STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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
E 000	Initial Comments The survey team entered the facility on 08/05/24 to conduct a recertification and complaint investigation survey and was unable to return to the facility on 08/08/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained remotely through 08/12/24. Therefore, the exit date was 08/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9OQP11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 08/05/24 to conduct a recertification and complaint investigation survey and was unable to return to the facility on 08/08/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained remotely through 08/12/24. Therefore, the exit date was 08/12/24. Event ID #9OQP11. The following intakes were investigated: NC00207415, NC00207993, NC00211783, NC00213178, NC00213390, NC00214227, NC00214325, NC00214515, NC00217524, NC00218244, NC00220030, and NC00220380. 3 of the 21 complaint allegations resulted in deficiency.	F 000		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		8/23/24

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

Electronically Signed | 08/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 760	Continued From page 1 Based on observations, record review, resident, staff, and the Nurse Practitioner's interviews the facility failed to implement an order for Metoprolol 50 milligrams daily (a beta blocker indicated for the treatment of hypertension and heart failure) that was prescribed for atrial fibrillation (irregular heart rhythm) following a cardiology appointment. The medication error resulted in 25 missed doses. This occurred for 1 of 1 resident (Resident #55) reviewed for medication administration. Findings included. Resident #55 was admitted to the facility on 07/21/20 with diagnoses including chronic atrial fibrillation and chronic systolic congestive heart failure. Review of a cardiology consult report dated 07/11/24 revealed Resident #55 had permanent atrial fibrillation. The electrocardiogram (ECG) showed atrial fibrillation with mildly increased ventricular rate at 114 beats per minute. The recommended best medical therapy was to add Metoprolol Succinate 50 milligrams (mgs) daily to help with ventricular rate control. Medication changes included: to add Metoprolol Succinate 50 mgs take one tablet by mouth daily with a start date of 07/11/24 and end date 07/11/25. Review of the Medication Administration Record (MAR) dated July 2024 for Resident #55 revealed no order for Metoprolol Succinate 50 mgs daily. The Minimum Data Set (MDS) quarterly assessment dated 07/25/24 revealed Resident #55 was cognitively intact. He experienced no shortness of breath.	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 the facility failed to implement an order for Metoprolol 50 milligrams daily (a beta blocker indicated for the treatment of hypertension and heart failure) that was prescribed for atrial fibrillation (irregular heart rhythm) following a cardiology appointment for resident #55. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/6/2024 the Liberty Advantage Nurse Practitioner assessed resident #55, there were no findings of harm to resident #55. Additionally, on 8/6/2024 the Liberty Advantage Nurse Practitioner initiated the order for Metoprolol 50 milligrams daily for chronic fibrillation. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The Director of Nursing identified that all patients who have had out of facility consultations have the potential to be affected by the practice. Beginning on 8/8/2024 all current residents who have had a consultation by outside provider in the past 30 days had their chart audited to identify if new orders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 760	Continued From page 2 During an interview on 08/05/24 at 11:34 AM Resident #55 was observed lying in bed. He was alert and oriented to person, place, and time. He stated he felt okay today but had not been up yet. He stated he did not have difficulty breathing, chest pain or dizziness at this time. During an interview on 08/06/24 at 01:58 PM Nurse #1 indicated Resident #55 did not have Metoprolol 50 mgs ordered for administration. She stated he was not on blood pressure medications. She stated she assessed Resident #55 today and his lungs were clear, his oxygen saturation was within normal limits, and he had no shortness of breath or complaints of chest pain. She stated Nurse Practitioner #1 also evaluated Resident #55 today and reported no shortness of breath or chest pain. She indicated she was not aware of an order for Metoprolol 50 mgs for Resident #55. During a phone interview on 08/07/24 at 9:55 AM the Director of Nursing (DON) stated the Nurse Practitioner evaluated Resident #55 yesterday on 08/06/24 and reviewed the cardiology report and that was when it was realized that Metoprolol 50 mgs daily had not been implemented for Resident #55 following the cardiology visit on 07/11/24. She stated when residents returned from an appointment the consult reports with any new orders were placed into the physician or Nurse Practitioners box. She stated that the delay in getting the medication ordered was because the order was placed in the box of a temporary physician who no longer worked for the facility. She stated the order was overlooked and not followed up on which was done in error. She stated the order for Metoprolol 50 mgs was	F 760	was recommended and to ensure the new orders were transcribed into PCC. This audit was completed on 8/18/2024. Results included: 1 of 45 residents were identified with new orders that had not been initiated. On 8/19/2024 Director of Nursing or nurse designee completed assessment on all identified residents that had missed orders to ensure no Change in Condition. Results included: No adverse effects from the medications not started on date ordered. On 8/19/2024 the Director of Nursing or nurse designee made corrective actions for those residents which included notification to provider, initiation of orders, notification to RP, completion of medication/treatment incident report and assessment of residents to ensure no changes in condition and immediate management of changes in condition. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 8/20/2024 The Nurse Consultant educated the Director of Nursing, Nurse Managers, Business office Manager, Social Services and Health Information Management on process of managing Consultation recommendations and Orders. On 8/15/2024, the RN Nurse Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 760	Continued From page 3 entered yesterday on 08/06/24 for Resident #55 and acknowledged that the Metoprolol order should have been initiated on 07/11/24 following the cardiology appointment. During a phone interview on 08/07/24 at 11:15 AM Nurse Practitioner #1 stated she saw the cardiology notes just yesterday on 08/06/24 to order Metoprolol 50 mgs daily for Resident #55. She stated once she read the cardiology consult and saw that Resident #55 was not on Metoprolol she wrote the order. She reported the cardiologist ordered Metoprolol for Resident #55 for the treatment of atrial fibrillation. She stated there had been no significant outcome from not receiving the medication and Resident #55's heart rate was never elevated enough to cause concern. She indicated his heart rate and blood pressure were within normal limits. She stated she was not aware of the facility process regarding getting physician consultation orders to her but expected the physician consultation notes would get to her for review within a reasonable timeframe. She indicated the order should have been implemented following the cardiology appointment on 07/11/24.	F 760	began in-servicing all Full time, part time, prn RN, LPN Nurses staff (including agency) on Transcribing Orders after Consultation. This training will include all current staff including agency. This training included: " Once returned from consulting provider all documents are reviewed. " Physician is to be notified of all new orders and confirmed to start. " ER visits and new admissions, contact primary provider and confirm ok to start meds. " Initiate new orders by transcribing into PCC. " Notify the family of new orders. " Missed treatment/medications notify provider and assess resident for changes and initiate new orders per provider. In order to prevent Medication Errors and delay in treatment it is very important that all Physician consultation paper work and hospital ER paperwork is reviewed promptly for new orders such as not limited to: New or Changed medications, treatments, or other care services. For all consultations such as not limited to: Audiology, wound care, podiatrist, cardiology, pulmonology, dietary, psychology, any orders received may be initiated after the physician has been made aware and the staff have confirmed that it is okay to start the new orders. Initiate the new orders by transcribing the orders into PCC using the Order Entry process. If the Primary Physician does not approve the recommended orders or interventions, enter a nurse□s note.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 760	Continued From page 4	F 760	This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 8/21/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F760 Quality Assurance Tool monitoring for Transcription of Orders after Consultation weekly x 2 weeks then monthly x 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 8/23/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 812	Continued From page 5	F 812		
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 - §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 observation and staff interviews the facility failed to maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and failed to repair peeling paint hanging from the ceiling above 2 of 2 food preparation tables. These practices had the potential to affect 90 of 91 residents' food quality and kitchen sanitation safety. Findings included: 1) The initial tour of the kitchen conducted on 08/05/24 at 11:35 AM the Dietary Manager (DM) said the staff used the solution in the red bucket	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 failed to maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and	8/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 812	Continued From page 6 to wipe down the main food preparation table area after food preparation and prior to manning the tray line. DM said their stainless-steel food preparation tables were wiped down before breakfast and again just before lunch tray line set-up using the sanitizing solution kept in the only red sanitizing bucket kept under the kitchen's food preparation tables. At 11:45 AM on 08/05/24 strips were used to check the sanitizing solution in the kitchen's only red sanitizing bucket. The solution in the bucket registered 0-parts per million (PPM) of quaternary sanitizer. DM reported she or her staff did not check the strength of the sanitizing solution in the bucket when it was filled that morning, prior to wiping down all foo. preparation table services. She said her dietary kitchen aide was new and did not know how to add sanitizing solution to the red bucket or how to test strip the solution's strength throughout the day, to keep it between 200 - 300 PPM. The DM then demonstrated with the help of the new dietary kitchen aide how to properly fill the red sanitizing bucket, by first filling the bucket with clean tap water, then she added the proper amount of sanitizing solution to the bucket, and finally she tested the red bucket's solution with a test strip that read 200 - 300 PPM, which the DM said was acceptable for disinfecting food preparation services. DM was interviewed on 08/05/24 at 11:50 AM said she preferred the quaternary solution in the red sanitizer bucket to register 200 - 300 PPM when checked with the appropriate strips. She reported when the strength was less than this there was a chance that the surfaces being wiped down were not properly disinfected. She commented the strength of the solution in the	F 812	failed to repair peeling paint hanging from the ceiling above 2 of 2 food preparation tables. 1. For dietary services, a corrective action was obtained on 8/23/2024 The initial tour of the kitchen conducted on 08/05/2024 strips were used to check the sanitizing solution in the kitchen□s sanitizing bucket. The solution in the bucket registered 0-parts per million (PPM) of quaternary sanitizer not reaching the recommended manufacturer strength. On 8/5/2024 The Dietary Manger properly fill the red sanitizing bucket, by first filling the bucket with clean tap water, then she added the proper amount of sanitizing solution to the bucket, and finally she tested the red bucket's solution with a test strip that read 200 - 300 PPM, which was acceptable for disinfecting food preparation services. During observation conducted of the kitchen on 08/05/2024 revealed the ceiling above 2 of the food preparation tables and tray line table had chipped and peeling paint hanging from the ceiling above the tables. Maintenance Director completed repair/repainting of effected area on 8/23/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 812	Continued From page 7 bucket should be checked when the bucket was made up and should not have registered 0-PPM. 2) A follow-up interview and observation were conducted of the kitchen on 08/05/24 at 12:00 PM revealed the ceiling above 2 of the food preparation tables and tray line table had chipped and peeling paint hanging from the ceiling above the tables. An interview was conducted on 08/06/24 at 9:00 AM with the Maintenance Director. He stated he was not aware of the kitchen's peeling ceiling paint. He stated the Dietary Manager had recently spoken to him about the need to repair the peeling ceiling paint area above the food preparation area. When the Maintenance Director observed the peeling paint on the kitchen's ceiling, he stated it needed to be repaired and he would see to it. An interview was conducted on 08/06/24 at 9:15 AM with the Administrator. She reported it was her expectation for the facility's kitchen staff to follow all regulatory guidelines for food and kitchen sanitation safety by testing disinfectant solution and keeping painted areas repaired per kitchen sanitation guidelines. She said the peeling ceiling in the kitchen needed to be repaired and will instruct the Maintenance Director to begin the process of repairing the ceiling. An interview was conducted on 08/06/24 at 12:15 PM with the Dietary Manager. She stated the Maintenance Director was notified of the kitchen's peeling ceiling paint and the need to be repaired. She said the peeling ceiling paint could be a food or sanitation hazard, if it fell onto the preparation tables or into residents' food.	F 812	On 8/20/2024, the Dietary Service Director completed testing of all quaternary solutions to ensure registered 200-400 PPM per manufacturer guidelines. On 8/20/2024 the Dietary Manager completed observation of all kitchen ceiling to identify any additional concerns of peeling paint. The maintenance director and administrator notified with repair/repainting of effected area on 8/23/2024. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary, environmental, and nursing staff on 8/20/2024 by Dietary Service Director. Topics included: " Following regulatory guidelines for food and kitchen sanitation safety by proper filling of quaternary sanitizer solution and testing to ensure solution registers 200-400 PPM when checked. " Shift inspections to observe for environmental concerns such as not limited to peeling ceiling paint and ensure any findings of needed repair are reported to the maintenance director by filling out order repair maintenance slip. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 812	Continued From page 8	F 812	4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures for following regulatory guidelines for foot and kitchen sanitation safety by testing disinfectant solution and keeping painted areas repaired per kitchen sanitation guidelines weekly x 2 weeks then monthly x 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Compliance date: 8/23/2024	