STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADE DISTRICT HOSP LTCU DBA LONE TREE RETIREMENT	801 E GRANT , MEADE, Kansas, 67864

(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
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in KS00194531. 2567 sent electronically on 09/04/2025	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550		

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 reverse for further 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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F0550 SS = D	Continued from page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents. The sample included 12 residents with two reviewed for dignity. Based on observation, interview and record review, the facility failed to treat residents in a dignified manner when Resident (R)4 received care without privacy. This deficient practice placed the resident at risk for decreased psychosocial well-being and embarrassment. Findings included: - R4's Electronic Health Record (EHR) included diagnoses of Alzheimer’s disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (a progressive mental disorder characterized by failing memory and confusion). R4's 07/17/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The assessment documented R4 was dependent on staff for transfers. The 07/17/25 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R4 had impaired cognitive function. The 07/17/25 "ADL Functional / Rehabilitation Potential CAA" documented R4 had a self-care performance deficit related to impaired balance, impaired coordination related to progression of Alzheimer’s disease, and other medical conditions. Observation on 08/19/25 at 01:07 PM revealed Certified Nurse Aide (CNA) M went into R4’s room with a mechanical lift and left the door to the hallway open, and the privacy curtain remained in the open position. CNA M pressed the call light for additional assistance,	F0550		

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F0550 SS = D	Continued from page 2 and while waiting for help, connected R4 to the mechanical lift. The procedure was fully visible from the hallway. At 08/19/25 at 01:09 PM, CNA N walked by R4's room, then went in and closed the door. During an interview on 08/19/25 at 01:20 PM, CNA M revealed the door and/or privacy curtain should have been closed to provide privacy and dignity for R4 when the resident was being connected to the mechanical lift. During an interview on 08/21/25 at 11:25 AM, Licensed Nurse (LN) G revealed when mechanical lifts are in use, or when connecting to a resident or resident's sling, the doors and privacy curtains should be closed to provide privacy and dignity for the residents. During an interview on 08/21/25 at 11:40 AM, Administrative Nurse D revealed doors should be closed and curtains drawn during every stage of mechanical lift use to provide privacy and dignity for the residents. The facility's "Resident Rights" policy, dated 01/10/25, documented all residents have the right to a dignified existence. The facility must protect and promote each resident's dignity and respect in all aspects of care and daily life. The policy documented residents would receive care in a manner that enhances and maintains their dignity and respect.	F0550		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible	F0628		

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F0628 SS = D	Continued from page 3 for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F0628		

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F0628 SS = D	Continued from page 4 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and	F0628		

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F0628 SS = D	Continued from page 5 Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold	F0628		

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F0628 SS = D	Continued from page 6 policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 33 residents. The sample included 12 residents with one resident reviewed for discharge. Based on observation, interview, and record review, the facility failed to provide a written discharge summary or recapitulation of the stay for Resident (R) 37. This placed the resident at risk for impaired rights related to continuity of care. Findings included: - R37's Electronic Health Record (EHR) documented diagnoses that included chronic pain and hypothyroidism (a condition characterized by decreased activity of the thyroid gland). R37's "Nursing Home Discharge Minimum Data Set" (MDS), dated 07/09/25, documented R37's discharge from the facility to the community on 06/19/25. R37's EHR noted "Physician Orders", which documented an order to discharge to independent apartments on Thursday, 06/19/25, dated 06/17/25. The EHR "Progress Notes" documented: On 06/11/25 at 11:09 AM, fax communication with the physician who requested orders to discharge the	F0628		

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F0628 SS = D	Continued from page 7 resident to home. On 06/12/25 at 10:25 AM, fax communication received from the physician with written orders to discharge the resident to home on or about 06/19/25 with medications and treatments. On 06/17/25 at 10:33 AM, the physician performed a routine 60-day visit with R37 and documented an order to discharge to independent apartments on 06/19/25. On 06/19/25 at 10:44 AM, staff documented R37's family was at the facility moving R37's belongings to an independent apartment due to R37 being discharged the same day. On 06/19/25 at 12:27 PM, staff documented a discharge meeting was held for R37. Administrative Nurse D reviewed the medication list with R37, and R37 had made arrangements for follow-up appointments with her primary healthcare provider as well as transportation arrangements with family in the community. On 06/19/25 at 01:26 PM, staff documented R37 was at the nurses' station at 01:00 PM and told staff she was leaving. Staff documented R37 was supplied with her medications. On 06/19/25 at 01:31 PM, staff documented fax communication with the physician to inform them R37 was discharged to home at 01:00 PM. R37's EHR lacked evidence that the facility provided a written discharge summary or recapitulation of the stay to R37 or R37's family. On 08/20/25, the facility provided a printed copy of R37's "Planned Discharge – Interdisciplinary" evaluation that documented a discharge date, brief reason for admission, treatment provided, treatment progression, and reason for discharge. The evaluation did not contain the condition at the time of admission, destination of discharge, to whom the resident was released, disposition of medications and/or personal possessions, instructions for after care/continuity of care, or summary of the stay. During an interview on 08/20/25 at 01:31 PM, Administrative Nurse D revealed the discharge summary and recapitulation should be in the EHR under the "Evaluations" tab. Administrative Nurse D confirmed that R37's EHR "Evaluations" tab lacked a recapitulation of the stay, and a brief recapitulation was documented on a "Planned Discharge –	F0628		

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F0628 SS = D	Continued from page 8 Interdisciplinary" evaluation. During an interview on 08/20/25 at 01:36 PM, Administrative Staff A stated the recapitulation should be in each resident's medical record. During an interview on 08/20/25 at 04:30 PM, R37 stated during the actual discharge process on 06/19/25, she was provided with a reconciliation of her medications and was not provided with a written discharge summary or recapitulation of the stay. R37 stated the facility did not assist her with coordinating transportation in the community or follow-up appointments with her primary care provider because she had already made those arrangements independently. The facility's "Resident Rights" policy, dated 01/10/25, did not address the discharge process. The facility's "Admission, Transfer, and Discharge Policy" policy, dated 01/10/25, documented the facility would comply with regulations to protect residents' rights during discharge. At least 30 days advanced written notice would be provided, except in case of emergency situations, and would include reason, effective date, location, contact information for LTCO (Long Term Care Ombudsman) and SA (State Agency), and appeal rights. The policy did not document providing a written discharge summary, recapitulation of stay, or reconciliation of medications to the resident or residents' representatives.	F0628		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of	F0641		

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F0641 SS = E	Continued from page 9 that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to accurately complete the "Minimum Data Set" (MDS) for five residents: Resident (R) 7, and R4 related to personal alarms; R5 related to pressure ulcers and medications; R2 related to dental; and R25 related to nutrition. This deficient practice placed the affected residents at risk for impaired care due to unidentified care needs. Findings included: During an observation and interview on 08/19/25 at 01:23 PM, R7 reported she has had some falls and hit her head, which she needed staples sometime this past year. Observation revealed a bed and chair alarm in her room. R7's "Care Plan" in the Electronic Health Record (EHR) directed staff to provide a silent alarm on R7's bed and chair dated 09/11/24. R7's EHR recorded a "Quarterly MDS," dated 02/25/25, and an "Annual MDS," dated 05/27/25, which both lacked documentation of R7's bed and chair alarm in Section P. During an observation and interview on 08/19/25 at 01:39 PM, R4 sat in a recliner with her representative present. R4's representative pointed out the silent alarm under R4 and stated the alarm was utilized while R4 was in bed or in the recliner. R4's EHR recorded a	F0641		

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F0641 SS = E	Continued from page 10 “Care Plan” that noted staff provided a silent alarm on the bed and chair dated 04/20/25. R4’s EHR recorded a "Significant Change MDS," dated 07/17/25, which lacked documentation of R4’s bed alarm in Section P. During an interview on 08/20/25 at 05:25 PM, Certified Nurse Aide (CNA) T reported that R4 and R7 had a silent alarm on their bed and chair, and have had them for quite some time. During an interview on 08/21/25 at 12:00 PM, Administrative Nurse E confirmed both R4 and R7's comprehensive and quarterly assessments were coded incorrectly for alarms. R5’s Electronic Health Record (EHR) recorded a "Physician Order" for Remeron (an antidepressant used to treat mood disorders) 30 milligram (mg) tablet dated 11/24/21. R5's "Quarterly MDS," dated 07/17/25, lacked documentation of R5's antidepressant in Section N. R5’s EHR recorded a “Skin/Wound Note” dated 12/30/24, which documented a wound to the coccyx had healed. R5’s EHR recorded a “Skin/Wound Note” dated 01/06/25, 01/13/25, 01/20/25, 01/27/25, documented no skin issues noted. A “Progress Note” dated 02/01/25 at 02:36 PM documented the resident transferred to the hospital. The “Admission Skin Note” dated 02/04/25 at 03:08 PM, documented a Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) on the coccyx (area over the tailbone); the wound was healed prior to leaving the facility but present on readmission. R5's "Quarterly MDS," dated 07/17/25, incorrectly recorded the resident had one facility-acquired Stage 3 (full-thickness pressure injury extending through the skin into the tissue below). During an observation on 08/21/25 at 8:50 AM, R5 had a dressing noted on her coccyx during care. During an interview on 08/21/25 at 12:55 PM, Administrative Nurse D confirmed that R5’s pressure ulcer was healed in December of 2024, and when R5 was readmitted from the hospital in February 2025, the wound was open.	F0641		

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F0641 SS = E	Continued from page 11 During an interview on 08/21/25 at 01:20 PM, Administrative Nurse E confirmed R5's quarterly assessment dated 07/17/25 was coded incorrectly for antidepressant and facility-acquired pressure ulcer. - R2's Electronic Health record (EHR) recorded a "Progress Note" 03/04/25 at 11:10 AM, which documented R2's upper dentures and lower dentures were broken. R2's EHR recorded an "Admission Assessment" dated 03/04/25 at 12:33 PM, which documented R2 had upper dentures. R2's "Care Plan", revised 03/10/25, documented the resident had upper dentures and directed staff to provide a toothbrush and soak the dental device at night. The plan instructed staff to report changes, problems with gums, dental devices, or signs of pain such as grimacing while eating. The plan noted R2's lower dentures were lost prior to admission. R2's EHR recorded an "Admission MDS," dated 03/10/25, which lacked documentation in Section L of R2's edentulous (no natural teeth) status. During an interview on 08/19/25 at 9:16 AM, R2 reported she had been without a lower denture for six months; she reported she lost them at dinner at a restaurant. During an interview on 08/21/25 at 01:20 PM, Administrative Nurse E confirmed the admission assessment was coded incorrectly for R2's dental status. R25's Electronic Health record (EHR) recorded a "Physician Order" for a regular portion-regular diet with soft texture; ground meat or cut up in small pieces; always serve with gravy or sauces, dated 12/25/24. R25's "Care Plan", revised 12/25/24, instructed staff to offer the resident a regular diet with regular portions, soft texture (meat cut up in small pieces or ground meat texture with gravy or sauce). R25's "Annual MDS," dated 02/24/25, and "Quarterly MDS," dated 08/05/25, lacked documentation in Section K of R25's mechanically altered diet (require change in texture of food or liquids). During an observation on 08/19/25 at 01:54 PM, R25 sat in his recliner, drooling from his mouth. R25 wiped off his face and gurgled when he talked.	F0641		

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F0641 SS = E	Continued from page 12 During an interview on 08/21/25 at 01:20 PM, Administrative Nurse E confirmed R2's comprehensive and quarterly assessments were coded incorrectly for his mechanically altered diet. The facility did not provide a policy on accurate MDS.	F0641		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents, and one main kitchen. Based on observation, record review and interview the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria. This placed the residents at risk for food borne illnesses. Findings included: - Observation of the kitchen and food storage areas on 08/19/25 at 07:40 AM revealed the following areas of concern: Dry storage concerns:	F0812		

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F0812 SS = F	Continued from page 13 Four cases of soda cans and a 50-pound bag of sealed flour were stored on the floor. One unsealed bag of marshmallows. One bag of unsealed russet instant mashed potatoes. A large container of pinto beans that was not sealed with the lid all the way. Several bottles of spices with no date opened and no expiration date. Walk-In Cooler concerns: Several containers of caffeine and sunshine drink with straws in them, with initials TP and no date. Two bags of fresh broccoli unsealed, One bag of sliced onions unsealed. One box of Pizza Hut pizza, no date, no name. One unsealed bag of shredded cheese, One bowl of mixed fruit labeled “Joyce”, no date. Walk-in freezer concerns: One bag of unsealed biscuits, an unsealed waffle, and a bag of unsealed ground beef. A plastic storage container on the top shelf, no date, no label, looks like ice and noodles. Two free-standing refrigerators in the kitchen had one bag of unsealed roast beef and an open gallon of milk with no date when opened. During the second observation on 08/20/25 at 10:20 AM, revealed several cooking pans with black colored debris on the bottom of them; one frying pan was dented, and four cutting boards had several scratches noted over the surfaces. During an interview on 08/20/25 at 07:55 AM, Certified Dietary Manager (CDM) BB reported that some of the items in the fridge and freezer were staff food items and that they have stored those items in the fridge for over 30 years, and no one had ever had a concern with staff items in the fridge. CDM BB reported that the flour and soda pop should not have been placed on the floor and verified that it was delivered on 08/13/25.	F0812		

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F0812 SS = F	Continued from page 14 CDM BB said staff were expected to keep items off the floor. Additionally, CDM BB stated staff were expected to label all food items in the kitchen when opened, and all items should be properly sealed. During an interview on 08/20/25 at 10:30 AM, CDM BB reported she would have the pans and cutting boards replaced. During an interview on 08/20/25 at 01:00 PM, Administrative Staff A stated she expected all food items to be stored, sealed, labeled, and dated properly. Additionally, Administrative Staff A said she expected kitchen equipment to be in good working order. The facility's policy "Food Receiving and Storage" dated 10/2017 documented personal staff items and food storage. Employees may store their personal items in employee refrigerators or designated storage areas that follow sanitation and appropriate storage. Employee personal staff items may be stored in designated areas, including food storage areas, provided they are properly covered, clearly labeled with the staff member's name, and maintained in a sanitary manner. The facility's policy "Dietary Food Storage" dated 01/10/25 documented food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items taken out of original packaging will be labeled and stored in air-tight containers. The label must include the received by date and/or open date. The facility's policy "Food Handling & Preparation" dated 01/10/25 documented to maintain clean, organized kitchens and equipment.	F0812		
F0814 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 33 residents. Based on observations, interviews and record review, the facility failed to maintain and/or dispose of kitchen garbage and refuse properly. This placed facility residents at risk for insect or rodent infestation.	F0814		

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F0814 SS = F	Continued from page 15 Findings included: - During a tour of the kitchen on 08/19/25 at 07:40 AM, observation revealed three garbage cans with no lids on them. During an observation on 08/20/25 at 10:20 AM, the same three garbage cans were found with no lids in the kitchen. Certified Dietary Manager (CDM) BB reported that the garbage cans did have lids and pulled a lid out from behind a garbage can and placed it on the can next to the steamer counter. CDM BB reported that the garbage cans should be covered. During an observation on 08/20/25 at 11:25 AM, the garbage can that was approximately three feet away from the stove had no lid. Dietary Staff CC had just finished cooking hamburgers and reported that the garbage cans in the kitchen rarely had a lid placed on them. During an interview on 08/20/25 at 01:00 PM, Administrative Staff A reported she expected all the garbage cans to always have the proper lids on them in the kitchen. The facility's policy "Waste Disposal," revised on 10/10/24, states that all garbage will be disposed of daily and as needed throughout the day. Trash will be deposited into a sealed container outside the premises. The facility did not provide a policy on waste management.	F0814		
F0851 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care	F0851		

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F0851 SS = C	Continued from page 16 management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents. Based on interview and record review, the facility failed to	F0851		

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F0851 SS = C	Continued from page 17 submit complete and accurate staffing information to the Payroll-Based Journaling (PBJ) as required. Findings included: - Review of the PBJ Staffing Data Report for Fiscal Year (FY) 2024 Quarter (Q) 3 (April 1 – June 30) and FY 2024 Q4 (July 1 – September 30) revealed the facility did not have Licensed Nursing Coverage 24 hours a day on the following dates: 04/13/24, 04/28/24, 05/04/24, 05/05/24, 05/10/24, 05/11/24, 05/12/24, 05/25/24, 07/03/24, 07/07/24, 08/18/24, 09/22/24. Review of the facility's nursing schedule and payroll data for the above dates revealed the facility had 24-hour nursing coverage. During an interview on 08/20/25 at 04:00 PM, Consultant HH provided the nursing schedule and payroll data that revealed the time-keeping system had automatically removed a 30-minute lunch period for the above dates, even though the nurses remained in the building. The facility did not provide a policy related to PBJ reporting.	F0851		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F0880		

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F0880 SS = E	Continued from page 18 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880		

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F0880 SS = E	Continued from page 19 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents. The sample included 12 residents. Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to a Resident (R) 5 with a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure injury. The facility further failed to ensure adequate hand hygiene during personal care for R5 and R32 when staff failed to complete adequate hand hygiene. The facility failed to deliver food in a sanitary manner for several residents in the dining room. These deficient practices had the potential to spread infections to the residents in the facility. Findings included: - Observation on 08/20/25 at 05:49 PM, Certified Medication Aide (CMA) R delivered food to the resident's tables with thumbs touching the eating surface of the plate. Observation on 08/20/25 at 05:49 PM, Certified Nurse Aide (CNA) P delivered food to residents with thumbs touching the eating surface of the plates. Observation on 08/20/25 at 05:55 PM, CNA O delivered food to residents with thumbs touching the eating surface of the plates. Observation on 08/20/25 at 06:09 PM, CNA Q delivered plates of food to the residents with thumbs touching the eating surface of the plates. Observation on 08/21/25 at 08:50 AM, CNA S and CNA M provided peri-care care to R5. R5 had EBP signage and personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) located outside her room. Neither CNA donned a gown, but only wore gloves. CNA S removed her glove from her right hand in between the dirty and clean actions during peri-care provided and applied a new glove to her right hand without performing hand hygiene. CNA S and CNA M	F0880		

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F0880 SS = E	Continued from page 20 completed peri-care to R5, then removed their gloves. Both CNA applied a clean pair of gloves without performing hand hygiene first and proceeded to assist R32, R5's roommate, with peri-care. CNA S and CNA M transferred R32 back to her recliner from the shared bathroom. CNA S and CNA M then removed their gloves but did not perform hand hygiene. They exited the room. CNA M pushed the mechanical lift out of the room and down the hall. CNA M stopped at R1's room as the resident asked the CNA M to do a couple of things in her room. CNA M entered R1's room without performing hand hygiene, adjusted the thermometer, and moved some items in the room; then CNA M came out of the room and, without performing hand hygiene, continued to push the mechanical lift down the hall to the storage room. CNA M pushed the lift into the room and then performed hand hygiene. The mechanical lift was not cleaned off after use and before being placed in the common storage area. During an interview on 08/20/25 at 06:00 PM, Consultant Staff GG said he expected staff to keep their hands clear of the eating surface of plates since that was an infection control concern. He stated staff were provided education. During an interview on 08/21/25 at 09:10 AM, CNA S and CNA M reported they should have worn a gown when providing care to R5, and reported they normally washed their hands after care was provided. CNA M reported she normally wiped down the mechanical lift after each use. During an interview on 08/21/25 at 10:18 AM, Licensed Nurse (LN) G reported the staff should perform hand hygiene after removing gloves and between resident care provided. LN G said the mechanical lift should be sanitized after use, and confirmed the staff were required to wear gowns and gloves with EBP residents during the hands-on care. During an interview on 08/21/25 at 01:06 PM, Administrative Nurse D stated she expected staff to wear the required PPE for residents who have EBP. She stated she expected staff to complete hand hygiene when gloves were removed and between resident care. She said she expected staff to sanitize the shared equipment between residents. The facility's policy "Infection Control" dated 01/10/25, documented staff perform hand hygiene before and after direct contact with a resident and immediately after removing gloves. The facility's policy "Enhanced Barrier Precautions" dated 11/12/24, documented EBP were implemented as one	F0880		

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F0880 SS = E	Continued from page 21 intervention this facility uses to reduce transmission of resistant organisms that employs targeted PPE use during high contact resident care activities. The facility's policy "Food Handling & Preparation" dated 01/10/25, documented ensuring safe, nutritious, and palatable food service in compliance with federal and state requirements. Use tongs, scoops, or utensils—not bare hands—to prepare and serve food.	F0880		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents. Based on interview and record review the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program (IPCP). This failure has the potential to affect all 33 residents. Findings included: - During an interview on 08/19/25 at 07:50 AM, Administrative Staff A revealed she was the facility IP, and Administrative Nurse D assisted with the task. Administrative Staff A provided a certificate for	F0882		

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F0882 SS = F	Continued from page 22 completion of “Nursing Home Infection Prevention Training Course” dated 01/22/25. During an interview on 08/21/25 at 01:06 PM, Administrative Staff A reported she had a bachelor's degree in Aging Sociology but no health-related degrees. She confirmed she was the IP of the facility while Administrative Nurse D was taking the IP class to receive her certification. During an interview on 08/21/25 at 01:10 PM, Consultant Staff GG stated he thought any staff member could be the IP of the facility. The facility’s “Infection Control Policy” dated 01/10/2025, documented the IP was responsible for overseeing the infection control program, including but not limited to surveillance of infections, tracking and trending infections in the facility, and having primary training in nursing, medical technology, microbiology, epidemiology, or another related field.	F0882		