided re-education to the dietary staff on checking the can storage for any dented cans. Cans are to be inspected upon delivery for the removal of any dented cans and return to distributor. Dietary staff will also inspect the can storage area for any dented cans during routine work assignments.</p>	3/21/13	

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F 371	Continued From page 6 All dry goods had been labeled and dated an opened date and an expiration date. No dented cans were observed on the canned goods rack.  A staff interview was conducted on 2/28/13 at 10:00 AM with the Dining Service Director.(FSD) When asked the reason why the dry goods were not labeled and dated, the FSD indicated, "They (referring to the Dietary staff) probably used it (referring to all of the items found undated and unlabeled) in a rush, and did not label and date the foods. The procedure is that they are supposed to label/write what the item is, the date it was opened, and the expiration date. If there is no expiration date on the item, then it is kept for three days as a safe rule. The labels are kept on the preparation table, and the prep (preparation) person and cooks are supposed to label and date the opened items. I do not know why they weren't labeled. Sometimes if the dinner service runs late, they might be rushed. They know better. We get our deliveries on Mondays and Thursdays. " When asked about the dented cans and the normal procedure for checking the cans, the FSD indicated, " Usually I take the responsibility of pulling all the cans so I can check them. If I can't get to it, they (Food Service staff) put the cans away for me, and I will check them the next day. This week, they put the cans away for me. This week we had several admissions and the staff put the cans away for me and missed the dented can. On Tuesday, I pulled every can on the cart, which is usually what I do so I can organize the cans for the cooks so they can have ready access, and so the cans are organized, and it helps me save money, if I know what I have. I'm in all of our inventory every day. "	F 371	Registered Dietician and Food Service Director will provide training to new dietary employees on proper labeling & dating of opened dry goods. They will also be trained on proper usage of printed food labels.  Registered Dietician and Food Service Director will provide training to new dietary employees on checking the can storage area for any dented cans and removal of dented cans. Cans are to be inspected upon delivery for the removal of any dented cans and returned to distributor. Dietary staff will also inspect the can storage area for any dented cans during routine work assignments.	3/29/13

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F 371	<p>Continued From page 7</p> <p>A staff interview with the Preparation Cook/Dietary Aide was conducted on 2/28/13 at 4:00 PM. When asked how to store leftover dry goods, the Cook/Dietary Aide indicated, "If it's a bag of cake mix, I am supposed to close it, and wrap it with plastic wrap, label it with the name of the product, and the date it was opened. If the name of the product is not visible, I write what it is on the label, and it should be dated with the date it was opened."</p> <p>A staff interview with the FSD was conducted 2/28/13 at 4:10 PM. The FSD indicated, "I did an In-Service on Tuesday 2/26/13 entitled Proper Labeling of Products That Are Opened, and also Leftover Prepared Products. All the Dietary Employees were in-serviced by 2/27/13.</p>	F 371	<p>Increased monitoring by Food Service Director and/or designee will prevent recurrence of this alleged deficit practice. Monitoring will be tracked by using the "Dry Food Storage and Dented Can Audit" tool. Food Service Director and/or designee will monitor for proper storage procedures &amp; removal of any dented cans daily for 30 days, then weekly for 60 days, with random monitoring to continue on a monthly basis to ensure continued compliance with this regulation. If at any time, this regulation is found to be not met, monitoring will resume at the beginning. Any dietary staff in violation of this regulation will be retrained immediately, with further disciplinary action for repeated occurrences. Unlabeled dry goods and dented cans will be addressed immediately by FSD and/or designee.</p> <p>The FSD will complete a summary of monitoring efforts to be presented at the next scheduled Quality Assurance Meeting. The committee will review the information and revise the action plan as necessary to ensure continued compliance.</p>		



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K 000	INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system.	K 000		
K 038 SS=D	The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	General Contractor contacted and bids obtained 3/21/13.  Maintenance Director completed facility audit to ensure that each manual door switch for mag lock system were operating properly . These audits will continue on a weekly basis until master system is repaired	
K 062 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 03/21/2013 the master door release switch located at the nurses station failed to release the magnetic door locks. B. Based on observation and staff interview on 03/21/2013 the staff did not know about the master door release switch located at the nurses station.. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	Proposal for repairs were obtained, approved and submitted to sprinkler company so work could begin on March 22, 2013.  Repairs to the existing control panel will be completed by approved contractor.	5/5/13

LABORATORY / DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE ADMINISTRATOR (X6) DATE 3/29/13

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K 062	Continued From page 1  This STANDARD is not met as evidenced by: A. Based on observation and documentation on 03/21/2013 the sprinkler water did not reach the test orifice within the sixty sec. (60) allowed. B. Based on observation on 03/21/2013 the valve on the sprinkler exhaustor was not electrically supervised. 42 CFR 483.70 (a).	K 062	Facility Maintenance Director will ensure master release system is operating properly with continue weekly preventive maintenance . Any issues will be reported to facility Administrator and contracting company immediately  K062  General Contracted contacted and bids obtained 3/21/13 and worked scheduled to begin 4/8/13 .  Repairs to existing sprinkler system will be completed by contractor.  General Contractor will monitor system for continued compliance per required life safety code.	5/5/13	