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 ______	C 05/05/2018

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

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F 000	INITIAL COMMENTS A revisit and a complaint investigation survey was conducted on 5/1/18-5/5/18. Tags E-0001, F550, F641, F656, F657 and F809 were in corrected as of 5/5/18. The facility continues to remain out of compliance at F658, F689, F806 and F812.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to administer medication for 1 of 2 residents (Resident #1) and failed to remove a 24-hour nicotine patch before applying a new one for 1 of 2 residents (Resident #8). Findings included: 1: Resident #1 was admitted to the facility on 2-16-17 with multiple diagnoses that included atrial fibrillation, hemiplegia affecting the left side, dysphagia, hypertension and diabetes. The resident's Minimum Data Set (MDS) dated 4-3-18 revealed that resident #1 was moderately cognitively impaired and that he had difficulty concentrating 2 to 6 days out of the week. The MDS also revealed that resident #1 needed extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene,	F 658	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. ROOT CAUSE The alleged noncompliance resulted from, Nurse # 3 failed to administer a clonidine transdermal patch on 5/1/2018 for resident #1 because the resident was not in the facility on 5/1/2018 at the time the	5/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/30/2018

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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extensive assistance with 2 people for transfers and limited assistance with one person for eating.

The care plan dated 4-3-18 revealed a goal that resident #1 will not have hypertension complications. The following were the interventions; observe vital signs, observe for complications, administer medication as ordered.

A review of the physician's orders dated 9-14-17 revealed that resident #1 was ordered a Clonidine patch 0.3 milligrams (mg) to be applied weekly (on Tuesdays) date and document patch site.

An observation of resident #1's mediation patch (Clonidine) for his blood pressure occurred on 5-2-18 at 1:50pm revealed a date of 4-24-18. The patch was located on the resident's left upper chest.

A review of the Medication Administration Record (MAR) revealed that resident #1 was not given his Clonidine Patch as ordered on 5-1-18 with remarks that the resident was not in the facility.

The Medication Aide (#1) was interviewed on 5-2-18 at 1:52pm. She stated that she did not work yesterday but that the 7a to 3pm nurse should have told the 3pm to 11pm nurse that the patch had not been changed so that the nurse could get orders to change the patch.

An interview with the nurse practitioner occurred on 5-2-18 at 3:15pm and she stated that resident #1 could have received his patch at any time during the day yesterday if staff contacted her to discuss the situation. She also stated she did not receive a call from the nurse yesterday stating that the resident was out of the facility and did not

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medication was due.

Licensed staff and Medication Aides failed to remove a nicotine transdermal patch noted on 5/3/2018 on resident #8 that was dated 4/29/2018. This was resulted from the facility's lack of process that requires licensed nurses and/or medication aides to inspect resident's full body to locate and remove an old transdermal patch before applying the new one.

IMMEDIATE ACTION
On 05/02/2018 Resident #1 was assessed by the unit coordinator for any signs or symptoms of any adverse reactions from this alleged noncompliance. The attending physician was notified on 5/2/2018 that the clonidine transdermal patch was not administered on 5/1/2018 as indicated on the Medication Administration Record.

The attending physician ordered the clonidine transdermal patch dated 4/29/2018 to be removed and for a new patch to be administered. The clonidine patch was administered by day nurse on 05/02/2018.

Resident #1 and the responsible party were notified on 5/2/2018 regarding the patch not being changed on 5/1/2018 and that a new patch was applied on 5/2/2018. Nurse# 1 was re-educated on the facilities policy on medication management and transdermal patches, by the Director of Nursing Services. The education emphasized to notify the attending

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receive his patch. She went on to state that she was called today and an order was given for the nurse to change his Clonidine patch today.

The nurse (Nurse #2) was interviewed on 5-2-18 at 3:20pm. Nurse #2 stated she worked 3-11 shift last night (5-1-18) and that she was not informed by the dayshift nurse that resident #1 did not receive his Clonidine patch. She went on to state that the resident returned to the facility around 5pm and that she did note later that evening that his Clonidine patch was in place and the date but was unaware of when his patch was to be changed.

An observation of resident #1's Clonidine patch occurred on 5-2-18 at 4:00pm and was noted to be placed on his right upper chest with a date of 5-2-18.

An interview with the nurse (Nurse #3) occurred on 5-3-18 at 11:15am and she stated resident #1 did not receive his patch because he was not in the facility and that she did not report resident #1 not receiving his patch to the 3-11 nurse or the physician. Nurse #3 stated "I documented it on the MAR." She went on to state she did not know how or who would follow up with the resident to ensure he received his medication.

A review of resident #1's blood pressure was as follows; 4-30-18 = 150/82, 5-1-18 = 146/68, 5-2-18 = 142/76, 5-3-18 = 124/82.

The corporate nurse consultant and the Director of Nursing was interviewed on 5-3-18 at 7:30pm. Both the nurse consultant and the Director of Nurses stated that they expect physician's orders to be followed and if the resident was unavailable

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physician if a resident is not available at the time medications are due for further instructions.

On 5/3/2018 Resident# 8's attending physician was notified that the resident had a nicotine transdermal patch on, that was dated 4/29/2018. The nicotine transdermal patch was removed. All nursing staff providing medication management for resident #8 between 4/29/2018 to 5/3/2018 were re-educated regarding the facilities policy on medication administration and transdermal patches on 5/3/2018 by the Director of Nursing Services. The education emphasized to assess the resident body to ensure the previous patch has been removed prior to applying a new patch.

IDENTIFICATION OF OTHERS
Starting 05/24/2018 the Director of Nursing Services, Staff Development Coordinator and Unit Coordinators Audited 100% of all residents with transdermal patches to ensure the patches were administered according to the physician's orders and that the Medication Administration Records reflected the accurate administration of such medication.

On 5/24/2018, all current residents with transdermal patches were also audited by the Director of Nursing Services and Unit Coordinators to ensure the date on the patches reflected the date of administration in the MAR and ensure no

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that the physician be notified.

2: Resident #8 was admitted to the facility on 1-3-18 with multiple diagnoses that included chronic kidney disease, abnormality of gait, diabetes and congestive heart failure.

The resident's Minimum Data Set (MDS) dated 4-16-18 revealed resident #8 was moderately cognitively impaired and had an absence of hearing and spoken words. The MDS also coded that the resident needed extensive assistance with one person for bed mobility and personal hygiene, limited assistance with one person for dressing and toileting, supervision with one person for eating and independent with no assistance for transfers.

A review of the physician orders revealed that resident #8 was ordered a Transdermal Nicotine Patch 14mg every 24 hours. Apply one patch to the skin daily discontinue on 5-3-18.

The Medication Administration Record (MAR) was reviewed from 4-28-18 to 5-3-18 revealing that resident #8 had received a 14mg Transdermal Patch daily.

While observing Activities of Daily Living (ADL) care on 5-3-18 at 10:35am a Transdermal Nicotine Patch was noted in the center of resident #8's back with a date of 4-29-18. Another Transdermal Nicotine patch was noted on resident #8 on the upper left arm dated 5-3-18. The aide providing the ADL care removed the patch from the center of the resident's back and threw it in the trash.

An interview with the nursing assistant (NA#5)

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additional patches were present on resident’s body. No other residents were identified with an additional patch or outdated patch.

SYSTEMIC CHANGES

Effective 5/31/2018 any resident that is not available during the time that medications are ordered to be administered, the attending physician will be notified by the licensed nurse and additional instruction will be obtained. Licensed nurse will follow Physician orders effective 5/31/2018.
Effective 5/31/2018, Licensed nurses and Medication Aides will inspect resident’s body to locate and remove an old transdermal patch before applying the new patch.

Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will complete 100% re-education for all current facility Licensed nursing staff and Medication Aides, to include full time, part time and as needed nursing employees. This education will include the facilities policy on medication administration, transdermal patches and emphasized to notify the attending physician if a resident is not available at the time medications are due for further instructions and to assess the resident body to ensure the previous patch has been removed prior to applying a new patch. This re-education will be completed by 5/31/2018 and will be given annually afterward. Any licensed nurses, medication aides not educated by

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occurred on 5-3-18 at 11:50am who stated she did give resident #8 a bed bath on 4-30-18 but could not remember if he had any type of patches on or how many.

The nurse (Nurse #6) was interviewed on 5-3-18 at 1:15pm and she stated she remembered taking "a patch" off resident #8 Monday morning (4-30-18) before placing a new patch but stated she could not remember the date on the patch she removed. Nurse #6 also stated she did not know how resident #8 still had a patch on him dated 4-29-18.

An interview with the Pharmacist occurred on 5-3-18 at 1:20pm who stated if 2 nicotine patches were placed on a resident then the resident would receive double the dose of nicotine. He also stated that nicotine patches release the nicotine into the body over a maximum of 30 hours and if the resident was receiving a double dose of nicotine the resident could experience headaches, nausea, loss of appetite and increased heart rate.

A review of the nursing notes dated 4-29-18 to 5-3-18 did not reveal that resident #8 had any adverse reaction to receiving 2 nicotine patches.

The corporate nurse consultant and the Director of Nursing were interviewed on 5-3-18 at 7:30pm. Both stated that they expect staff to follow physician orders and check for placement of patches as well as the dates on the patch.

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5/31/2018 will not be allowed to work until educated.

MONITORING PROCESS
Effective 5/31/2018, The Director of Nursing Services, Staff Development Coordinator and or Unit Coordinator will monitor the compliance of the administration, removal and placement of all transdermal patches daily, Monday – Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. The audit will be reviewed and documented in clinical stand up meeting.

Effective 5/31/2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance.

REPONSIBLE PARTY
Effective 5/31/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.

Compliance Date 5/31/2018

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F 689	Continued From page 5	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation the facility failed to provide 1 of 1 residents (resident #1) supervision of 2 people while transferring the resident from his bed to his wheelchair. Findings included: Resident #1 was admitted to the facility on 2-16-17 with multiple diagnoses that included atrial fibrillation, hemiplegia affecting the left side, dysphagia and diabetes. The residents Minimum Data Set (MDS) dated 4-3-18 revealed that resident #1 was moderately cognitively impaired and that he had difficulty concentrating 2 to 6 days out of the week. The MDS also revealed that resident #1 needed extensive assistance with one person for bed mobility, dressing, toileting and personal hygiene, extensive assistance with 2 people for transfers and limited assistance with one person for eating. A review of the care guide card for the nursing assistance revealed that resident #1 was an extensive assistance with 2 people for transfers.	F 689	ROOT CAUSE The alleged noncompliance resulted from CNA # 5 failed on 5/3/2018 to provide resident #1 supervision of 2 people while transferring and used her own judgment instead of following the residents care plan and care guide. IMMEDIATE ACTION Resident # 1 was assessed by the unit coordinator on 5/3/2018 and identified no negative outcome. CNA # 5 was reeducated regarding the transfer status of resident # 1 and the use of the resident care guide to determine transfer status. IDENTIFICATION OF OTHERS 100% audit of all resident's transfer status was completed on 5/24/2018 through 5/28/2018 by the Director of Nursing, Staff Development Coordinator and Unit coordinators to determine if each resident's transfer status is reflected on resident's care plan and care guides.All resident's transfer status was reflected accurately on resident's care plan and	5/31/18

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A transfer of resident #1 from the bed to his wheelchair was observed on 5-3-18 at 11:55am. There was only one nursing assistant (NA #5) in the room and she had the resident sitting on the side of the bed. The resident was noted to have on one tennis shoe on his right foot and a protective plastic boot on his left foot. NA #5 was noted to transfer the resident on her own manually from his bed to his wheelchair.

An interview with the nursing assistant (NA #5) occurred on 5-3-18 at 11:57am at which time she stated she was aware that resident #1's care guide stated that 2 people should transfer the resident but that she used her own judgment. NA #5 stated if the resident could sit on the side of the bed then she felt comfortable transferring him by herself.

The interview with the corporate nurse consultant and the Director of Nursing occurred on 5-3-18 at 7:30pm. The Director of Nursing stated that her expectations would be that staff follow the residents care plan and care guide when providing care and during transfers.

F 689

care guide.

100% observation for all current residents who require assistance with transfers was completed by the Director of Nursing Services, Staff Development Coordinator and Unit Coordinators starting 05/24/2018 to 5/28/2018.all residents were transferred according to their care plan and Care guides.

SYSTEMIC CHANGES
Effective 5/31/2018, resident’s transfer status will be noted and located on electronic kiosks that reflect the level of assistance each resident requires. All nursing staff will have access to see each resident’s transfer status that will be reviewed quarterly or with any changes with transfer capability. The revision will be completed by the ‘Unit Coordinators and/or MDS nurses.

Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will complete 100% re-education for all current facility Licensed nursing staff, Medication Aides, and Certified Nurse Aides to include full time, part time and as needed nursing employees. This education will include utilizing the care plans and care guides to ensure proper transferring of residents. This re-education will be completed by 5/31/2018 and will be given annually afterward. Any licensed nurses, medication aides, or nursing assistant not educated by 5/31/2018 will not be allowed to work until educated.

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F 689	Continued From page 7	F 689	Effective 5/31/2018 all new employees will receive orientation regarding the utilization of care plans and care guides to determine a resident's transfer status. MONITORING PROCESS Effective 5/31/2018 The Director of Nursing, Staff Development Coordinator and Unit Coordinators will monitor compliance by a random observation of 10 resident transfers daily, Monday – Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. Effective 5/31/2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 5/31/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 806	Continued From page 8	F 806		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews the facility failed to honor the food preferences for 1 of 3 residents reviewed for food palatability (Resident #121). Findings Included: Resident #121 was admitted to the facility on 12/26/09 and diagnoses included diabetes and hypertension. A quarterly minimum data set (MDS) dated 3/1/18 for Resident #121 identified she received a therapeutic diet, was independent with eating and her cognition was intact. A review of the March 2018 physician orders for Resident #121 identified an order for a RCS (reduced concentrated sweet) diet. An observation of Resident #121 on 5/2/18 at 12:30 pm revealed she was eating her lunch meal. She had been served a bowl of mixed corn and lima beans which she had not eaten and had	F 806	ROOT CAUSE The alleged noncompliance resulted from the facility failure to honor the food preference of resident # 121. On 5/2/2018 resident # 121 was served by CNA # 3, a combination of corn and Lima beans (succotash) and "corn "was listed on the resident tray card as a dislike. CNA # 3 and dietary staff failed to identify that succotash contained corn and corn was served to resident #121 IMMEDIATE ACTION The facility staff member, (NA) # 3 removed the corn from the resident's lunch tray and informed the kitchen staff that this resident received corn. The kitchen offered an alternative to the corn. The Dietary Manager was reeducated regarding the proper procedure for monitoring tray cards both before and after plating of food to ensure food preferences are honored, by the facilities Administrator.	5/31/18

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set aside off of her meal tray.

An interview with Resident #121 on 5/2/18 at 12:31 pm revealed she couldn ' t eat corn because of her diverticulitis. She stated she continued to be served corn even though she had told the staff she couldn ' t eat it.

Review of the tray card that was present on Resident #121 ' s lunch meal tray revealed she was on a RCS and corn was identified as a dislike on the tray card.

An interview on 5/2/18 at 12:35 pm with Nursing Assistant (NA) #3 revealed she had served resident #121 her lunch meal. NA #3 stated she would check the residents name on the tray card to make sure she was delivering it to the right resident, but she didn ' t check that the diet or foods served were correct. NA #3 added she thought the dietary staff were supposed to make sure the resident was served the correct foods.

An interview on 5/2/18 at 1:00 pm with Dietary Manager #1 revealed Resident #121 should not have been served the mixed corn and lima beans because corn was identified as a dislike on her tray card.

An interview on 5/4/18 at 7:40 pm with a corporate representative revealed it was his expectation that resident ' s food preferences were honored.

F 806

IDENTIFICATION OF OTHERS
On 5/28/2015 the Dietary Manger audited 100% of all tray cards to ensure all residents food preferences were correct and that all other residents food preferences were honored. No other residents were identified as not having food preferences honored.

SYSTEMIC CHANGES
Effective 5/22/2018 – 5/31/2018 the Dietary Manager in-serviced 100% of all dietary staff on the Facilities process for managing the tray line, to include, checking the tray card both prior to and after plating of the food, to ensure all food preferences were honored.
Effective 5/31/2018 all new dietary employees will receive orientation regarding the tray line process and ensuring food preferences are honored.

MONITORING PROCESS
Effective 5/31/2018 Dietary Manager will monitor compliance by observing the tray line and plating of food during breakfast, lunch and dinner, Monday – Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting.

Effective 5/31/2018, Dietary Manager will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring

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 ______	C 05/05/2018

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

(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 806	Continued From page 10	F 806	or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 5/31/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 812	ROOT CAUSE	5/31/18

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

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F 812	Continued From page 11 facility failed to allow dishes to air dry before being stored. This was evident in 2 of 2 kitchen observations. Findings Included: An observation of the kitchen on 5/2/18 at 5:00 pm with Dietary Manager (DM) #1 revealed 9 of 10 insulated plastic plate bottoms were stacked together wet on a storage shelf and 10 of 12 plastic meal trays were stacked together wet on a cart ready for supper meal service. An interview with DM #1 on 5/2/18 at 5:10 pm revealed the staff should have allowed the plate bottoms and meal trays to air dry before they were stored. An observation of the kitchen on 5/3/18 at 7:10 am revealed 10 of 10 insulated plastic plate bottoms were stacked together wet on a storage shelf and were observed being used for service of the breakfast meal. Meal trays were observed to be stacked on a cart at the steam table. Dietary Aide #1 was observed to be wiping water off of the meal trays with a napkin as the meal trays were being prepared. An interview with Dietary Aide #1 on 5/3/18 at 7:20 am revealed the night shift had not allowed the meals trays to air dry before they stacked them together on the storage cart. He stated if the meal trays had a lot of water on them he wouldn ' t use them, but if they were just slightly wet he would dry them off. Dietary Aide #1 added dishes were supposed to be allowed to air dry before stacking them. On 5/3/18 at 7:25 am DM #2 was informed of the	F 812	The alleged noncompliance resulted from the facilities Dietary Managers failure to allow dishes to air dry before being stored on 5/2/2018 and 5/3/2018. The dietary staff did not allow enough time for the dishes to air dry and stored them wet. IMMEDIATE ACTION 0n 5/3/2018 the Dietary Manager removed all wet insulated plastic plates and plastic meal trays from storage and re-washed and air dried them per facility protocols. The Dietary Manager was reeducated regarding the proper drying and storage of meal deliver devices by the facilities Administrator. IDENTIFICATION OF OTHERS Effective 5/3/18 the Dietary Manager audited all food delivery devices to ensure that all devices were dried prior to storage. No other issues were identified. SYSTEMIC CHANGES Effective 5/31/2018 The Dietary Manager will in-service 100% of all dietary staff on the facilities process and procedures for air drying plastic plates and trays (food delivery devices) prior to storage. The Dietary Manager will assign this process to dietary staff person each day and maintain an audit tool. The assigned persons will be responsible to ensure the food delivery devices will have sufficient time to dry prior to storage and document on the audit tool. MONITORING PROCESS Effective 5/31/2018 the Dietary Manager	

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BLUMENTHAL NURSING & REHABILITATION CENTER	**3724 WIRELESS DRIVE** **GREENSBORO, NC 27455**

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F 812	Continued From page 12 wet plate bottoms and wet meal trays being used for the breakfast meal service. She stated the second shift must have stacked them together wet and they knew they were supposed to allow them to air dry. DM #2 stated it was a constant battle to allow these to air dry due to the lack of storage space. An interview on 5/3/18 at 8:40 am with DM #1 revealed he had reviewed the procedure for air drying with the second shift on 5/2/18 and he expected the staff to follow this procedure. An interview on 5/3/18 at 7:40 pm with the corporate representative revealed it was his expectation that all dishes be allowed to air dry before being stored.	F 812	will monitor compliance of the drying and storage of meal delivery devices daily, Monday – Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. Effective 5/31/2018, the Dietary Manager will report the findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 5/31/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	