

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Willows of Shelbyville		STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S Miller St Shelbyville, IN 46176	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25054</p> <p>Based on interview and record review the facility failed to accurately document a resident's code status in the clinical record for 1 of 1 resident reviewed for advanced directives (Resident 40).</p> <p>Findings include:</p> <p>The clinical record for Resident 40 was reviewed on [DATE] at 12:02 p.m. The resident's Indiana physician orders for scope of treatment (POST) form, dated [DATE], indicated the resident was to receive Cardiopulmonary Resuscitation (CPR) in the event the resident had no pulse and was not breathing. The form was signed by Resident 40 and the physician. The physician recapitulation (recap) orders for Resident 40, dated ,d+[DATE], indicated the resident was not to be resuscitated in the event the resident had no pulse and was not breathing.</p> <p>Review of the record of Resident 40, on [DATE] at 1:44 p.m., indicated the diagnoses included, but were not limited to, cerebral palsy, hypertension, anxiety, anemia, atrial fibrillation, and major depressive disorder.</p> <p>During an interview with the Director of Nursing (DON) on [DATE] at 1:58 p.m., indicated Social Services had an ongoing binder with the POST forms. Medical records were responsible to ensure that the POST form and physician orders matched.</p> <p>During an interview with the Social Service Director on [DATE] at 2:02 p.m., indicated Social Services did not have an ongoing binder with residents' current code status.</p> <p>During an interview with the DON on [DATE] at 10:13 a.m., indicated what she believed happened was when Resident 40 was readmitted back to the facility, on [DATE], the floor nurse had the resident sign the POST form without explaining to him what it really meant.</p> <p>The communication of code status policy provided by the DON, on [DATE] at 10:15 a.m., indicated the facility would adhere to the resident's right to formulate advanced directives and the facility would implement procedures to communicate a resident's code status to those individuals who needed to know this information. The nurse who notates the physician order was responsible for documenting the directions in all relevant sections of the medical record. The Social Services Director shall maintain a list of residents who have Advanced Directives on file.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3XXX,d+[DATE](f)(4)(A)(ii) 3XXX,d+[DATE](f)(5) 3XXX,d+[DATE](f)(7)

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>45291</p> <p>Based on interview and record review, the facility failed to encode minimum data set (MDS) assessments accurately for 2 of 2 residents reviewed for MDS accuracy. (Resident 44 and Resident 53)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 44 was reviewed on 10/1/2024 at 11:00 a.m. The medical diagnoses included benign neoplasm of cerebral meninges (layers of membranous connective tissue that cover and protect the brain and spinal cord).</p> <p>A Quarterly MDS assessment, dated 9/4/2024, indicated Resident 44 had a six month or less life expectancy, but did not receive hospice services.</p> <p>A hospice plan of care, dated 6/20/2024, indicated Resident 44 was admitted to hospice on 7/31/2023.</p> <p>During an interview, on 10/1/2024 at 12:00 p.m., the MDS Coordinator indicated Resident 44 was admitted on hospice care, had received hospice services continuously since admission, and the, 9/4/2024, MDS assessment was coded inaccurately.</p> <p>2. The clinical record for Resident 53 was reviewed on 9/30/2024 at 1:03 p.m. The medical diagnoses included dementia.</p> <p>An Admission MDS assessment, dated 8/13/2024, indicated Resident 53 received an anticoagulant medication in the seven days prior to the admission reference date.</p> <p>The physician orders, provided by the facility on 10/1/2024 at 1:00 p.m., for Resident 53 did not include an order for anticoagulant medication.</p> <p>During an interview with the MDS Coordinator, on 10/1/2024 at 12:00 p.m., they indicated Resident 53 had not been on an anticoagulant during the review period of the Admission MDS assessment, on 8/13/2024, and the assessment was coded in error. The facility's expectation was to code the MDS assessments to the most recent standards set forth in the Resident Assessment Instrument Manual.</p> <p>A policy entitled, Conducting an Accurate Resident Assessment, was provided by the DON on 10/1/2024 at 1:00 p.m. The policy indicated, The purpose of this policy is to assure that all residents receive an accurate assessment .</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50436</p> <p>Based on interview and record review the facility failed to conduct care plan meetings for 1 of 4 residents reviewed for care plans. (Resident 10)</p> <p>Findings include:</p> <p>The clinical record for Resident 10 was reviewed on 9/30/24 at 11:02 a.m. The diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, and major depressive disorder.</p> <p>During an interview with Resident 10 on 9/26/24 at 12:17 p.m., indicated they did not recall having care plan meetings.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated Resident 10 was cognitively intact.</p> <p>The EHR (electronic health record) indicated Resident 10 had a comprehensive care plan meeting, on 12/14/23, with no further care plan meetings held until 7/1/24.</p> <p>During an interview with the Social Service Director (SSD) on 10/1/24 at 12:30 p.m., indicated he was unable to find where Resident 10 had a care plan meeting. The SSD indicated social services were responsible to set up care plan meetings and meetings were conducted quarterly and as needed.</p> <p>A Comprehensive Care Plan policy was provided by the Director of Nursing on 10/1/24 at 1:10 p.m. The policy indicated, . This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care) .10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan</p> <p>3.1-35(d)(2)(B)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36942</p> <p>Based on interview and record review, the facility failed to ensure neurological checks, that included vital signs, were fully conducted for a resident who experienced an unwitnessed fall for 1 of 4 residents reviewed for accidents. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 9/27/24 at 10:00 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, hypertension, anxiety, weakness, and repeated falls.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 5/24/24, indicated moderate cognitive impairment, impairment to one side of the lower extremity, and substantial/maximal assistance with bathing, toileting, and personal hygiene. Resident B had a history of falls prior to admission to the facility and one fall since admission to the facility.</p> <p>A fall care plan, last revised on 8/5/24, indicated Resident B had a history of falls and required assistance from at least one staff member for safe transfers. The interventions included, but were not limited to, observe for and report changes in mobility and/or range of motion.</p> <p>A health status note, dated 8/2/24 at 11:44 p.m., indicated the following, .Res [Resident B] fell in bathroom and QMA [qualified medication aide] found her on the floor. 2 skin tears received, one on left wrist and one on left leg. Cleaned, non-stick dressing applied and kerlix applied. Family and NP [Nurse Practitioner] notified</p> <p>A document, dated 8/2/24, indicated Resident B had an unwitnessed fall on 8/2/24 at 11:00 p.m. Resident B was laying on her left side with oxygen in place and was incontinent of bowel. There was a skin tear to the left wrist and the left leg. Resident B was documented as being alert to person only, had gait imbalance, and impaired memory. The family member and nurse practitioner were notified. The document was indicative as not being a part of the clinical record.</p> <p>The next consecutive health status note, dated 8/3/24 at 9:15 p.m., indicated the following, .Noted [sic; Noted] left arm and leg appears weaker. Left hand grip is good. Left leg with poor weight bearing. Denied pain/discomfort. Alert per baseline. Son poa [power of attorney] [name of POA] informed</p> <p>A fall follow up document, dated 8/3/24, indicated not applicable for documentation of physician and/or family notification, a head-to-toe assessment was completed, no new injury was discovered, and vital signs were documented, as obtained, on 8/3/24 at 9:14 p.m.</p> <p>A document titled Neuro Assessment, initiation date of 8/2/24, indicated neurological checks were being conducted after Resident B exhibited the fall on 8/2/24. The document indicated to conduct neurological checks every 15 minutes four times, every 30 minutes two times, every hour two times, every four hours five times, and every eight hours six times. The following was noted:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 8/3/24 at 6:45 p.m. included vital signs, pupil response, pain response, hand grasp, level of consciousness, and motor response,</p> <p>- 8/3/24 at 10:45 p.m. was left blank, and</p> <p>- 8/4/24 at 6:45 a.m. listed Resident B being at the hospital.</p> <p>A fall follow up document, dated 8/4/24, indicated to document physician and/or family notification was left blank, neurological checks continued, a head-to-toe assessment was completed, no new injury was discovered, and vital signs were documented, as the most recent, dated 8/3/24 at 9:14 p.m.</p> <p>There were no vital signs recorded for Resident B after 8/3/24 at 9:14 p.m., in the electronic health record.</p> <p>The next consecutive health status note, dated 8/4/24 at 8:25 a.m., indicated Resident B was sent to the hospital due to being unresponsive. The family and nurse practitioner were notified.</p> <p>A policy titled Fall Management, dated August 1, 2023, was provided by the Director of Nursing on 10/1/24 at 10:15 a.m. The policy indicated, .Post fall .A neurological assessment will be initiated on all un-witnessed falls and or resident with suspected head injuries every 15 minutes/x4 [times 4] = [equal] (1 hour), then every 30 min/x2 [every 30 minutes two times] = (1 hour), then every 1 hour x2 = (2 hour), then every 4 hours x 5, and lastly every 8 hours x 6 .This information will be found on (paper) Neuro Assessment .2. If there are no injuries, notify the physician during normal business hours .5. Fall follow up assessment will be completed and documented by licensed nurse every shift x 72 hours</p> <p>This citation relates to Complaint IN00444117.</p> <p>3.1-37(a)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>30344</p> <p>Based on observation, interview, and record review, the facility failed to redirect residents with wandering behaviors from other residents' rooms resulting in a lack of privacy for other residents for 5 of 8 residents reviewed for dementia care. (Residents 4, 22, 24, 27, 41, 157, 159)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 22 was reviewed on 10/1/24 at 1:10 p.m. The diagnoses included, but were not limited to, dementia. She resided on the memory care unit of the facility.</p> <p>The 6/16/24 care plan indicated she had alteration in mood and/or behavioral status related to depression, elopement risk, wanders, and history of hallucinations. Three of the five goals were for her to exhibit fewer episodes of physical/verbal behaviors toward others; to be accepting of redirection from triggered episodes of behavioral disturbances; and to be easily redirected and free from injury/adverse outcome related to wandering. Two of the interventions were to assist her with developing coping techniques that diminish/alleviate physical/verbal behaviors toward others and to redirect her from confrontational interactions as necessary. There was no intervention to intervene as necessary to protect the rights and safety of others.</p> <p>2. The clinical record for Resident 41 was reviewed on 10/1/24 at 1:08 p.m. The diagnoses included, but were not limited to, Alzheimer's disease and anxiety. She resided on the memory care unit of the facility.</p> <p>The 6/10/24 care plan, revised 8/29/24, indicated she had the behavior of intrusive wandering and taking things that did not belong to her. The goal was for her to decrease this behavior. One of the interventions was to intervene as necessary to protect the rights and safety of others; to approach/speak in a calm manner; divert attention; and remove from the situation and take to an alternate location as needed, effective 6/10/24. Another intervention was to provide a program of activities that was of interest and accommodated the resident's status, effective 8/29/24.</p> <p>3. The clinical record for Resident 27 was reviewed on 10/1/24 at 1:08 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder with delusions, and bipolar disorder. She resided on the memory care unit of the facility.</p> <p>The 6/10/24 care plan indicated she had the behavior of intrusive wandering in other residents' rooms and pushing objects/staff to get what she wanted. The goal was for her to have no evidence of behavior problems of intrusive wandering or pushing objects/staff to get what she wanted. One of the interventions was to intervene as necessary to protect the rights and safety of others; to approach/speak in a calm manner; divert attention; and remove from the situation and take to an alternate location as needed, effective 6/10/24. Another intervention was to provide a program of activities that was of interest and accommodated resident's status, effective 6/10/24</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation was conducted on 9/26/24 at 12:26 p.m., Resident 27 was wandering down the hallway and went into an empty room, where she fiddled with the bedside table and bed. No staff intervened to redirect her out of the room, and there were no structured activities on the unit at that time.</p> <p>On 9/26/24 at 12:04 p.m., an interview was conducted with Resident 157, who was admitted to the memory care unit of the facility, on 9/9/24, and her husband was in her room. There was no stop sign for Resident 157's doorway, and there were no structured activities occurring on the unit at that time. Her husband indicated there were two or three different female residents who came in Resident 157's room uninvited and went through her drawers. Some of Resident 157's things went missing. None of the residents were aggressive with Resident 157, that he knew of, but he worried about Resident 157 at night when he wasn't there, that one of them may come in and whack her.</p> <p>An interview was conducted with Resident 157 and her husband in her room on 10/1/24 at 12:10 p.m. There were no structured activities occurring on the unit at this time. Resident 157 indicated the residents who entered her room uninvited came in and out quickly. One, or two, of them would touch her things and it bothered her. Resident 157's husband described Resident 22 as one of the residents who came in Resident 157's room uninvited, at least 15 to 20 times over the past week. Staff did not intervene any of those times, as he was the one who would direct her out of the room, and staff never discussed use of a stop sign in the doorway with them.</p> <p>On 9/30/24 at 2:15 p.m., an interview and observation were conducted with Resident 159, who was admitted to the memory care unit of the facility, on 9/27/24, in her room. During this interview, Resident 22 came into the room holding a cup with a red liquid inside. Resident 22 was repeatedly making statements such as okay, gotta go, going home, excuse me, etc. After leaving the room, Resident 22 went into the room across the hall, then came back into Resident 159's room, but this time she no longer had the cup she was holding. She left the room a second time, then came back into the room a third time. The third time, Resident 22 walked over to Resident 159's bed, touched her pillows and bedspread, and moved things around on Resident 159's bedside table. No staff came to intervene during any of these observations. Resident 159 indicated Resident 22 coming into her room bothered her, because she didn't know her. She stated, Ain't that sad? It's always her, four to five times a day. I don't know what to say to her . just makes me nervous. There was no stop sign for Resident 159's doorway, and there were no structured activities occurring on the unit at that time.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) 5 on 9/30/24 at 1:55 p.m. She indicated she worked second shift starting at 2:00 p.m. and left at 10:30 p.m. Resident 27 sometimes wandered into other residents' rooms. When she did, LPN 5 tried to redirect her. LPN 5 turned on music, gave her a snack, or danced a bit. Staff tried to keep Resident 27 in the common area until after residents ate their meals.</p> <p>An interview was conducted with LPN 4 on 10/1/24 at 12:20 p.m. There were no structured activities occurring on the unit at that time. She indicated some of the more alert residents, like Resident 24 and Resident 4, have complained to her about residents coming into their rooms. If staff saw it, they took them out of the room and brought them to an activity or gave them a snack. They used stop signs in the past for a resident who no longer resided on the unit, and it helped some. It was usually Resident 22 and Resident 41 who went into other residents' rooms.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview and observation were conducted with LPN 4, on 10/1/24 at 1:21 p.m., at the nurse's station. During this interview, Resident 22 approached the nurse's desk and asked where to go, stated that she wanted to get going, and didn't know what to do. LPN 4 indicated they didn't currently have a regularly scheduled activity staff person for the unit. They used to have one, but they recently stopped working at the facility, so there were no routine activities scheduled right now. When there were activities, it was things like ball toss, balloon toss, or bubbles in the courtyard. Indoor activities were things like coloring, nails, bingo, card games, cooking activities, decorating cupcakes, etc. Resident 22, Resident 41, and Resident 27 would all participate, but Resident 22 was harder to stay focused.</p> <p>The Elopements and Wandering Residents policy was provided by the Director of Nursing (DON) on 10/1/24 at 10:15 a.m. It read, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering .c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.</p> <p>The Dementia Care policy was provided by the DON on 10/1/24 at 10:38 a.m. It read, 1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. 2. The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals 4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. 5. Individualized, non-pharmacological approaches to care will be utilized to include meaningful activities aimed at enhancing the resident's well-being.</p> <p>3.1-37(a)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30344</p> <p>Based on observation, interview, and record review, the facility failed to store food and silverware properly and wear hair restraints in the kitchen. This had the potential to affect 57 of 57 residents in the facility.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the DS (Dietary Supervisor) on 9/25/24 at 11:15 a.m. Interviews were conducted with the DS at that time.</p> <p>During the tour, an observation of the clean dish racks was made. The silverware was stored in a cylindrical container with the handles facing downward, instead of upward.</p> <p>During the tour, an observation of the dry storage room was made. Masking tape was used to keep an opened package of vanilla wafers, an opened package of vanilla milk shake thickener, and opened package of graham cracker crumbs sealed, but the tape was no longer sticking. There were three bottles of syrup on a rack with opened tops and no lids, exposing the syrup to air. The DS indicated the opened packages of vanilla wafers, graham cracker crumbs, vanilla milk shake thickener, and bottles of syrup with no lids could have saran wrap used to keep them sealed.</p> <p>During the tour, an observation of the walk-in cooler was made. There was an opened bag of celery on a shelf with the celery sticking out of the bag and resting directly on the shelf.</p> <p>During the tour, an observation of and interview with [NAME] 5 near the steam table was made. He just finished serving the lunch meal and was not wearing a beard cover over his beard. [NAME] 5 indicated he normally wore one, but he took it off, because they were done serving.</p> <p>During the tour, an observation of the stove hood was made. There was a large cobweb strung from the front of the stove hood to the back of the stove hood, and there was fuzzy debris hanging from the sprinkler heads. The DS indicated there was a company that was supposed to come to clean the stove hood, on 9/19/24, but they didn't come.</p> <p>During the tour, an observation of the food preparation counters in the back of the kitchen was made. There was debris hanging from the ceiling area surrounding a vent, over the food preparation counters. The ceiling light fixtures over the food preparation counters had a thick amount of debris on the ends of the light covers. Some of the light covers had dead insects resting in them. The DS indicated when they tried to clean the ceiling, parts of the ceiling would flake off. The DS was unsure about cleaning of the light fixtures.</p> <p>On 10/1/24 at 10:15 a.m., the Director of Nursing (DON) provided the Dietary Employee Cleanliness and Dress Code Policy. It read, Hair restraints shall be worn in a way that effectively keeps hair from contracting [sic] exposed food, clean equipment, utensils, linens and unwrapped single-use articles.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Willows of Shelbyville		STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S Miller St Shelbyville, IN 46176	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 10/1/24 at 10:15 a.m., the DON provided the General Storage Policy. It read, Dishes and Utensils 1.) Spoons, knives, and forks shall be stored in containers with handles upward.</p> <p>On 10/1/24 at 10:15 a.m., the DON provided the Cleaning Equipment Policy and Procedures. It read, Food Prep Areas/Dish Machine/3 Compartment Sink/All Counters/Garbage Disposal: All the areas listed above are to be kept free from dirt and germs.</p> <p>3.1-21(i)(3)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>30344</p> <p>Based on observation, interview, and record review, the facility failed to maintain the kitchen in a cleanly manner and in good repair for the potential to affect 57 of 57 residents in the facility.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the DS (Dietary Supervisor) on 9/25/24 at 11:15 a.m. Interviews were conducted with the DS at that time. The wall behind the ice chest was missing baseboard. There was a cracked wall corner cover by the handwashing sink. The dishwasher counter area had four missing tiles underneath it. There was one missing tile underneath the three-compartment sink. The dry storage room had a significant amount of dirt and debris, including macaroni, on the floor against the baseboards underneath the food storage racks. The baseboard under the racks was peeling away from the wall in the corner. There was a solidified brown liquid substance on the floor underneath one of the racks. The DS indicated the brown substance may have been from previous banana boxes. The walk-in cooler had spills all over the floor. The DS indicated one area on the floor may have been old rust with liquid over it. There were cracked and missing floor tiles underneath the steamer. There were three missing tiles directly in front of the back kitchen door.</p> <p>On 9/25/24 at 12:15 p.m., the DS provided the, August 2024 to present, weekly kitchen cleaning logs. The weekly cleaning logs for 8/28/24 to 9/3/24, 9/4/24 to 9/10/24, 9/11/24 to 9/17/24, and 9/18/24 to 9/24/24 were not signed off as having the following areas cleaned: walls and baseboards from the walk in cooler to around the back door; both prep tables in back area-bottom, wall, baseboard, drawers, and legs; the cook's help table on serving line; the walls and baseboards behind all dish carts on clean side of dish area; and the refrigerator/freezer next to the sink. The weekly kitchen cleaning logs for the first three weeks of August 2024 were missing.</p> <p>Cleaning Equipment Policy and Procedures were provided by the Director of Nursing on 10/1/24 at 10:15 a. m. It read, Walk-In Refrigerator .Floor is to be swept and mopped at least once a week. The racks are to be removed and the floors and walls scrubbed with sanitizing agent at least once a year .</p> <p>3.1-19(f)</p>		