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	345342	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG ELM RETIREMENT AND NURSING CENTERS	1285 WEST A STREET KANNAPOLIS, NC 28081

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E 000	Initial Comments An unannounced recertification and complaint investigation urvey was conducted on 7/8/24 through 7/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #23EY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/8/24 to 7/11/24. Event ID #23EY11. The following intakes were investigated NC00215159, NC00214592, NC00212522, NC00205431. 0 of the 21 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews, the facility failed to assess a resident's ability to self-administer medications for 1 of 1 resident reviewed for medication at the bedside (Resident #32). The findings included: Resident #32 was admitted to the facility 8/18/2021 with diagnoses including dementia and heart failure. The most recent quarterly Minimum Data Set assessment dated 4/26/2024 assessed Resident #32 to be cognitively intact without	F 554	1) Resident #32 has had her over-the-counter antacids removed from her bedside. Resident was assessed by an RN and it was determined that the resident was unable to manage their over-the-counter medications due to her diagnosis of dementia. In addition, Resident #32 has an order for scheduled antacids and an order of chewable antacids was added as needed (PRN). These medications are stored on the medication cart and administered by	8/4/24

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

Electronically Signed | 08/02/2024

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F 554	Continued From page 1 behaviors. Review of the medication orders for Resident #32 revealed no over-the-counter antacid had been ordered for her to take. There was no assessment completed related to self-administration of medications. Resident #32 was observed on 7/8/2024 at 11:08 AM and noted on her nightstand at the end of her bed (which was visible from the door into the room) were two bottles of over-the-counter antacid chews. The antacids were noted to be multiple colors, rounded tablets that from a distance resembled candy. One bottle appeared to be full and unopened, the second bottle appeared to have 10 or less antacid chews in the bottle. Resident #32 was interviewed at the time of the observation, and she reported her family purchased the antacids for her to keep in her room. Resident #32 explained she took the chews when she needed an antacid, and she thought the facility was aware of the antacids in her room. Resident #32's room was observed on 7/10/2024 at 10:24 am. The antacids were on the nightstand at the end of Resident #32's bed and visible from the doorway into the room. The Unit Manager (UM) was asked to come to Resident #32's room on 7/10/2024 at 10:25 AM. When the UM was shown the over-the-counter antacid chews, the UM stated, "This should not be in her room," and she removed the antacids. The UM reported if a resident wanted over-the-counter medications in their room, the	F 554	facility staff only. The Director of Nursing completed an in-service on for facility nurses (RNs/LPNs) and medication aides on the facility bedside medication policy and procedure to include proper assessment of resident's cognitive ability to properly store and administer their own medications at bedside. In addition, staff training included them to question if they see medications that are at the bedside and verify the proper storage and administration if identified as at times family or visitors may bring a bedside medication into the facility without getting approval of facility staff. 2) The facility completed a physical audit of each resident's bedside tables, bathrooms, and closet areas by the nurse supervisor on July 10, 2024 in order to identify if any other resident had medications stored improperly. No other improperly stored medications were identified during this review nor do any residents currently have orders for bedside medications. In addition, the administrator wrote a letter that was included in the August 2024 facility monthly billing statements regarding the survey that included a reminder for guest and families to please notify staff when bringing in bedside medications that are commonplace at people's homes. 3) There are no systemic changes	

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F 554	Continued From page 2 facility needed to do an assessment, get a physician order for the medications, and provide a lock box for the resident to store the over-the-counter medications in and Resident #32 had not had that process completed. The UM reported she was not aware Resident #32 had the over-the-counter antacids in her room. An interview was conducted with Nursing Assistant (NA) #1 on 7/11/2024 at 9:22 AM. NA #1 explained she provided care for Resident #32 frequently and she had not noticed the over-the-counter antacids on her nightstand. NA #1 explained she would remove any over-the-counter medications from resident rooms if she found any. Nurse #3 was interviewed on 7/11/2024 at 9:29 AM. Nurse #3 reported she gave Resident #32 her medications each morning, but she had never noticed the over-the-counter antacids in her room. Nurse #3 explained residents at the facility did not usually have medications at the bedside and she thought an assessment needed to be completed and a lock box provided. The UM was interviewed again on 7/11/2024 at 9:38 AM and she reported Resident #32 was unable to manage over-the-counter medications due to her diagnoses of dementia and forgetfulness. The UM explained Resident #32's family visited her, and they may have brought the over-the-counter antacids for her. The Nurse Practitioner (NP) was interviewed on 7/11/2024 at 10:09 AM and she explained that Resident #32 was unable to manage medications due to her diagnoses of dementia and forgetfulness. The NP reported Resident #32 was	F 554	necessary. In this instance the family provided the chewable antacids to resident without informing staff. Family education, staff education, and physical room inspections will correct the deficient practice. 4) The director of nursing, unit manager, and 7PM-7AM charge nurse will conduct physical audits weekly for four weeks, monthly for four months, and quarterly thereafter to ensure compliance. Results of these audits will be reviewed with the facility's overall QAPI program and corrective actions taken as identified. The Administrator is responsible for overall compliance.	

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F 554	Continued From page 3 not harmed by the over-the-counter antacids, but staff should manage all her medications. The Administrator was interviewed on 7/11/2024 at 1:15 PM. The Administrator reported that Resident #32's family visited her, and Resident #32 also went out with her family so she might have bought the over-the-counter antacids, or the family might have brought them in for her. The Administrator reported she did not know why the staff had not noticed the over-the-counter medications in Resident #32's room. The Administrator reported she expected staff to remove over-the-counter medications in resident rooms if the resident had not been assessed to self-administer the medication.	F 554		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send	F 576		8/4/24

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F 576	Continued From page 4 and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to provide mail delivery to the residents on Saturdays for 7 of 7 (Resident #5, #13, #15, #17, #32, #36, and #40) residents interviewed in resident council. Findings included: An interview with members of the resident council on 7/10/24 at 10:02 AM revealed that the facility did not deliver any mail on Saturdays. The members present for the meeting were Resident #5, Resident #13, Resident #15, Resident #17, Resident #32, Resident #36, and Resident #40. All residents that were present indicated they did not receive mail on Saturdays. The residents reported that mail was only delivered during the week.	F 576	1) The facility Business Office Manager, Receptionist, Social Worker and the Weekend Supervisor were reeducated on the facility policy that mail delivered needs to be distributed the same day to the resident. The facility social worker ensured that Residents # 5,#13, #15, #17, #32, #36, and #40 were informed how the facility plans to handle mail on the weekends by August 2, 2024. The facility will also review this requirement with residents during the next resident council meeting on 8/15/2024 to inform them to ask staff about mail if they do not receive Monday Saturday or if they are expecting a package to be delivered to ensure mail is	

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F 576	Continued From page 5 An interview was conducted on 7/10/24 at 10:31 AM with the Activity Director (AD). She revealed the mail was picked up by the Business Office Manager (BOM) from the mailbox and was given to the Social Worker (SW) to deliver daily during the week (Monday through Friday), but not on the weekend. She explained the BOM did not work on the weekend, so the mail was delivered the following Monday. She stated there was no system in place for mail delivery on the weekend and the residents received their weekend mail on Monday. An interview with the Administrative Assistant on 7/10/24 at 11:09 AM revealed she picked up the mail twice a day, not the BOM, from the mailbox and gave it to the SW to distribute during the week (Monday through Friday). The Administrative Assistant explained she put the mail that came in over the weekend in the Director of Nursing's (DON) office on Mondays and the SW would deliver it to the residents. An interview with SW on 7/10/24 at 11:58 AM revealed the Administrative Assistant sorted the mail and delivered the resident mail to her to give to the residents during the week. She explained there was no set time she would receive the resident mail, and the Administrative Assistant handed her a stack of mail daily (Monday through Friday) during the week, and weekend mail was delivered to residents on Monday. The SW stated she did not work on the weekends and was not sure if the mail was checked by anyone else on the weekends. During an interview on 7/11/24 at 1:02 PM, the Administrator revealed the weekend mail was	F 576	delivered timely. Mail times and deliveries can vary based on carriers, weather, and by residents purchasing items online such as Amazon deliveries. 2) The facility Business Office Manager, Receptionist, Social Worker and the Weekend Supervisor were reeducated on the facility policy that mail delivered needs to be distributed the same day to the residents. The facility will also review this requirement with residents during the next resident council meeting on 8/15/2024 to inform them to ask staff about mail if they do not receive Monday □ Saturday or if they are expecting a package to be delivered to ensure mail is delivered timely. Mail times and deliveries can vary based on carriers, weather, and by residents purchasing items online such as Amazon deliveries. 3) There are no systemic changes needed. The in-servicing and following up with residents should be sufficient to be compliant. 4) Compliance will be monitored by conducting audits of mail on Monday by the facility. Audits will be conducted by Administrative Assistant and Activities Director weekly for four weeks, monthly for three months, and quarterly thereafter. Monthly, the Activities Director will address the resident council to assure residents are receiving their mail on Saturdays. The results will be presented to the facility quality assurance	

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F 576	Continued From page 6 checked by the weekend Unit Manager and personal mail was delivered to the residents over the weekend. She had the expectation that mail would be delivered to residents on the weekend.	F 576	performance improvement (QAPI) program and corrective actions taken as necessary. Administrator is responsible for overall compliance.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/4/24

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F 584	Continued From page 7 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain lighting and walls in good repair for 2 of 2 areas (resident room 212 and nurse's desk) when reviewed for environment. The findings included: An observation on 7/8/24 at 12:05 PM in Room 212 revealed large black marks and scuffs on the green wall on the left side of Resident #42's bed and three black clusters of marks on the wall behind Resident #38's bed. An observation on 7/10/24 at 12:19 PM at the nurse's desk revealed an uncovered fluorescent light fixture which included two missing bulbs and one burnt out bulb. An interview with the Maintenance Director on 7/11/24 at 11:46 AM revealed there were maintenance request sheets on the door at the nurse's desk. Staff filled them out for any maintenance concerns reported to them by residents or visitors. When the task is completed, the request was signed off by a maintenance staff member. The Maintenance Director stated a paper documentation system worked well for the facility. A facility tour with the Maintenance Director and	F 584	1) Resident #38's wall was repaired and painted on July 11, 2024. Light fixtures above nurses station were replaced on July 12, 2024. 2) Administrator and Maintenance Technician rounded all rooms and made note of any repairs which need to be completed. The identified repairs were completed July 15, 2024. 3) Maintenance Director and Administrator will continue facility rounds to assure any maintenance concerns are addressed timely. These audits will be conducted by Administrator and Maintenance Director weekly for four weeks, and monthly thereafter and will continue as part of routine maintenance rounds. 4) The results of these audits will be reviewed with the facilities overall QAPI program and corrective actions taken as necessary to ensure compliance. Administrator is responsible for overall compliance.	

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F 584	Continued From page 8 Administrator occurred on 7/11/24 at 11:50 AM. It revealed they was not aware of the marks and scuffs on the walls in Room 212 or the uncovered light with burned out and missing bulbs above the nurse's desk. The Maintenance Director stated new round light fixtures were installed as the old ones burned out. This fixture had not been replaced yet. The Maintenance Director had the expectation that staff would have reported these concerns. An interview with the Administrator during the facility tour revealed she was not aware of the marks and marring on the walls in Room 212 or the uncovered light fixture with the burned out and missing bulbs above the nurse's desk. She stated that the marks were due to furniture and equipment against the walls. She stated Maintenance was in the process of updating resident rooms that were unoccupied and Room 212 had not been completed as it was occupied.	F 584		
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 observations, record review, and staff interviews, the facility failed to maintain a safe environment by storing a chemical disinfectant cleanser spray and a handheld hair dryer with the	F 689	1) On July 8, 2024 the shower room was closed and locked immediately to ensure the hairdryer and spray bottle were not accessible by residents.	8/4/24

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F 689	Continued From page 9 cord hanging over a mounted power strip for 1 of 1 shower rooms observed. The shower room door was propped open and unlocked when it should have been closed and locked. Findings included: An observation on 07/08/2024 at 12:36 PM of a propped open shower room door revealed an unplugged handheld hair blow dryer hanging over a mounted blue power strip to the left of the shower room sink. A spray bottle of cleanser labeled as deodorizing bathroom cleaner was observed on the top shelf of a metal shelf on the back wall of the shower room. The warning label on the front of the spray bottle read, "strong corrosive, sanitizer, irritant, combustible." The label on the back of the spray bottle included if the spray disinfectant came in contact with eyes to flush eyes immediately for 15 minutes. If the contents were swallowed, drink a glass of water to dilute and call the physician immediately. There was no staff observed in the shower room and no residents observed in the hallway outside of the shower room. On 07/08/2024 at 1:22 PM a phone interview was conducted with Nurse Assistant (NA#1). NA #1 reported she was the full-time shower staff and another Nurse Assistant (NA #2) filled in on her days off. NA #1 and she reported the shower room door was always locked unless a staff member was present. NA #1also reported that no disinfectant sprays were stored in the shower room and if needed, it was requested from the housekeeper and returned to the housekeeper after use. NA #1 added that the handheld hair dryer was to be stored in a locked storage drawer	F 689	On July 8, 2024 and July 9, 2024 all staff were educated by the Director of Nursing on proper storage of all chemicals and appliances and the requirement for the shower room door to remain locked. 2) The Housekeeping Supervisor and Administrator completed rounds throughout the facility to identify if there were any other chemicals or hazardous items in the facility. If identified those items were discarded. 3) There are no systemic changes necessary. The cleaning solution and hairdryer should be locked behind closed doors or locked in the storage bin or on housekeeper's cleaning carts. Staff in-servicing by Unit Manager and Director of Nursing will continue as part of on-boarding process for all newly hired staff as well as during annual staff training to achieve compliance. 4) Compliance with these requirements will be monitored through rounding and audits of shower room to be completed on every shift daily for two weeks, weekly for four weeks, monthly for three months and quarterly thereafter. These audits will be completed by Unit Manager, MDS Coordinator, Director of Nursing and Charge Nurse/Weekend Supervisor. The results of these audits will be reviewed with the facilities overall QAPI program and corrective actions taken as necessary to ensure compliance. Administrator is responsible for overall compliance.	

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F 689	Continued From page 10	F 689		

in the shower room.

An observation and interview with NA #2 on 07/08/2024 at 2:29 PM in the shower room revealed the shower room door was closed and locked. NA #2 obtained the key from the beauty salon. On observation the handheld blow dryer remained unplugged hanging over the mounted blue power strip and the disinfectant spray bottle remained on the top shelf of the metal rack at the back wall of the shower room. NA #2 reported the blow dryer was to be locked in a cabinet drawer also at the back wall. The 5 drawers of the cabinet revealed no lockable drawers. NA #2 revealed she did not know why the disinfectant spray bottle was left in the shower room because she either got the spray from the housekeeper or had the housekeeper come into the shower room to clean equipment.

Housekeeper #1 was interviewed at 2:46 PM on 07/08/2024. Housekeeper #1 revealed she had never observed the shower room door propped open; it was always locked. She used the disinfectant spray to clean all equipment 1 to 2 times a day and it was always locked in her housekeeping cart. Housekeeper #1 was unable to explain how the bottle was located in the shower room.

On 07/08/2024 in an interview with the Director of Nurses (DON) at 2:58 PM she revealed the shower room door was to be maintained locked at all times
and not propped open. The DON went on to explain that only housekeeping should have access to disinfectant spray to clean equipment which was to be stored and locked in the housekeeping cart. The DON also reported she

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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
F 689	Continued From page 11 was not aware of a handheld blow dryer not being stored in a locked storage drawer in the shower room, she was also not aware there was not a locked cabinet or drawer in the shower room. The DON revealed there were no wandering residents in the facility at the time. The expectation she explained, is the door to remain locked at all times, no disinfectant items were to be stored in the shower room and all other items were to be locked in a cabinet in the shower room. An observation of the shower room on 07/09/2024 at 8:34 AM revealed the shower room door was locked. On 07/10/24 at 9:13 AM revealed the shower room door was closed and locked. Unit Manager (UM) #1 was interviewed on 07/10/2024 at 2:42 PM. UM #1 revealed she had never observed the shower room propped open because it was always closed, locked and no spray chemicals were to be left in the shower room. UM #1 revealed she was not aware of a handheld blow dryer being used. On 07/11/2024 at 9:16 AM during an interview with the Administrator, she explained she expected the shower room door to be locked at all times, no chemicals were to be stored in the shower room and she expected resident care items in the shower room were to remain locked in a cabinet in the shower room when not in use.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		8/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345342	A. BUILDING _____ B. WING _____	C 07/11/2024

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F 812	Continued From page 12 §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 interviews, the facility failed to label a container of thickened juice with an open date, discard expired milk, clean grease off the burner valve knobs and burner grates of the stove. Additionally, 3 of 3 dietary workers failed to wear beard coverings. These practices had the potential to affect food served to residents. The findings included: 1. The facility kitchen was toured on 7/8/2024 with the Dietary Manager (DM) at 9:55 AM. a. The walk-in refrigerator was observed to have an open, undated carton of thickened juice. The DM reported the carton should have dated when it was opened. The DM explained thickened liquids were used for 24 hours after opening. The DM discarded the thickened juice.	F 812	1) The pre-thickened juice and milk identified were discarded immediately by the dietary manager on July 8, 2024. In addition, the dietary manager audited the remaining items in the refrigerator and no other outdated items were identified during the inspection process. The stovetop and the grease that was identified to include the burner knobs, grates and stove were deep cleaned on July 9, 2024. On July 11, 2024 the Administrator in-serviced all Dietary Staff on proper food storage, labeling, kitchen and stove cleaning schedule and beard/hair coverings requirements. The facility will utilize quality assurance efforts to monitor and achieve substantial compliance. 2) The facility administrator has	

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F 812	Continued From page 13 b. The reach-in cooler was observed with the DM at 10:05 AM on 7/8/2024. A half-gallon of milk was noted with an expiration date of 7/5/2024. The DM reported the milk should have been discarded on 7/5/2024 and he did not know why it was not thrown away. The DM discarded the expired milk. c. The stove was observed at 10:11 AM on 7/8/2024. The burner valve knobs were noted to be coated with a sticky substance that did not wipe off. The burner grates were noted to have a black, charred substance and burnt on food covering them, and the grates were shiny with a greasy appearance. The DM reported it had been about a month since the stove had been cleaned, but the kitchen staff wiped off the stove after using it. d. During the tour of the kitchen on 7/8/2024 from 9:55 AM until 10:22 AM, the DM did not wear a beard covering his facial hair. The facial hair on the DM's chin was greater than ½ inch in length. The DM was noted to go in and out of the walk-in refrigerator without a beard covering and was observed assisting the dietary staff with meal preparation for the noon meal that date. 2. An observation of the kitchen was conducted on 7/9/2024 at 11:35 AM. a. The burner grates were noted to have a black, charred substance and burnt on food covering them and the grates were shiny with a greasy appearance. The DM reported he was going to remove the burner grates and soak them to remove the charred substance.	F 812	reviewed the cleaning schedule and has hired a new dietary manager who has been trained on cleaning schedule to include the stovetop, monitoring and removing any outdated items daily, and to ensure her staff with beards are wearing beard covers and appropriate hair nets while in the kitchen. On July 11, 2024 the Administrator in-serviced all Dietary Staff on proper food storage, labeling, kitchen and stove cleaning schedule and beard/hair coverings requirements. The facility will utilize quality assurance efforts to monitor and achieve substantial compliance. 3) In review of the system the weekend staff did not adequately clean the stove or discard the expired milk from the weekend. The administrator and dietary supervisor has assigned the weekend cook to be responsible for daily checks on the weekend. The dietary manager and/or her designee will be responsible for monitoring compliance with cleaning the oven and expired food items during the week. 4) The facility's Dietician and Administrator will conduct weekly audits for three months and monthly thereafter for a period of one year to review the walk-in cooler to ensure proper storage and labeling of all food. The dietician will also conduct monthly sanitation audits and report findings to Administrator for follow-up when necessary.	

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F 812	Continued From page 14 b. The DM was observed with his facial hair uncovered during the observation on 7/9/2024. The DM had facial hair on his chin that measured more than ½ of an inch. The DM was noted to assist the dietary staff with food preparation and was observed entering the walk-in fridge. Dietary Aide #1 was observed preparing the noon meal and checking food temperatures. Dietary Aide #1 was observed to have facial hair on his chin measuring more than ½ inch. Dietary Aide #2 was setting up meal trays and preparing food for the meal. Dietary Aide #2 was observed to have facial hair on his chin measuring more than ½ inch. Both Dietary Aide #1 and #2 were observed without beard coverings. An interview was conducted with Dietary Aide #1 at 11:40 AM on 7/9/2024 and he reported he was aware he needed to wear a beard covering. The DM was interviewed on 7/9/2024 at 11:41 AM and he explained they had run out of beard coverings, and he had reordered stock of beard coverings, but they had not been delivered. The DM reported he and Dietary Aides #1 and #2 would wear a hair net to cover their beards. The DM was interviewed on 7/11/2024 at 12:58 PM. The DM explained all perishable items should have an open date marked on the container, and expired foods should be thrown away on the expiration date. The DM reported he thought the kitchen staff were cleaning the stove burner grates daily, but the staff were not cleaning it, which caused food and grease from cooking to become burnt and charred. The DM reported he and the Dietary Aides had forgotten to wear the beard covering because they were out of stock, but they would use the hair nets until	F 812	The Administrator will conduct beard-covering audits weekly for 4 weeks, monthly for three months and quarterly for one year to assure requirements are being met. The results of these audits will be reviewed with the facilities overall QAPI program and corrective actions taken as necessary to ensure compliance. Administrator will be responsible for complete compliance.	

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F 812	Continued From page 15 their order was delivered. The Administrator was interviewed on 7/11/2024 at 1:15 PM and she reported the kitchen staff had a high turnover rate and she thought that training was an issue regarding the undated thickened juice, the expired milk, the burnt and charred stove burner grates, and wearing beard coverings.	F 812		