STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555244	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANBERRY NURSING AND REHABILITATION CENTER	**1685 SHAFFER RD ATWATER, CA 95301**

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F 0582 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on interview and record review, the facility failed to provide a written Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN-a notice to provide information to residents/beneficiaries if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume responsibility) and Notice of Medicare Provided Non-Coverage (NOMNC) for one of three sampled residents (Resident 57) when the Medicare coverage was terminated. This deficient practice resulted in not protecting Resident 57's (and the resident representative) right to appeal the termination of Medicare Part A and possibly denying Resident 57 needed services. Findings: During a concurrent interview and record review on 3/10/2020, at 1:44 P.M., with Director of Social Services (DSS), the DSS reviewed the facility document titled, Skilled Nursing Facility Beneficiary Protection Notification Review which indicated Resident 57's Medicare Part A Skilled Services Episode start date was on 1/8/2020 and the last covered day of Medicare Part A Services was on 1/17/2020. The DSS stated she did not issue a SNFABN to Resident 57 or the Resident Representative (RR) because she did not know Resident 57 received Medicare Part A services. The DSS stated, I thought (Resident 57) was only under Medicare part B when she came back from the hospital. The DSS stated the SNF-ABN and NOMNC letter should have been issued at least three days prior to the last day of Medicare A coverage for Resident 57. The DSS stated the SNF-ABN and NOMNC forms were very important because they provided Resident 57 and the RR steps to follow if they wanted to continue receiving Medicare A benefits and steps to follow for an appeal. The DSS stated Resident 57 and RR were not able to appeal because they were not given the forms and information. During an interview on 3/11/2020, at 10:20 a.m., with Minimum Data Set Coordinator (MDSC), the MDSC stated the business office determined the insurance and sent an email to all the department heads if a new or readmitted resident has under Medicare part A or part B coverage. The MDSC stated the DSS was responsible in making sure the SNF-ABN and NOMNC letters were signed prior to the last covered Medicare A day. The MDSC stated the SNF-ABN and NOMNC letters were both important because it gave the residents and family an opportunity to appeal the discontinuation of Medicare A coverage. During an interview on 3/11/2020, at 2:05 p.m., with Resident 57's Resident Representative (RR), the RR stated she did not receive a notice her Medicare part A coverage was going to be discontinued on 1/17/2020. The RR stated she did not receive information from the facility staff explaining Resident 57 had the right to appeal the discontinuation of Medicare part A coverage and believed Resident 57 would have benefited from additional physical therapy. During an interview on 3/11/2020, at 3:32 p.m., with the Administrator (ADM), the ADM stated the SNF-ABN and NOMNC letters were supposed to be issued three days prior to the last covered Medicare part A day to Resident 57 and was not. During a review of the facility's policy and procedure titled, Notice of Medicare Provider Non-Coverage, (NOMNC) dated 5/31/17, the policy and procedure indicated, .All residents must receive a NOMNC prior to discharge from the facility or at the time that Medicare coverage is terminated . 10. Residents or their responsible party have the right to appeal the facility's decision to discontinue Medicare coverage if the do not agree with the decision . During a review of the facility's policy and procedure titled, Skilled Nursing Facility Advance Beneficiary Notice (SNF-ABN) of non-Coverage, dated 5/31/17, the policy and procedure indicated, . It is the policy of this facility to keep residents informed of their Medicare coverage and those items or services that are not covered by Medicare . 10. When the facility properly issues the appropriate SNF-ABN, timely to the beneficiary, and Medicare denies payment on the related claims, the facility must wait for the beneficiary to receive a Medicare Summary Notice before collecting payments from the resident. 11. The SNF-ABN may not be issued to shift financial responsibility to the resident in the case of services for which full payment is bundled into other payments .
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission to the facility for one of three sampled residents (Resident 45), when Resident 45 did not have a care plan for his customary routines and activities. This failure had the potential to result in Resident 45's activity needs to go unmet. Findings: During a review of Resident 45's clinical record titled, ADMISSION RECORD (a document containing resident profile information) undated, the admission record indicated, Resident 45 was admitted to the facility on [DATE]. During a review of Resident 45's Minimum Data Set (MDS- assessment of healthcare and functional needs) dated 1/11/2020, the MDS assessment indicated Resident 45's Brief Interview for Mental Status (BIMS- an assessment of cognitive status) had a score of 2 of 15 points which indicated Resident 45's cognition was severely impaired. The MDS Preference for Customary Routines and Activities indicated Resident 45's activity preferences; very important to listen to music, keep up with the news, do favorite activities, go outside to get fresh air when weather is good and participate in religious services or practices. During a concurrent interview and record review on 3/10/2020, at 8:45 A.M., with the Director of Activities (DOA), the DOA reviewed Resident 45's facility record and stated, I did not find a care plan for activities for Resident 45. The DOA stated the care plan should had been started within two days of Resident 45's admission to the facility. The DOA stated a care plan was important because it provided guidance for the staff to provide the care or activity that are important for Resident 45. The DOA stated Resident 45 was confused and needed assistance with daily needs and that included activities. The DOA stated without the care plan the staff did not know what type of activities Resident 45 preferred and enjoyed. During an interview on 3/10/2020, at 3:51 p.m., with the Unit Manager (UM), the UM stated she was a Licensed Nurse and helped develop care plans for all residents. The UM stated Resident 45's care plan for activities was supposed to be completed within 24 hours of Resident 45's admission to the facility. The UM stated the interdisciplinary team was supposed to review all care plans with the residents and or their families within 48 hours of admission. The UM stated Resident 45's activity care plan was missed. The UM stated a care plan was very important because it measured if the interventions were meeting the goals for the resident. During an interview on 3/11/2020, at 10:45 a.m., with the Director Of Nursing (DON), the DON stated Resident 45's care plan should have been started within two days after admission. The DON stated the activity care plan was very important in order for the staff to implement the type of activities Resident 45 preferred and enjoyed. During a review of the facility's policy and procedure titled, Care Plans dated 11/24/2017, the policy and procedure indicated, . The facility is to develop and implement a baseline care plan for each resident within 48 hours after admission to the facility . 1. Baseline care plan is to be developed by the interdisciplinary team within 48 hours of the resident's admission .3. The baseline care plan is to be reviewed with the resident, and their representative

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

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) if the resident is unable to participate .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to revise a person centered comprehensive care plan in a timely manner for one of three sampled residents (Resident 87) when Resident 87's care plan did not accurately reflect the current physician's orders [REDACTED].). This failure had the potential to result in respiratory complications and failure for Resident 87. Findings: During a concurrent interview and record review, on 3/11/2020, at 10:42 a.m., with LN 4, she reviewed Resident 87's care plan dated 3/11/2020 which indicated, focus- (Resident 87) is at risk for alteration in respiratory function related to [MEDICAL CONDITION] ([MEDICAL CONDITION]-a group of lung diseases that makes it harder to breathe) .OSA . revision 8/14/19 . Goal indicated, Resident 87 will display optimal breathing pattern daily through review date, with a target date of 5/18/2020 .interventions/tasks, Bi-Pap as ordered, 10-6 with continuous oxygen 2-3 L (liters per minute-a measurement of oxygen flow) date initiated 8/30/19. During a review of the current physician order [REDACTED]. LN 4 stated the current physician order [REDACTED]. LN 4 stated Resident 87 was at risk to not receive LN the correct dosage of oxygen because the care plan and doctors orders did not match. During a concurrent interview and record review, on 3/11/20, at 2:05 p.m., with the Director of Nurses (DON), Resident 87's care plan and physician orders [REDACTED]. During a review of the clinical record for Resident 87, the Face Sheet (a document with resident demographic and medical [DIAGNOSES REDACTED]. Resident 87's [DIAGNOSES REDACTED]. [MEDICAL CONDITION]. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 1/01/2011, the P&P indicated, purpose: to provide comfort and administer high-purity oxygen for the treatment of [REDACTED].It is the policy of this facility that oxygen will only be administered by physician's orders [REDACTED]. Oxygen use is to be noted on the resident's care plan .
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review, the facility failed to meet the minimum requirement of a registered nurse on duty for eight consecutive hours per day, seven days per week when a registered nurse was not on duty for the minimum eight consecutive hours per day for six of 30 days sampled. This failure had the potential to result in residents not receiving services required to be provided by an RN. Findings: During an interview on 3/11/2020, at 8:20 a.m., with the Staffing Coordinator (SD), the SD stated, the facility was a 99 bed facility and the Director of Nurses (DON) served as the RN from Monday to Friday eight hours a day. The SD stated she was not aware she was required to schedule an RN seven days a week for eight hours a day. The SD stated she was directed by the DON to schedule an RN on Saturday and Sunday when the facility admitted residents who had intravenous (IV) therapy (therapy that delivers fluids and medications directly into a vein). The SD stated, the facility had a total of three Registered Nurses, the DON, one full time RN and one on-call RN (a person able to be contacted in order to provide a professional service if necessary, but not formally on duty). The SD stated when the facility had IV's on the weekends an RN was scheduled to come into the facility and was instructed to stay for two hours and did not have to work eight hours. During a concurrent interview and record review on 3/11/2020, at 8:45 a.m., with the SD, the Assignment Sheet (AS) dated February 2020 were reviewed. The AS indicated on 2/1/20, 2/8/2020, 2/9/2020, 2/15/2020, 2/29/2020 and 3/1/2020, there were no RN's scheduled to work eight hours a day for the morning, evening or night. The SD verified all the nurses who were scheduled were LVN's and not RN's. During an interview on 3/11/2020, at 10:56 a.m., with the DON, the DON stated, the facility process to schedule an RN was five days a week because the facility had a bed capacity of 99. The DON stated, she worked in the facility Monday through Friday. During an interview on 3/11/2020, at 12:04 p.m., with the Administrator (ADM), the ADM stated she believed the facility required RN coverage Monday to Friday. The ADM stated, she was not aware the facility required coverage on Saturday and Sundays. During an interview, on 3/11/2020, at 2:18 p.m., with the ADM, the ADM stated, she did not have a policy and procedure on the required RN coverage.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation and interview, the facility failed to ensure medications stored in the Central Supply Room were disposed of after the expiration date was reached. This failure had the potential to place ninety-one residents at risk of receiving expired medications. Findings: During a concurrent observation and interview on 3/10/20, at 10:20 a.m., with Director of Nursing (DON), in the Central Supply Room, five bottles of centirizine (medication used for allergy symptoms) 10 milligrams, (mg a unit of measurement) 90 tablets in each bottle, were found to have gone past their expiration date of 2/2020 and remained on the shelf with the non-expired medications. The DON confirmed the medication bottles were expired and should have been removed from the shelf. A review of the facility's policy and procedure titled, Medication administration dated 8/8/18, indicated, To ensue that all medications are handled and administered accurately and safely to each resident .bottles that are clearly marked .expiration date.
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely notify the ordering physician for a laboratory result that fell outside of the normal reference range for one of two sampled residents (Resident 65) when Resident 65's urinalysis (UA-urine sampled to test for the presence of bacteria) result was positive for bacteria that was resistant to the physician ordered antibiotic (a medication to treat infections) regimen. This failure resulted in the administration of antibiotic treatment to Resident 65 that she was resistant to from 1/18/2020 through 1/25/2020 and placed her at risk for further complications from the Urinary Tract Infection [MEDICAL CONDITION]. Findings: During an interview on 3/9/2020, at 9:35 a.m., with Resident 65, Resident 65 stated she recently had a urinary tract infection and was in isolation. Resident 65 stated she was not sure what the infection was, but believed she may have had [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA- a bacteria that causes infections) in the urine. During an interview on 3/10/2020, at 11:05 a.m., with the licensed vocational nurse (LVN) 3, LVN 3 stated the certified nurse assistant (CNA) would report if there were any changes in the residents mental status or if there was smell and change in the appearance of urine. LVN 3 stated the nurse would then perform a dip strip to test for [MEDICATION NAME] (an enzyme sometimes present in urine when certain bacteria is present during a urinary tract infection). LVN 3 stated if the urine was positive for [MEDICATION NAME] the doctor was notified and would order a urinalysis with a culture and sensitivity (UA C&S-test that verifies what antibiotic will be effective). During a concurrent interview and record review on 3/11/2020, at 10:51 a.m., with LVN 4, the Situation Background Assessment and Recommendation (SBAR) progress note for Resident 65, dated 1/18/20 10:41 a.m., was reviewed. The SBAR progress note indicated, situation: c/o burning with voiding, fishy foul odor to urine . background: Hx (history) UTI . assessment: noted urine dark yellow, fishy odor . request/recommendation: MD (Resident 65's doctor) made aware of ultrasound results and resident current symptoms. In house UA dip positive for [MEDICATION NAME]. MD ok to send UA sample to lab for C&S if indicated. MD also gave t.o. (telephone order) via phone for new ABX (antibiotics-a medication used to treat infection) for [MEDICATION NAME] (a cephalosporin antibiotic) 500 mg BID (twice a day) x7 days for UTI . LVN 4 stated the doctor did not have the results for the UA with C&S prior to ordering [MEDICATION NAME], LVN 4 stated if the resident is symptomatic of a UTI the doctor will order an antibiotic before receiving the results. Review of the UA C&S, dated

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F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 1/22/2020 was reviewed. LVN 4 stated the UA C&S result was received on 1/22/2020 at 3:30 p.m. The UA C&S, indicated .Org (organism) #1 ESBL (Extended Spectrum Beta-Lactamase -an enzyme made by some bacteria which prevents certain antibiotics from being able to kill the bacteria) pos. (positive) (resistant to all cephalosporins and [MEDICATION NAME]-types of antibiotics) . the sensitivity list indicated, Organism #1: >100,000 COLONIES/ML Escherichia coli (a type of bacteria) . sensitivity results indicated Antibiotics . [MEDICATION NAME] R (resistant) . [MEDICATION NAME] S (sensitive) . Review of the social services note written on 1/22/2020 at 18:42 by LVN 5, indicated . Resident was placed in isolation for ESBL in urine. Dr. (Resident 65's doctor) was made aware of Urine cx (culture) via fax . LVN 4 stated while she reviewed Resident 65's medical record, she could not find an acknowledgement from Resident 65's physician that he received or reviewed the UA C&A results. LVN 4 stated Resident 65's physician signed and faxed the UA C&S back to the nurses station on 1/25/2020. LVN 4 stated the physician usually would sign and fax the result back with new orders written on it. LVN 4 stated on the UA C&S results there was a hand written note by LVN 5 which indicated started 1/18/20 [MEDICATION NAME](antibiotic)500 mg 1 BID (twice daily) X 7 days . on isolation for ESBL . faxed to MD (Resident 65's doctor) 1/25/20 1642 (4:42 p.m.), the UA C&S results have Resident 65's physician signed initial at bottom of page with the date of 1/25/2020. LVN 4 stated there was no documentation to indicate nursing staff called to notify the physician after the 1/22/2020 fax. LVN 4 stated an abnormal UA C&S especially with ESBL should have been followed up with a phone call to the physician. LVN 4 stated if Resident 65's primary doctor did not acknowledge the abnormal test results on 1/22/20, the nurse should have called the medical director of the facility to discuss the results. LVN 4 stated Resident 65's UTI could have worsened from being on an antibiotic that is not sensitive to the bacteria. LVN 4 stated the resident could have wound up in the hospital with a serious infection like ESBL. LVN 4 stated Resident 65's physician orders [REDACTED]. LVN 4 stated according to the nurses note dated 1/29/20 at 11:12 a.m., written by LVN 3 indicated .MD notified of resident (Resident 65) s/p (after) ABX and c/o (complained of) dysuria (painful urination) this AM shift. Noted cloudy yellow urine in bedside commode with noted foul odor. MD gave new orders for ABX. LVN 4 stated the physician ordered a second and different antibiotic [MEDICATION NAME] 50 mg from 1/29/20 until 3/10/20 because the first antibiotic was not effective. During a concurrent interview and record review on 3/11/2020, at 2:34 p.m. with the Director of Nurses (DON), Resident 65's nurses notes were reviewed. The DON stated the UA C&S result indicated Resident 65's physician was faxed on 1/25/2020. The DON stated there was no way to verify if the doctor reviewed the UA lab result that day. The DON stated the LVN should have also called the doctor because the UA C&S was abnormal. The DON stated if Resident 65's physician did not return the nurses phone call the LVN should have called the medical director. The DON stated the LVN should have followed up on the lab result prior to the end of her shift. The DON stated the resident received the wrong antibiotic for 3 days after the UA C&S results were received. Review of the nurses note dated 1/29/20 at 11:15 a.m. written by LVN 3 , indicated .(Resident 65) continues with isolation for ESBL in the urine. MD notified of resident s/p ABX and c/o (complains of) dysuria this AM (morning) shift. Noted cloudy yellow urine in bedside commode with noted foul odor MD gave new orders for ABX, The DON stated because the bacteria was resistant to the antibiotic ([MEDICATION NAME]) Resident 65 was originally prescribed, Resident 65's urinary tract infection did not completely clear. The DON stated the physician gave a new order on 1/29/20 for [MEDICATION NAME], which showed sensitivity to the bacteria in Resident 65's urine on the UA C&S. The DON stated if Resident 65 was not started on correct treatment the resident could have wound up with dehydration, confusion [MEDICAL CONDITION] (a potential life threatening response to an infection). A review of the facility's policy and procedure titled, Laboratory Services, dated 11/24/17, indicated Purpose: to provide laboratory services for residents .it is the policy of this facility that all physician ordered laboratory tests are carried out per the physician's orders [REDACTED]. on a timely basis .5. the laboratory is to send all resident results to the facility via facsimile (fax) . 8. Licensed nurse is to communicate lab results to the ordering physician . based on the physician's communication preference: fax or telephone . b. Results Abnormal: Telephone/page physician and fax to physician with date and time noted on results. If no response from physician within four (4) hours, call again. If no response, contact the Medical Director . 11. The licensed nurse is to monitor for timely physician response . 12. Faxed lab reports are to be filed in the resident medical record after the physcian has responded with acknowledgment and/or new orders.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, staff interview and document review, the facility failed to ensure the nutritional needs were met for residents on a small portions diet when the lunch meal on 3/9/2020 was not plated in accordance with menu guidance for one of two sampled residents (Resident 34). This failure had the potential to result in weight gain, further compromising the medical status. Findings: During a concurrent observation, interview and record review on 3/9/2020, at 12:36 p.m., with Cook 1 and Director of Dietary Services (DD), in the kitchen during tray service, all portions of chicken were observed in the same pan with no separation of portion sizes. Cook 1 stated she checked the portion sizes when she prepared the chicken and separated the small and regular portions within the tray. Cook 1 stated the small portions were at the top side of the pan and the regular portions were at the bottom side of the pan. Cook 1 placed a large piece of chicken on Resident 34's plate. When the plate was at the end of the tray line Cook 1 removed the chicken from plate and weighed the piece of chicken with the DD, chicken observed to weigh 4 ounces. Cook 1 stated a small portion for the chicken was required to weigh 2 ounces in accordance to the menu. Cook 1 stated, The chicken was too big for Resident 34's small portions diet. Review of tray ticket for Resident 34 indicated, .Special Diets: NAS (no added salt), small portions . The DD stated the portion was too large for Resident 34's prescribed diet. Cook 1 stated residents were usually on a small portion diet to control how much they were eating and for weight control. During an interview 03/09/2020, at 12:57 p.m., with the Registered Dietician (RD), in presence of the DD, the RD stated that Resident 34's prescribed diet was small portions as part of his weight loss program. The RD stated if the resident received bigger portions than ordered it could affect Resident 34's ability to lose weight. A review of the lunch meal on the, Spring Menus cook's spreadsheet, dated 3/9/2020, indicated, Chicken with Parmesan .small portions, 2 ounces meat .regular portions, 3 ounces meat . large portions, 3 ounces meat. A review of Resident 34's doctor's orders titled, Order Summary Report dated 3/11/2020, indicated Dietary, Small Portions Diet . order date 8/20/19 . A review of dietician note, dated 2/28/2020, 3:05 p.m., titled RD weight note indicated Pt. (patient) reviewed d/t (due to) being on a weight loss program .weight went up slightly .Pt. (patient) wishes to lose weight but happy his weight remains stable. Diet remains regular texture, small portions Wt (weight): 221 lbs (pounds) (2/4/20), 219 lbs (1/6/20) . Dietician (e-signed). A review of the facility's policy and procedure titled, Trayline and Delivery of Carts, revision dated 5/1/2016, indicated, .All meals are checked by the Food and Nutrition Services personnel for accuracy .1. The menu spreadsheet displays food items and amounts for each regular or therapeutic diet .3. tray line and/or meal service positions for breakfast, lunch and dinner are determined and planned: a. according to menu .c. to obtain maximum accuracy .4. The meal is checked against the therapeutic diet spreadsheet to assure foods are served as listed on the menu .
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure food was stored, prepared and served in accordance with professional standards for food service safety for 91 residents when: 1. There was expired food in the refrigerators and freezer available for resident consumption. 2. Food items in the dry storage area were open and past the use by date. 3. Two kitchen staff members failed to properly cover facial hair while they performed kitchen duties. These failures had the potential for unsafe food handling in a highly susceptible resident population. Findings: 1. During a concurrent observation and interview on [DATE], at 9:36 a.m., with Cook 1, in the kitchen, a jar of tartar sauce with an expiration date written on it of [DATE] and a container of ketchup with an expiration date of [DATE] written on it was found in the reach in refrigerator with the other condiments. Cook 1 stated condiments were to be thrown out within one month of being opened. During a concurrent observation and interview on [DATE], at 9:36 a.m., with Cook 1, the refrigerator contained two opened jugs of milk with no open or use by date. Cook 1 stated refrigerated liquids were to be discarded within 3 days of being opened. Cook 1 stated all items in the refrigerator should have had a label to indicate the open and

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) use by date. Cook 1 stated if a resident consumed expired milk, it could cause GI (gastrointestinal) illness. During an observation, in the freezer with Cook 1, a box of bacon was on the bottom shelf with a stamped manufacturer's expiration date [DATE]. Cook 1 stated the expired bacon should have been discarded and was not. During a concurrent interview and record review on [DATE], at 10:46 a.m., with the Director of Dietary Services (DD), he stated the policy and procedure on food storage did not have specific dates for discarding food. The DD stated the (untitled) charts hanging in the kitchen were considered the policy for discarding food for the kitchen staff to follow. He stated the charts indicated bottled containers in the reach in refrigerator should have been discarded after 1 month of being opened. 2. During a concurrent observation and interview on [DATE], at 9:36 a.m., with Cook 1, in the dry storage area, two packs of hamburger buns were on the shelf with a use by date of [DATE]. Cook 1 stated they should have been thrown away. A container of ketchup was on the shelf with an expiration date of [DATE]. Cook 1 stated these items should not be in the dry storage area and available for use. On a cart in the dry storage area there was one jug each of liquid cooking ingredients found and available for use during preparation of residents food. Cook 1 referred to a chart hanging on the door of the dry storage room, stated all open liquid items in the dry storage room were supposed to be discarded within one month of opening. Cook 1 stated the chart hanging on the door was the policy for the kitchen staff to follow regarding dates to discard food. Cook 1 found the following expired items in the kitchen storage: Liquid Smoke, opened [DATE], Worcestershire sauce opened [DATE], White Cooking Wine opened [DATE], Apple Cider Vinegar opened [DATE], Red Wine Vinegar opened [DATE], Light Corn Syrup with vanilla opened and unmarked, and Red Cooking Wine opened [DATE]. During a concurrent interview and record review on [DATE], at 10:46 a.m., with the DD, he stated the policy on food storage did not have specific dates for discarding food. The DD stated the (untitled) the charts hanging in the kitchen were considered to be the policy for discarding food in the kitchen and the kitchen staff needed to follow the charts. A review of the facility's policy and procedure titled, Dry Good Storage dated [DATE], indicated, .5. .products should be dated .7. .Food items will be labeled and dated with an open date and use by date . 3. During an observation on [DATE], at 11:18 a.m., in the kitchen, two employees, the director of dietary (DD) and a dietary aide (DA) 2, had facial hair exposed outside of the beard guards. During an interview on [DATE], at 12:57 p.m., with the DD and the registered dietician (RD), the DD stated all hair including facial hair needed to be covered. The DD stated if hair was not completely covered it could cause physical contamination, visual contamination and cross contamination of the food. The RD stated facial hair should have been covered to prevent cross contamination. During a concurrent observation and interview on [DATE], at 12:51 p.m., with DA 2, DA 2's side burn hair was exposed and not covered completely by the beard guard. DA 2 stated he was trained that the beard guard must cover all facial hair to keep hair out of the resident's food. DA 2 stated hair could cause cross contamination of food. A review of the facility's policy and procedure titled, Personal Hygiene dated [DATE], indicated Purpose: To ensure all Food and Nutrition Services staff maintain sanitary conditions .it is the policy of this facility that Food and Nutritional Services staff will maintain good personal hygiene .3. Men with beards or mustaches will be required to have their beards or mustaches closely cropped and neatly trimmed. Men without a clean-shaven face will be required to wear a beard/mustache net when working in the kitchen . A review of the professional reference from the 2017 Federal Food and Drug Administration (FDA) Food Code, indicated, .Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and Linens; and unwrapped single-service and single-use articles.