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	175424	A. BUILDING _____ B. WING _____	01/09/2023

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LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #176678, #176661 and #176394. This 2567 was electronically sent to the facility on 01/12/23.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		

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 583	Continued From page 1	F 583		

(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 47 residents, with 14 residents sampled including three residents reviewed for privacy. Based on interview, record review, and observation, the facility failed to provide privacy for two Residents (R)1 and R 19, while staff performed cares in the resident's rooms.

Findings included:

- Review of Resident (R)1's electronic medical record (EMR), revealed the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The annual "Minimum Data Set" (MDS), dated 11/22/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. She required total assistance of one staff for toileting and total assistance of two staff for bed mobility. She had limited range of motion (ROM) on both sides of her upper and lower extremities.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 11/22/22, documented the resident required staff assistance with all aspects of ADLs.

The "Quarterly MDS," dated 09/08/22,

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documented the resident had a BIMS score of four, indicating severe cognitive impairment. She required extensive assistance of two staff for bed mobility and extensive assistance of one staff for toilet use. She had limited ROM on both sides of her upper and lower extremities.

The "ADL Care Plan", revised 03/23/22, instructed staff the resident required physical assistance with bed mobility and transfers.

On 01/04/23 at 09:57 AM, Licensed Nurse (LN) G and Certified Nurse Aide (CNA) O entered the resident's room to provide cares. While staff performed peri-care (the cleansing of the genitals), LN G exited and entered the resident's room to obtain needed supplies without closing the privacy curtain. The resident was naked from mid chest to her lower legs and exposed to anyone in the hallway when LN G opened and closed the door to the resident's room without pulling the privacy curtain closed.

On 01/04/23 at 10:00 AM, CNA O stated staff should close the privacy curtain before exiting a resident's room to ensure their privacy.

On 01/04/23 at 10:01 AM, LN G stated she had forgotten to close the privacy curtain before exiting the resident's room. The privacy curtain should be closed to ensure the resident's privacy during cares.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated staff should ensure the resident's privacy by closing the privacy curtain before exiting their rooms during cares.

The facility policy for "Resident Rights", undated,

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included: Each resident has the right to privacy.

The facility failed to provide privacy for this dependent resident while cares were given in her room.

- Review of Resident (R)19's electronic medical record (EMR), revealed the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The annual "Minimum Data Set" (MDS), dated 03/16/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. She required extensive assistance of two staff for bed mobility and toileting and had no limitation in range of motion (ROM).

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 03/16/22, documented the resident required assistance with most ADLs.

The "Quarterly MDS," dated 09/09/22, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She required extensive assistance of one staff for bed mobility and toileting and had no limitation in ROM.

The "Care Plan" for ADLs, dated 07/07/22, instructed staff to encourage the resident to toilet before and after meals and before bed.

On 01/05/23 at 11:26 AM, Licensed Nurse (LN) G

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F 583	Continued From page 4 and Certified Nurse Aide (CNA) O gave cares to the resident in her room. Staff assisted the resident to lie on her left side, with her pants down, while giving cares. LN G exited the resident's room without closing the privacy curtain which left the resident visible to anyone in the hall. On 01/05/23 at 11:26 AM, CNA O stated staff should close the privacy curtain before exiting a resident's room to ensure their privacy. On 01/05/23 at 11:26 AM, LN G stated she had not thought to close the resident's privacy curtain. The privacy curtain should be closed to ensure the resident's privacy during cares. On 01/09/23 at 10:02 AM, Administrative Nurse D stated staff should ensure the resident's privacy by closing the privacy curtain before exiting their rooms during cares. The facility policy for "Resident Rights", undated, included: Each resident has the right to privacy. The facility failed to provide privacy for this dependent resident while cares were given in her room.	F 583		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents with 14 sampled for review. Based on	F 641		

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observation, interview, and record review the facility failed to complete an accurate assessment/"Minimum Data Set" (MDS) for three residents, which included Resident (R) 11, related to restraints, and R 38 and R 40, related to terminal condition with life expectancy of less than 6 months.

Findings included:

- Review of R 11's 's, "Physician Orders," dated 12/5/22 revealed diagnoses which included age related physical debility and contractures (abnormal permanent fixation of a joint).

The "Annual Minimum Data Set" (MDS) dated 02/10/22, documented the "Brief Interview for Mental Status" (BIMS) score of 15 which indicated he was cognitively intact. He required extensive assistance of staff with bed mobility, transfer, dressing, and toilet use. He required limited assistance for locomotion and walking did not occur. His balance during transition was not steady but he was able to stabilize with staff assistance. He exhibited functional limitation in range of motion on both sides of his upper extremities and on one side of his lower extremities. The resident used a wheelchair as an assistive mobility device. He used siderails as a restraint.

The "Quarterly MDS," dated 10/27/22 documented the resident used siderails as a restraint.

The "Physical Restraint Care Area Assessment" (CAA), dated 02/18/22, documentation included physical restraint CAA triggered related to the use of a 1/4 side rail. The resident requested this

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siderail for bed mobility assistance and self-positioning. He can lift it and move it out of the way when needed.

Observation on 01/03/23 at 02:48 PM, revealed R 11 laid on his back in bed. The resident had bilateral siderails on his bed. The resident stated he used the siderails to self-position in his bed. He reached for and grasped the bedrails and scooted himself up in the bed. The resident stated the siderails did prevent him from getting in and or out of bed voluntarily and that he needed assistance from the staff to transfer.

Interview on 01/04/23 at 11:57 AM, Certified Nurse Aide (CNA) NN, stated the facility did not have any residents with restraints. She verified the resident had siderails on both sides of his bed, but the resident used them to reposition himself in bed. She reported the resident could not transfer or walk without assistance. He was alert and oriented and used his call light to get assistance from staff to transfer him. CNA NN reported the resident wanted the siderails to help him be more independent and not to restrict him in any way.

Interview on 01/05/23 at 01:55 PM, Certified Medication Aide (CMA) T, stated the facility did not have any residents restrained. She verified the resident requested the siderails on both sides of his bed for his self-positioning.

Interview on 01/05/23 at 08:18 AM, Administrative Nurse F, confirmed R 11's MDS was inaccurate. She reported the resident requested and used the siderails to reposition himself in the bed. His movements were not restricted by the requested siderails and did not limit his access to his body.

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The siderails should not have been coded as a physical restraint because they do not meet the definition of a restraint as defined in the RAI Manual. Administrative Nurse F stated the facility used the "Resident Assessment Manual," (RAI) to direct staff in the accurate coding of the MDS.

The RAI manual, dated 10/2019, documented definition for physical restraints included which restricts freedom of movement or normal access to one's body. Additionally, the RAI Manual direct staff, ". . . Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition."

The facility failed to complete an accurate assessment/"Minimum Data Set" (MDS) for the resident related to physical restraints.

- Review of the resident (R) 40's, "Physician Orders," dated 12/05/22, revealed diagnoses which included age related cognitive decline and hypertension (high blood pressure).

The "Significant Change in Status Minimum Data Set" (MDS) dated 08/08/22, documented the "Brief Interview for Mental Status" (BIMS) score of 06 indicating severe cognitive impairment. She did not have a condition or chronic disease that result in a life expectancy of less than 6 months, and she received hospice care.

Review of the "Hospice Certification," dated 07/21/22, revealed R 40's hospice start of service was 08/24/22. The terminal diagnosis noted was Senile Degeneration of the Brain. The physician signed the certification on 8/25/22 and noted R

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40's life expectancy of less than 6 months and was appropriate for hospice care.

Observation on 01/04/23 at 10:27 AM, R 38 laid on her right side with pillows beneath her head and right elbow. Certified Medication Aide (CMA) T provided incontinence care, turned and repositioned the resident on her left side using a wedge behind the resident's back.

Interview on 01/0 4/23 at 11:57 AM, CNA NN confirmed the resident received hospice services.

Interview on 01/05/23 at 08:18 AM, Administrative Nurse F, verified R 40's MDS was inaccurate. She reported the resident's MDS should had been coded to reflect the resident's prognosis as life expectancy of less than six months. Administrative Nurse F stated the facility used the "Resident Assessment Manual," (RAI) to direct staff in the accurate coding of the MDS.

The RAI manual, dated 10/2019, documented to Code 1, yes: if the medical record included physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.

The facility failed to complete an accurate assessment/"Minimum Data Set" (MDS) for the resident related the resident's prognosis of life

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expectancy of six months or less.

- Review of the resident's (R)38's, "Physician Orders," dated 12/05/22, revealed diagnoses which included senile degeneration of the brain (dementia a progressive mental disorder characterized by failing memory), muscle weakness, pressure ulcer (PU-localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the left heel stage 2 (partial thickness of dermis middle layer of skin] presents as a shallow open ulcer with a red or pink wound bed) and a PU to the right heel, stage 2.

The "Significant change in Status Minimum Data Set" (MDS) dated 08/30/22, documented the "Brief Interview for Mental Status" was not completed due to the resident rarely/never understood. She did not have a condition or chronic disease that result in a life expectancy of less than 6 months, and she received hospice care.

The "Quarterly MDS," dated 11/23/22, documented the resident did not have a condition or chronic disease that result in a life expectancy of less than 6 but received hospice care.

Review of the "Hospice Certification," dated 08/25/22, revealed the R 38's hospice start of service was 08/24/22. The terminal diagnosis noted was Senile Degeneration of the Brain. The physician signed the certification on 8/25/22 and noted R 38's life expectancy of less than 6 months and was appropriate for hospice cares.

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Observation on 01/04/23 at 10:27 AM, R 38 laid on her right side with pillows beneath her head and right elbow. Certified Medication Aide (CMA) T provided incontinence care, turned and repositioned the resident on her left side using a wedge behind the resident's back.

Observation on 01/04/23 at 1:46 PM, Certified Nurse Aide NN (CNA) and CAN O transferred the resident using a full body lift and sling.

Interview on 01/0 4/23 at 11:57 AM, CNA NN confirmed the resident received hospice services.

Interview on 01/04/23 at 10:33 AM, Licensed Nurse (LN) J confirmed hospice services started for this resident on 08/24/22, with a terminal diagnosis of senile degeneration of the brain. She reported the resident's certification was signed by a physician and documented the resident's life expectancy was less than six months.

Interview on 01/05/23 at 08:18 AM, Administrative Nurse F, verified R 38's MDS were inaccurate. She reported the resident's MDS should had been coded to reflect the resident's prognosis as life expectancy of less than six months. Administrative Nurse F stated the facility used the "Resident Assessment Manual," (RAI) to direct staff in the accurate coding of the MDS.

The RAI manual, dated 10/2019, documented to Code 1, yes: if the medical record included physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. A program for terminally ill persons where an array of services is provided for the palliation and management of terminal

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F 641	Continued From page 11 illness and related conditions. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record. The facility failed to complete an accurate assessment/"Minimum Data Set" (MDS) for the resident related the resident's prognosis of life expectancy of six months or less as required.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		

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team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 47 residents with 14 residents sampled. Based on interview, record review, and observation, the facility failed to review and revise the care plans for two Residents (R)5 and R 19, regarding catheter tubing anchors.

Findings included:

- Review of Resident (R)5's electronic medical record (EMR) revealed a diagnosis of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The "Significant Change Minimum Data Set" (MDS), dated 08/12/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The resident required total assistance of one staff for toileting and had an indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 08/12/22, documented the resident had an indwelling urinary catheter due to a diagnosis of neurogenic bladder. Staff were to assist with cleaning, emptying, and maintaining the catheter.

The "Quarterly MDS," dated 10/25/22 lacked documentation of the resident's cognition. She required total assistance of one staff for toilet use and had an indwelling urinary catheter.

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The "Care Plan" for urinary catheter, revised 06/29/22 instructed staff to clean around the suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow) with soap and water daily. The care plan lacked staff instruction for anchoring of the catheter tubing.

On 01/04/23 at 01:37 PM, Certified Nurse Aide (CNA) NN and CNA O repositioned the resident in her bed. The staff slightly tugged on the catheter tubing, which lacked an anchor during the repositioning.

On 01/05/23 at 08:20 AM, the resident's suprapubic catheter tubing continued to lack an anchor.

On 01/05/23 at 08:20 AM, Licensed Nurse (LN) G stated care plans were updated by the nurses with any changes in the resident's cares.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated, all of the nurses were able to revise a resident's care plan.

The facility lacked a policy for reviewing and revising of resident care plans.

The facility failed to review and revise the care plan for this dependent resident with a urinary catheter.

- The "Physician Order Sheet" (POS), dated 12/19/22, for Resident (R)19, included a

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diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 03/16/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. She had an indwelling urinary catheter and required extensive assistance of two staff for toileting.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), 03/16/22, documented the resident had an indwelling urinary catheter and was at risk for injury due to the catheter.

The "Quarterly MDS," dated 09/09/22, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She had an indwelling urinary catheter and required extensive assistance of one staff for toileting.

The "Care Plan", revised 07/07/22, instructed staff the resident had an indwelling urinary catheter due to a stage IV pressure ulcer (PU) (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle and bone). Staff were to provide catheter care every shift. The care plan lacked staff instruction for anchoring of the catheter tubing.

On 01/04/23 at 10:13 AM, Certified Nurse Aide (CNA) O gave cares to the resident. CNA O changed the large urinary catheter drainage bag to a leg bag. The catheter tubing lacked an anchor.

On 01/05/23 at 10:45 AM, the resident's catheter

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F 657	Continued From page 15 tubing continued to lack an anchor. On 01/05/23 at 08:20 AM, Licensed Nurse (LN) G stated, care plans were updated by the nurses with any changes in the resident's cares. On 01/09/23 at 10:02 AM, Administrative Nurse D stated, all of the nurses were able to revise a resident's care plan. The facility lacked a policy for reviewing and revising of resident care plans. The facility failed to review and revise the care plan for this dependent resident with a urinary catheter.	F 657		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents with 14 residents sampled, including five residents reviewed for pressure ulcers (PU).	F 686		

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Based on observation, interview, and record review, the facility failed to perform clean dressing changes for four of the Residents (R) 1, R5, R19 and R29 reviewed.

Findings included:

- Review of Resident (R)1's electronic medical record (EMR), revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The annual "Minimum Data Set" (MDS), dated 11/22/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. She was at risk for the development of pressure ulcers (PU) and had one unhealed, stage II PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough), present on admission.

The "Pressure Ulcer (PU) Care Area Assessment" (CAA), dated 11/22/22, documented the resident currently had a PU. Staff were to report abnormal findings to the physician and receive treatment orders. Staff were to reposition the resident every two to three hours for comfort.

The "Quarterly MDS," dated 09/08/22, documented the resident had a BIMS score of four, indicating severe cognitive impairment. She was at risk for the development of PUs and had no unhealed PUs at the time of the assessment.

The "PU Care Plan", revised 03/23/22, instructed staff to know R1 had a stage II PU to her right buttock. Staff were to apply Triad (cream used for the local management of partial- and

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full-thickness pressure ulcers) twice daily (BID), until resolved, ordered 11/21/22.

On 01/05/23 at 09:30 AM, Licensed Nurse (LN) G and Certified Nurse Aide (CNA) P entered the resident's room to do wound care. LN G cleansed the stage II PU to the right thigh and measured the wound to be 1.1 (length) X 1.0 (width) X 0.1 (depth) centimeters (cm). The wound had a red, beefy wound bed with the peri-wound (skin surrounding the wound) normal, blanchable. The wound had no drainage or odor.

On 01/09/23 at 06:51 AM, CNA O and CNA MM, gave morning cares to the resident. After performing peri-care (cleansing of the genitals), CNA O applied Triad cream to the open area on the resident's right thigh. CNA O did not change his gloves after performing peri-care and applying the medicated cream to the resident's open wound.

On 01/09/23 at 06:51 AM, CNA O stated he did not change his gloves after performing peri-care and applying the cream to the resident's open wound.

On 01/09/23 at 10:15 AM, LN G stated the staff should ensure they are wearing clean gloves before putting cream on a resident's open wound.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated she expected staff to change gloves after performing a dirty task and to put on clean gloves before performing a clean task.

The facility policy for "Clean Dressing Changes", undated, included: It was the policy of the facility to ensure dressing changes were performed in

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accordance with State and Federal regulations and national guidelines.

The facility failed to use a clean technique when applying a medicated cream to an open wound on this dependent resident with a stage II PU to her thigh.

- Review of Resident (R) 5's electronic medical record (EMR) revealed a diagnosis of Multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord).

The "Significant Change Minimum Data Set" (MDS), dated 08/12/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. She required total assistance of one staff for personal hygiene and dressing and total assistance of two staff for bed mobility. She had limited range of motion (ROM) on both sides of her upper and lower extremities. She was at risk for the development of pressure ulcers (PU) and had one stage IV PU (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle or bone), present on admission and three unstageable PUs (covered by a thick layer of other tissue and pus that may be yellow, grey, green, brown, or black), present on admission.

The "Pressure Ulcer (PU) Care Area Assessment" (CAA), dated 08/12/22, documented the resident had a stage IV PU to her coccyx (tailbone), an unstageable PUs to her left ischium (bone of the pelvis that forms the lower and back part of the hip bone), right ischium and right hip.

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The "Quarterly MDS," dated 10/25/22, lacked documentation of the resident's cognition. She required total assistance of two staff for bed mobility and total assistance of one staff for personal hygiene. She had limited ROM on both sides of her upper and lower extremities. She was at risk for the development of PUs and had two stage IV PUs, present on admit and one stage III PU (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle or bone), not present on admission.

The PU care plan, revised 06/29/22, instructed staff to turn and reposition the resident every two to three hours, use pillows to maintain her position in bed, and to complete treatments as directed.

On 01/05/23 at 08:20 AM, Licensed Nurse (LN) G entered the resident's room to perform a dressing change to the PUs. LN G removed the dressing and packing previously applied to the PUs, cleaned the areas with wound cleanser, then patted the area dry with clean gauze pads. LN G then packed the wounds with wet gauze and covered the area with an absorbent dry pad. LN G failed to remove her gloves and perform hand hygiene after removing the dirty dressing and packing from the wound and before applying the new packing and dressing to the open wounds.

On 01/05/23 at 08:20 AM, LN G stated she had not removed her dirty gloves after removing the dirty dressing and packing and before applying the clean packing and dressing. LN G stated she should have changed gloves, but did not.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated, she expected staff to change gloves after

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performing a dirty task and to put on clean gloves before performing a clean task.

The facility policy for "Clean Dressing Changes", undated, included: It was the policy of the facility to ensure dressing changes were performed in accordance with State and Federal regulations and national guidelines.

The facility failed to use a clean technique when applying a medicated cream to an open wound on this dependent resident with multiple PUs.

- The "Physician Order Sheet" (POS), dated 12/19/22, documented Resident (R)19 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 03/16/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. She required extensive assistance of two staff for bed mobility and extensive assistance of one staff for personal hygiene. She was identified as at risk for the development of pressure ulcers (PU), with one stage IV PU (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle or bone), present on admission.

The "Pressure Ulcer (PU) Care Area Assessment" (CAA), dated 03/16/22, documented the staff were to notify the physician with any abnormal findings and to follow the treatment orders.

The "Quarterly MDS," dated 09/09/22,

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documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She required extensive assistance of one staff for bed mobility and personal hygiene. She was at risk for the development of PUs and had one stage IV PU, present on admission.

The "Care Plan" for PUs, revised 07/07/22, instructed staff to reposition the resident every two hours and to use pillows to reduce pressure on her heels.

On 01/05/23 at 11:16 AM, Licensed Nurse (LN) G entered the resident's room to do a dressing change. LN G removed the dressing from the resident's PU, cleansed the area with normal saline (NS), and patted the area dry with gauze pads. She then applied alginate (helps with the formation of granulation tissue) and covered the area with a clean dressing. LN G failed to change her gloves after cleansing the area and before applying the clean dressing.

On 01/05/23 at 08:20 AM, LN G stated she had not removed her dirty gloves after removing the dirty dressing and packing and before applying the clean packing and dressing. LN G stated she should have changed gloves, but did not.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated she expected staff to change gloves after performing a dirty task and to put on clean gloves before performing a clean task.

The facility policy for "Clean Dressing Changes", undated, included: It was the policy of the facility to ensure dressing changes were performed in accordance with State and Federal regulations and national guidelines.

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The facility failed to use a clean technique when applying a medicated cream to an open wound on this dependent resident with a stage IV PU.

- Resident (R) 29 admitted to the facility on 07/26/22. The 11/14/22 "physicians order" included the diagnosis of pressure ulcer (localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction) of the sacral region (the large triangular bone between the two hips), stage II.

The "Minimum Data Set" (MDS) dated 10/18/22 revealed the resident, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance for activities of daily living (ADLs). A clinical assessment was performed determining the resident was at high risk for pressure ulcers.

The "Pressure Ulcer Care Area Assessment" (CAA) dated 07/18/22 revealed the resident had a potential for pressure ulcers. Contributing factors included extensive assistance required for ADLs, functional and mobility impairment, and incontinence. Risk factors include pain, the development of pressure ulcers and skin conditions, and fluid deficit risk.

The 12/22/22 "Care Plan" included that the resident would remain free of skin breakdown through the next review. The care plan noted it

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was reported the resident had a stage III pressure ulcer (full thickness skin loss involving damage or tissue death of the innermost layer of skin that may extend down to, but not through, underlying connective tissue) to his sacrum, facility-acquired, due to suspected sheering from the slide board transfers, and the resident preferred to continue slide board transfers with caution. On 11/14/22, a wound was identified as a sheering/pressure ulcer stage II (the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful). On 11/21/22, the pressure ulcer was downgraded to unstageable (the stage is not clear because the base of the sore cannot be seen due to being covered by a thick layer of other tissue and pus that may be yellow, grey, green, brown, or black). On 11/28/22, the wound was re-staged to stage III. On 12/29/22, the ulcer was downgraded to unstageable.

On 01/05/22 at 07:45 AM, Licensed Nurse (LN) G and Certified Nurse Aide (CNA) O entered the resident's room wearing gloves, gowns, and masks. LN G cleaned the resident's overbed table with a body cleansing wipe and partially covered the top of the table with paper towels. She removed her gloves and did not perform hand hygiene. She then pulled a pair of gloves out of a pocket on her uniform top and put them on. The tabletop was partially covered with paper towels, but there were still gaps between the paper towels where opened ABD pads (a highly absorbent dressing that provides padding and protection for large wounds) and gauze pads were directly touching the tabletop. Three normal saline (saline water solution) containers were opened and sat on the paper towels. There were three unopened packages of calcium alginate (a light, nonwoven fabric derived from algae or

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seaweed, designed for moderately to heavily draining wounds) and cotton-tipped applicators on the tabletop. LN G removed the dressing from the resident's sacral wound. There was a large amount of foul-smelling serosanguineous (semi-thick reddish drainage) on the removed dressing, which LN G discarded. LN G removed her gloves and did not perform hand hygiene. LN G then pulled new gloves out of her pocket and put them on. The wound was then cleansed with normal saline soaked gauze, cleaning from the inside of the wound to the outside and the perimeter. LN G retrieved the medihoney gel tube and medication cup, put some medihoney in a liquid medication cup, then set the cup on the tabletop. LN G then opened the cotton-tipped applicator package and used a cotton-tipped applicator to apply medihoney to the wound bed. CNA O retrieved a body wipe and wiped the resident's anus, contacting the wound's lower periphery, which LN G had cleansed with normal saline soaked gauze. The calcium alginate dressing packages were opened. LN G retrieved a cotton-tipped applicator and packed the tunneling areas of the wound with the calcium alginate. LN G removed gloves, pulled a pair of scissors from her pants pocket, laid them on a clean field, removed gloves from her shirt pocket and donned gloves, and applied ABD pads. CNA O did not change gloves and held the ABD in place while LN G used the scissors on the tabletop to cut bandage tape to the appropriate length. LN G removed gloves and did not perform hand hygiene. She retrieved a pen from her shirt pocket and initialed and dated the dressing. LN G removed the remaining packages and paper towels from the tabletop and threw them in the resident's trash can. She removed her gloves and gown and washed her hands in the resident's

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bathroom.

On 01/09/23 at 10:11 AM, Administrative Nurse E put on a gown and gloves from the cart in the hallway outside of the resident's room. The Consultant Staff HH removed the dressing. The health care provider instructed Administrative Nurse E to apply a wet-to-dry dressing (gauze soaked in normal saline and covered with dry dressing). Administrative Nurse E removed her gloves and did not perform hand hygiene before leaving the resident's room. Administrative Nurse E returned to the room and did not perform hand hygiene. She put on a pair of gloves and put a paper towel down on half of the resident's bedside table but did not remove the resident's belongings from the table and did not wipe the tabletop with any cleaner. Administrative Nurse E did not change her gloves and opened three normal saline containers. She sprayed the normal saline in the wound bed to cleanse and touched the tip of one of the normal saline containers to the inside of the wound edge. She soaked some gauze with normal saline and put it in the wound bed. She opened an ABD pad and covered the wound, taping it in place. She removed her gown and gloves and washed her hands in the resident's bathroom.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated, it was the expectation for staff to change gloves after performing a dirty task and to put on clean gloves before performing a clean task.

The facilities undated policy for "Clean Dressing Change Infection Control" documented the dressing change procedure should include donning gloves, cleaning bedside table with germicidal disposable cloth, remove gloves,

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F 686	Continued From page 26 perform hand hygiene, don clean gloves, and establish a clean field. After removing the dressing, doff gloves, perform hand hygiene and don clean gloves. After cleansing wound, doff gloves, perform hand hygiene, don clean gloves. After applying treatment if ordered, doff gloves, perform hand hygiene, don clean gloves. After all disposable items discarded into appropriate receptacle, clean bedside table with germicidal disposable cloth. The facility failed to provide the resident the necessary treatment and services of a pressure ulcer, consistent with professional standards of practice, to promote healing and prevent infection.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		

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as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 47 residents, with 14 residents sampled, including three for urinary catheter care. Based on observations, interviews, and record review, the facility failed to provide appropriate and sufficient services, treatment, and care for a resident with a clinically justified indwelling catheter, based upon current standards of practice to ensure that Residents (R) 29, R 19 and R 5 received appropriate treatment and services to prevent urinary tract infections to the extent possible.

Findings included:

- The "Physician's Orders" dated 07/26/2022 indicates R 29 was admitted on 07/26/22 with diagnoses of Neuromuscular Dysfunction of the Bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and benign prostatic hyperplasia (BPH - a noncancerous enlargement of the prostate which can lead to the interference with urine flow,

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urinary frequency, and urinary tract infections.)

A review of the resident's "Quarterly Minimum Data Set" (MDS) dated 10/18/22 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R29 was incontinent of urine, had an indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag), and was dependent on caregivers for perineal care. The resident performed none of his own perineal care.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 07/18/22 revealed urinary incontinence was triggered secondary to the use of an indwelling urinary catheter. Contributing factors included neurogenic bladder and BPH. Risk factors included recurrent urinary tract infections (UTIs) and injury from using an indwelling urinary catheter. The resident was dependent on staff for incontinence care. The resident required total staff assistance with catheter care and checks.

The 12/22/22 "Care Plan" documented a goal that the resident would remain free of UTIs during the period of catheterization. Interventions included:

1. Changing the drainage bag weekly and as needed.

2. Emptying the catheter each shift.

3. Recording output.

4. Notifying the charge nurse of changes in the color or odor of urine or low urinary production.

5. The catheter tubing was to remain below the

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bladder level and free of kinks or twists. A licensed nurse would change the catheter every month and as needed. Nursing would clean around the catheter with soap and water each shift. Those providing care would report any sign of infection (temperature, pain, urine that looks cloudy, dark, or with blood).

On 01/03/23 at 03:07 PM, the resident's catheter bag was on the floor and contained moderate dark, amber-colored urine. The resident's catheter was not anchored to his leg and the tube holder was not used, resulting in tension at the catheter insertion site.

On 01/04/23 at 09:24 AM, the resident's catheter was not anchored to his leg and the tube holder was not used, resulting in tension at the catheter insertion site.

On 01/04/23 at 12:26 PM, Certified Nurse Aide (CNA) O emptied the resident's urinary drainage bag. The drainage tube touched the inside of the urinal and was not cleansed before being reinserted into the drain holder.

On 01/04/23 at 06:41 PM, the resident's catheter was not anchored to his leg, and the tube holder was not used, resulting in tension at the catheter insertion site.

On 01/05/23 at 10:28 AM, the resident's catheter was not anchored to his leg and the tube holder was not used, resulting in tension on at the catheter insertion site. CNA O emptied the resident's urinary drainage bag. The drainage tube touched the inside of the urinal and was not cleansed before trying to reinsert it in the drain holder. While attempting to reinsert the drain tube

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into the holder, the drainage bag fell onto the floor. Nurse Aide O did not pick the drainage bag up, but continued to try to insert the drain tube into the holder, scooting the drainage bag across the floor.

On 01/09/23 at 10:27 AM, the resident's catheter was not anchored to his leg and the tube holder was not used, resulting in tension at the catheter insertion site.

On 01/03/23 at 03:07 PM, R 29 reported his catheter had never been anchored to his leg.

On 01/04/21 at 12:26 PM, CNA O reported the resident's catheter had never been anchored to his leg. CNA P reported that sometimes catheters are anchored, but not all of the time. She is unsure who determined when catheter anchors were used and said, "I'd have to ask the nurse."

On 01/04/23 at 01:55 PM, Licensed Nurse (LN) G reported catheters were usually not anchored. She stated, "most of the time, they refuse." She said R 29's catheter had never been anchored, as far as she knew.

On 01/09/23 at 10:29 AM, Administrative Nurse E reported the resident's catheter had not been anchored, because she was afraid an anchor would tear the resident's skin and she was worried about the swelling in the resident's legs, so she would not want to put an anchor strap on him.

The facilities policy for "Indwelling Catheter Protocol" with no date documented the catheter tubing will always be secured to the elder's thigh with an approved catheter securement device to

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prevent movement, irritation, and decrease risk of infection.

The facility failed to provide appropriate and sufficient services, treatment, and care based on current standards of practice to ensure that the resident received appropriate treatment and services to prevent urinary tract infections to the extent possible.

- Review of Resident (R)5's electronic medical record (EMR), revealed a diagnosis of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The significant change "Minimum Data Set" (MDS), dated 08/12/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The resident required total assistance of one staff for toileting and had an indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 08/12/22, documented the resident had an indwelling urinary catheter due to a diagnosis of neurogenic bladder. Staff were to assist with cleaning, emptying, and maintaining the catheter.

The "Quarterly MDS," dated 10/25/22, lacked documentation of the resident's cognition. She required total assistance of one staff for toilet use and had an indwelling urinary catheter.

The "Care Plan" for urinary catheter, revised 06/29/22, instructed staff to clean around the

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suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow) with soap and water daily.

On 01/04/23 at 01:37 PM, Certified Nurse Aide (CNA) NN and CNA O repositioned the resident in her bed. The staff slightly tugged on the catheter tubing, which lacked an anchor, during the repositioning.

On 01/05/23 at 08:20 AM, the resident's suprapubic catheter tubing continued to lack an anchor.

On 01/04/23 at 01:37 PM, CNA NN stated, the resident did not have an anchor for her catheter tubing.

On 01/05/23 at 08:38 AM, CNA P stated, the resident did not have an anchor for her catheter tubing. Not all residents needed an anchor.

On 01/05/23 at 08:20 AM, Licensed Nurse (LN) G stated, not all resident's needed an anchor for their catheter tubing.

On 01/09/23 at 10:02 AM, Administrative Nurse D stated, staff should ensure residents have an anchor for their catheter tubing if the anchor would not cause skin damage to the resident.

The facility policy for "Indwelling Catheter Protocol", undated, included: The catheter tubing will always be secured to the elder's thigh with approved catheter securement device to prevent movement, irritation, and decrease risk of infection.

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The facility failed to ensure this dependent resident with an indwelling urinary catheter had a tubing anchor to ensure non-displacement of the catheter.

- The "Physician Order Sheet" (POS), dated 12/19/22, for Resident (R)19, included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The annual "Minimum Data Set" (MDS), dated 03/16/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. She had an indwelling urinary catheter and required extensive assistance of two staff for toileting.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), 03/16/22, documented the resident had an indwelling urinary catheter and was at risk for injury due to the catheter.

The "Quarterly MDS," dated 09/09/22, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She had an indwelling urinary catheter and required extensive assistance of one staff for toileting.

The "Care Plan", revised 07/07/22, instructed staff the resident had an indwelling urinary catheter due to a stage IV pressure ulcer (PU) (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle and bone). Staff were to provide catheter care every shift.

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F 690	Continued From page 34 On 01/04/23 at 10:13 AM, Certified Nurse Aide (CNA) O gave cares to the resident. CNA O changed the large urinary catheter drainage bag to a leg bag. The catheter tubing lacked an anchor. On 01/05/23 at 10:45 AM, the resident's catheter tubing continued to lack an anchor. On 01/04/23 at 01:37 PM, CNA NN stated, the resident did not have an anchor for her catheter tubing. On 01/05/23 at 08:38 AM, CNA P stated, the resident did not have an anchor for her catheter tubing. Not all residents needed an anchor. On 01/05/23 at 08:20 AM, Licensed Nurse (LN) G stated, not all residents needed an anchor for their catheter tubing. On 01/09/23 at 10:02 AM, Administrative Nurse D stated, staff should ensure residents have an anchor for their catheter tubing if the anchor would not cause skin damage to the resident. The facility policy for "Indwelling Catheter Protocol", undated, included: The catheter tubing will always be secured to the elder's thigh with approved catheter securement device to prevent movement, irritation, and decrease risk of infection. The facility failed to ensure this resident with an indwelling urinary catheter had a tubing anchor to ensure non-displacement of the catheter.	F 690		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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F 755	Continued From page 35 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents. Based on observation, interview, and record review the facility failed to establish a system to keep drug records in order for all controlled drugs	F 755		

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F 755	Continued From page 36	F 755		

to be maintained and reconciled.

Findings included:

- An environmental tour of the locked medication room on 01/09/23 at 09:52 AM, with Administrative Nurse D, revealed the following areas of concern:

1. An emergency kit (e-kit) in the unlocked refrigerator contained two vials of Lorazepam (a controlled anti-anxiety medication) 2 milligrams (mg)/milliliter (ml). The small plastic e-kit was closed only with a thin, numbered plastic pull-lock. The medication room lacked documentation of the number of the pull lock.

2. An e-kit on top of the refrigerator contained the following medications in a container closed only with a thin, numbered plastic pull-lock. The medication room lacked documentation of the pull-lock number:

1. Ten tabs of Alprazolam (a controlled anti-anxiety medication), 0.25 mg.

2. Five tabs of Tylenol with Codeine (a controlled pain medication), 300 mg/30 mg.

3. Ten tabs of Lorazepam 0.5 mg.

4. Ten tabs of Tramadol (a controlled pain medication), 50 mg.

5. Five tabs of Zolpidem (a controlled hypnotic medication), 5 mg.

6. A large wooden box, used for discontinued controlled medications, contained 47 bottles

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F 755	Continued From page 37 and/or medication bubble cards with controlled medications. A hole in the wooden box was large enough to stick a hand through and obtain controlled medications. The facility lacked a system to reconcile these medications. On 01/09/23 at 10:02 AM, Administrative Nurse D stated the controlled medications needed to be double locked and were not adequately double locked at that time. The facility policy for "Managing Controlled Medications", revised 07/01/21, included: Drugs subject to abuse will be stored in separately locked, permanently affixed compartments contained in a locked medication cart or medication storage room. The facility failed to establish a system to keep drug records in order for all controlled drugs to be maintained and reconciled.	F 755		
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	F 812		

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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:
The facility reported a census of 47 residents. Based on observation and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility, as exhibited by the failure to test the sanitizing solution for appropriate concentrations of chlorine, or iodine appropriately to prevent the potential for food borne bacteria.

Findings included:

- Observation on 01/09/23 at 10:37 AM, revealed the sanitizing test strips used to test the concentrations of chlorine and iodine of sanitizing solution expired on 04/01/2018.

On 01/09/23 at 10:37 AM, Dietary Staff BB verified the above and stated she was not aware the test strips had an expiration date. She confirmed the sanitizing solution should be checked daily to ensure the solution used to sanitize the cookware was an appropriate concentration to prevent food borne bacteria. Additionally, Dietary Staff BB checked the facility stock for test strips and reported that all available test strips exceeded the expiration date.

The facility failed to provide a policy to address the procurement and use of sanitizing solution test strips prior to the expiration date.

The facility failed to test sanitizing solutions for

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F 812	Continued From page 39 appropriate concentration of chlorine or iodine to prevent the potential for food borne bacteria.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents. Based on observation and interview, the facility failed to dispose of garbage and refuse properly. Findings included: - On 01/04/23 at 09:36 AM, observation revealed four dumpsters outside of the facility. One of the four dumpsters was missing the lid and two of the remaining dumpster's lids were left open. There was trash and debris laying on the ground surrounding the dumpsters and adjacent grounds. On 01/04/23 at 10:37 AM, Dietary Staff BB confirmed the above findings and stated she requested a lid for the dumpster and noted the lid was missing for at least a month prior. Nursing and dietary staff used the dumpsters and should close the lids to contain the trash and debris. She further stated the surrounding area should be free of trash and debris to provide a safe, sanitary environment. The facility lacked a policy regarding the use and upkeep of the facility dumpsters. The facility failed to dispose of garbage and refuse properly for the residents of the facility.	F 814		

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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 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 47 residents. Based on observation and interview, the facility failed to provide necessary maintenance services for the kitchen to provide a safe, functional and sanitary environment. Findings included: - The kitchen tour on 01/04/23 09:36 AM, with Dietary Staff BB, revealed the following concerns: 1. The linoleum floor in the dry storage area of the kitchen was worn, exposing black tread marks resulting in an unsanitizable surfaces throughout the floor. 2. Approximately three feet by six inches of the linoleum flooring was missing at the door jam of the junction of the food prep area and the dry food storage area. There was black grime build-up lodged in the area where the linoleum was missing. On 01/04/23 09:36 AM, interview with Dietary Staff BB revealed the dietary staff mopped the floor daily but were not able to get the black streaks out of the linoleum because they were due to the grooves worn into the linoleum, which trapped grime build-up. Dietary Staff BB confirmed the linoleum needed to be replaced.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175424	A. BUILDING _____ B. WING _____	01/09/2023

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F 921	Continued From page 41 The facility lacked a policy addressing maintenance and repair of the kitchen flooring. The facility failed to provide necessary maintenance services for the kitchen to provide a safe, functional, and sanitary environment.	F 921		