

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Big Elm Retirement and Nursing Centers		STREET ADDRESS, CITY, STATE, ZIP CODE  1285 West A Street Kannapolis, NC 28081	
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)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</b></p> <p>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).</p> <p>The findings included:</p> <p>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 [DATE] assessed Resident #32 to be cognitively intact without behaviors.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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 not harmed by the over-the-counter antacids, but staff should manage all her medications.</p> <p>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.</p>		

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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>49366</p> <p>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.</p> <p>Findings included:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview on 7/11/24 at 1:02 PM, the Administrator revealed the weekend mail was 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.</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366</b></p> <p>Based on observations and staff interviews, the facility failed to maintain lighting and walls in good repair for 2 of 2 areas (resident room [ROOM NUMBER] and nurse's desk) when reviewed for environment.</p> <p>The findings included:</p> <p>An observation on 7/8/24 at 12:05 PM in room [ROOM NUMBER] 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.</p> <p>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.</p> <p>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.</p> <p>A facility tour with the Maintenance Director and Administrator occurred on 7/11/24 at 11:50 AM. It revealed they were not aware of the marks and scuffs on the walls in room [ROOM NUMBER] 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.</p> <p>An interview with the Administrator during the facility tour revealed she was not aware of the marks and marring on the walls in room [ROOM NUMBER] 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 [ROOM NUMBER] had not been completed as it was occupied.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35758</p> <p>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 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.</p> <p>Findings included:</p> <p>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.</p> <p>There was no staff observed in the shower room and no residents observed in the hallway outside of the shower room.</p> <p>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 #1 also 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 in the shower room.</p> <p>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.</p> <p>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.</p> <p>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</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>An observation of the shower room on 07/09/2024 at 8:34 AM revealed the shower room door was locked.</p> <p>On 07/10/24 at 9:13 AM revealed the shower room door was closed and locked.</p> <p>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.</p> <p>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.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37281</p> <p>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.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. The facility kitchen was toured on [DATE] with the Dietary Manager (DM) at 9:55 AM.             <ol style="list-style-type: none"> <li>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.</li> <li>b. The reach-in cooler was observed with the DM at 10:05 AM on [DATE]. A half-gallon of milk was noted with an expiration date of [DATE]. The DM reported the milk should have been discarded on [DATE] and he did not know why it was not thrown away. The DM discarded the expired milk.</li> <li>c. The stove was observed at 10:11 AM on [DATE]. 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.</li> <li>d. During the tour of the kitchen on [DATE] 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 ,d+[DATE] 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.</li> </ol> </li> <li>2. An observation of the kitchen was conducted on [DATE] at 11:35 AM.             <ol style="list-style-type: none"> <li>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.</li> <li>b. The DM was observed with his facial hair uncovered during the observation on [DATE]. The DM had facial hair on his chin that measured more than ,d+[DATE] 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 ,d+[DATE] 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 ,d+[DATE] inch. Both Dietary Aide #1 and #2 were observed without beard coverings.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was conducted with Dietary Aide #1 at 11:40 AM on [DATE] and he reported he was aware he needed to wear a beard covering.</p> <p>The DM was interviewed on [DATE] 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.</p> <p>The DM was interviewed on [DATE] 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 their order was delivered.</p> <p>The Administrator was interviewed on [DATE] 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.</p>