STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Pittsburg	2520 S Rouse Street Pittsburg, KS 66762

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 29 residents with 14 residents selected for review, which included one resident reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide grooming for one Resident (R)5 in a manner of his choosing. Findings included: - Review of Resident (R) 5's medical record revealed diagnoses that included schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and pneumonia (inflammation of the lungs), due to SARS (severe acute respiratory syndrome) due to COVID. The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The resident had no impairment in upper or lower extremities but required set up assistance for personal hygiene. The Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 04/11/24, assessed R5 required partial assistance with hygiene due to illness. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of five, which indicated severe cognitive impairment. R5 had no impairment in upper or lower extremities and required substantial to maximal assistance with personal hygiene. The Care Plan reviewed 07/19/24, instructed staff R5's ability to perform ADL varied and staff advised to offer assistance for ADLs and daily shaving. Observation, on 09/17/24 at 04:42 PM, revealed the resident seated in his wheelchair in the dining room. R5 had several days worth of facial hair, overgrown sideburns and eyebrows, hair in his ears and nose, and fingernails approximately 1/4 inch in length. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 09/18/24 at 01:26 PM, revealed the R5 positioned in his bed. R5 had several days' worth of facial hair, overgrown sideburns and eyebrows, hair in his ears and nose, and fingernails approximately 1/4 inch in length. R5 stated he did not think his electric razor worked properly and he tried to use fingernail clippers but could not cut his fingernails. Interview with Certified Nurse's Aide (CNA) N, reported he needed assistance with grooming, and this was usually done on bath days, which were Sundays and Thursdays. Interview, on 09/18/24 at 02:53 PM, Social Service Staff X reported he was in the process of finding a beautician to provide grooming services to the resident and did not know when the last time the resident received grooming services. Social Service Staff X stated he would investigate the problem with R5's electric razor. Interview, on 09/19/24 at 08:30 AM, with Administrative Nurse D, revealed she would expect staff to provide grooming services to R5 per the standard of practice. The facility failed to provide a policy for grooming. The facility failed to provide grooming services for R5 who required assistance with personal hygiene which included facial hair removal and fingernail trimmings to maintain himself in a dignified manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 28560 The facility reported a census of 29 residents. Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike environment on four of five resident halls. Findings included: - During an environmental tour on 09/19/24 at 11:26 AM with Housekeeping/Maintenance Staff U, the following areas of concern were noted: 1. One resident room on the northeast hall had a strong urine odor. 2. A shower room on the northeast hall had rust around the drain and contained a large amount of loose hair. A clean linen cart, stored in the shower room and containing clean linen, was uncovered. The handrails on each side of the toilet were loose. 3. The beauty shop on the central hall had a large glob of cut hair in the drain of the sink. 4. The laundry room's handwashing sink contained dead bugs and small pieces of trash. 5. A shower room on the southeast hall had a toilet riser stored directly on the floor next to the toilet. The cove base underneath the handwashing sink was peeling from the floor and the wall leading into the shower corner was in poor repair with peeling and broken tile. On 09/19/24 at 11:30 AM, Maintenance/Housekeeping Staff U confirmed these areas of concern needed to be corrected. The facility policy for Housekeeping, Laundry and Maintenance, undated, included: The goals of Housekeeping and Maintenance are to follow accepted practices and procedures of good institutional housekeeping. The facility failed to maintain a clean, comfortable, and homelike environment on four of five resident halls for the residents of the facility. 34056 The facility reported a census of 29 residents. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable and homelike environment on four of five resident halls. Findings included: - During an environmental tour on 09/19/24 at 11:26 AM with Housekeeping/Maintenance Staff U, the following areas of concern were noted: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One resident room on the northeast hall had a strong urine odor. 2. The shower room on the northeast hall had rust around the drain and contianed a large amount of loose hair. A clean linen cart, stored in the shower room and containg clean linen, was uncovered. The handrails on each side of the toilet were loose. 3. The beauty shop on the central hall had a large glob of cut hair in the drain of the sink. 4. The laundry room's handwashing sink contained dead bugs and small pieces of trash. 5. A shower room on the southeast hall had a toilet riser resting directly on the floor next to the toilet. The covebase underneath the handwashing sink was peeling from the floor and the wall leading into the shower corner was in poor repair with peeling and broken tile. On 09/19/24 at 11:30 AM, Maintenance/Housekeeping Staff U confirmed these areas of concern needed to be corrected. The facility policy for Housekeeping, Laundry and Maintenance, undated, included: The goals of Housekeeping and Maintenance are to follow accepted practices and procedures of good institutional housekeeping. The facility failed to maintain a clean, cmfortable and homelike environment on four of five resident halls for the residents of the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 29 residents with 14 residents sampled for review. Based on observation, interview, and record review, the facility failed to complete an accurate Significant Change Minimum Data Set (MDS), dated [DATE], as required, for Resident (R)83, regarding falls. Findings included: - Review of Resident (R)83's electronic medical record (EMR) included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe impairment. The resident had no limitation in functional range of motion (ROM), used a wheelchair for mobility and had one non-injury fall and one injury (except major) fall since the prior assessment. The Fall Care Area Assessment (CAA), dated 01/25/24, lacked information regarding the resident's falls. The Modification of Significant Change MDS, dated [DATE], documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for mobility, had no limitation in ROM, and had two non-injury falls and one injury (except major) fall since the prior assessment. The care plan, revised 01/02/24, instructed staff the resident could be impulsive. Staff were to ensure his room was free from clutter and not leave him alone in the wheelchair while in his room. Staff were to ensure he wore geri-sleeves (a protective covering on his arms) to help prevent injuries. Review of the resident's EMR revealed multiple Fall Assessments which placed the resident at a high risk for falls, dated: 01/22/24, 01/07/24, 12/28/23 and 12/08/23. On 09/19/24 at 11:36 AM, Administrative Nurse D confirmed the falls CAA for this resident lacked fall information. The facility used the Resident Assessment Instrument (RAI) for the accurate completion of MDSs. The facility failed to complete an accurate Significant Change MDS, dated [DATE], for this resident with a history of falls.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 29 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to review and revise the care plan for one Resident (R)3, related skin tear prevention. This deficient practice placed R3 at risk for repeated skin tears. Findings included: - Review of Resident (R)3's undated Physician Orders, (POS) documentation included diagnoses of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) right hand, diabetes (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure), sleep apnea (absence of breathing during sleep), gout (inflammation of the joints) , anxiety disorder, (mental or emotional disorder characterized by reactions of apprehension, uncertainty and irrational fear), and pain. The Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The resident demonstrated verbal and physical behavioral symptoms directed towards others during the look back period. He had functional limitation in active range of motion of upper and lower extremities on both sides of his body. The resident reported almost constant pain. The clinical skin assessment identified the resident was at risk for pressure ulcer injury (PU) and was without identified skin treatments. He received anticoagulant (blood thinners) and opioids. (narcotic pain medication). The Quarterly MDS, dated [DATE], revealed changes which included a BIMS score of 09, indicating further decline in moderate cognitive impairment. He received application of nonsurgical dressings (with or without topical medications) other than to feet. The Functional Abilities and Mobility Care Area Assessment (CAA) dated 01/29/24, documentation included he had cerebral palsy. The resident was not ambulatory, (able to walk) and confined to his bed He was totally dependent on staff for his activities of daily living (ADLs) due to his contractures (abnormal permanent fixation of a joint or muscle) to upper and lower extremities. His finger/hand contractures put him at risk of spills of liquids/foods and used an adaptive cup for his coffee. The Care Plan dated 07/27/24, directed staff the resident required staff assistance with ADL's related to his physical limitations. He used two bilateral (both) position bars at the head of his bed (HOB) to assist with his bed mobility. He was at risk for skin breakdown and staff should encourage him to wear long sleeved shirts to help protect his arms from skin tears. The care plan included the following interventions, with corresponding initiation dates for interventions related the treatment and prevention of skin tears to the resident's arms: 1. On 01/21/2020, use caution with hand placement while transfers with full body lift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 03/02/23, the resident sits at a small table by himself in the dining room. The staff to assist the resident when leaving the dining room to remove him from the table to decrease the likelihood so of him scrapping his extremities against the table. 3. On 05/16/23, related to a small skin tear to his right forearm - offer arm protectors/long sleeves and if the resident refused, skin tear noted in a scarred area of his arm. The care plan lacked an intervention for treatment of a current left hand skin tear. Additionally, the care plan lacked an updated revision to interventions to prevent further skin tears to the resident's skin tear to the resident's arm and interventions to prevent further injuries to his arms. Review of R 3's Physician Orders dated 09/12/24 through 09/09/17/24, documentation revealed the resident lacked an order for a skin tear. Review of R3's Progress Note, dated 09/12/2024 at 6:14 PM, documentation included the resident was in the dining room. He had his left hand under the table, pulled his left hand out from under the table, and hit his left hand on the edge of the table. The skin tear measured 0.8 centimeters (cm) by 0.8 cm by 0.1 cm. The skin tear cleansed, and transparent dressing applied. On 09/17/24 at 01:37 PM, R3 laid in his bed on his right side that faced the window. He yelled out he wanted to be turned over to face the wall. The bed had bilateral grab bars at the head of the bed. He stuck his left arm through the grab bar on the right side of the bed. He had a red discolored area with scarring on his lower arms with a transparent adhesive dressing on his left lower arm. The dressing was dated 09/15/24. The edges of the wound were approximated six to seven inches with clotted brown blood approximately six to seven inches in length. Certified Nurse Aide (CNA) M entered the room and repositioned the resident towards the wall. On inquiry, she reported the resident had a table in the dining room where he sits alone, and he bumped his arm on the table and the facility changed his table. CNA M confirmed the care plan provided the staff with guidance on how to give care to the resident. Identified causes of injury should have an immediate intervention addressed in the care plan to prevent further injuries. On 09/18/24 at 01:45 PM, the resident sat in the wheelchair at the nurse's station. The left top of his right hand had a clear dressing dated 09/15/24. The left hand with red area with intermittent blue areas that extended approximately two inches above his wrist to the knuckles. Administrative Nurse E verified the date of the dressing as 09/15/24. On 09/19/24 at 11:12 AM, Administrative Nurse E confirmed the above findings. Upon review of the resident's electronic medical record (EMR) revealed the lack of a physician's order or on R3's Treatment Administration Record (TAR) for the existing skin tear. He reported the staff that identified the existence of the skin tear should have assessed the area to include measurements, initiated an immediate intervention to prevent further injury and updated the care pan to guide the staff in providing care to prevent further injury and promote healing. On 09/18/24 at 01:57 PM, CNA O reported the skin tear on his hand was due to hitting it on the dining room table and staff removed the table. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/24 at 09:02 AM, Administrative Nurse D stated when a resident received a skin tear, the nurse should assess and initiate an investigation to determine the cause and/or contributing factors. The immediate intervention should be implemented to prevent further injury. An intervention should be documented in the care plan. He hit his arm on the table which caused a skin tear, so staff turned the table around, but he continued to use the same table. She verified the facility failed to update the care plan to alert the staff of a change in resident care to prevent further skin care. On at 09/19/24 at 09:18 AM, CNA OO verified she saw the resident sustain the existing skin tear on his left hand. She reported the resident was in the dining room sitting at the old style 60s type table with metal trim around the edge of the table. She reported she attempted to obtain his blood pressure and he hit his hand under the table which caused a skin tear. On 09/19/24 at 11:19 AM, Administrative Nurse D verified a small table with the metal edge/trim remained in the dining room and should be removed to prevent injury to residents of the facility. She confirmed the resident had reoccurring skin tears due to the resident use of the table. The facility should have removed the table and communicated with the staff by updating the care plan. The facility policy Wound Prevention and Management, dated 2018, documentation included the staff develop interventions to providing guidelines for optimal care to promote healing for residents with all identified kin alteration. The plan of care will address problems, goals, and interventions directed towards prevention skin integrity concern. The facility failed to review and revise the care plan for one Resident (R)3, related skin tear prevention. This deficient practice placed R3 at risk for repeated skin tears.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 29 residents. The sample included 14 residents, with one resident sampled for skin condition, not related to pressure ulcer/injury. Based on observation, interview, and record review, The facility failed to ensure that Resident (R)3 received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices and provide adequate treatment and monitoring of one cognitively impaired, dependent resident's skin condition, to ensure resolution of multiple reoccurring skin areas and prevention of further injury. Findings included: - Review of Resident (R)3's undated Physician Orders, (POS) documentation included diagnoses of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) right hand, diabetes (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure), sleep apnea (absence of breathing during sleep), gout (inflammation of the joints) , anxiety disorder, (mental or emotional disorder characterized by reactions of apprehension, uncertainty and irrational fear), and pain. The Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The resident demonstrated verbal and physical behavioral symptoms directed towards others during the look back period. He had functional limitation in active range of motion of upper and lower extremities on both sides of his body. The resident reported almost constant pain. The clinical skin assessment identified the resident was at risk for pressure ulcer injury (PU) and was without identified skin treatments. He received anticoagulant (blood thinners) and opioids. (narcotic pain medication). The Quarterly MDS, dated [DATE], revealed changes which included a BIMS score of 09, indicating further decline in moderate cognitive impairment. He received application of nonsurgical dressings (with or without topical medications) other than to feet. The Functional Abilities and Mobility Care Area Assessment (CAA) dated 01/29/24, documentation included he had cerebral palsy. The resident was not ambulatory, (able to walk) and confined to his bed He was totally dependent on staff for his activities of daily living (ADLs) due to his contractures (abnormal permanent fixation of a joint or muscle) to upper and lower extremities. His finger/hand contractures put him at risk of spills of liquids/foods and used an adaptive cup for his coffee. The Care Plan dated 07/27/24, directed staff the resident required staff assistance with ADL's related to his physical limitations. He used two bilateral (both) position bars at the head of his bed (HOB) to assist with his bed mobility. He was at risk for skin breakdown and staff should encourage him to wear long sleeved shirts to help protect his arms from skin tears. The care plan included the following interventions, with corresponding initiation dates for interventions related the treatment and prevention of skin tears to the resident's arms: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 01/21/2020, use caution with hand placement while transfers with full body lift. 2. On 03/02/23, the resident sits at a small table by himself in the dining room. The staff to assist the resident when leaving the dining room to remove him from the table to decrease the likelihood so of him scrapping his extremities against the table. 3. On 05/16/23, related to a small skin tear to his right forearm - offer arm protectors/long sleeves and if the resident refused, skin tear noted in a scarred area of his arm. The care plan lacked an intervention for treatment of a current left hand skin tear observed. Additionally, the care plan lacked an updated revision to interventions to prevent further skin tears to the resident's skin tear to the resident's arm and interventions to prevent further injuries to his arms. Review of R 3's Physician Orders dated 09/12/24 through 09/09/17/24, documentation revealed the resident lacked an order for a skin tear. Review of R3's Progress Note, dated 09/12/2024 at 6:14 PM, documentation included the resident was in the dining room. He had his left hand under the table, pulled his left hand out from under the table, and hit his left hand on the edge of the table. The skin tear measured 0.8 centimeters (cm) by 0.8 cm by 0.1 cm. The skin tear cleansed, and transparent dressing applied. On 09/17/24 at 01:37 PM, R3 laid in his bed on his right side that faced the window. He yelled out he wanted to be turned over to face the wall. The bed had bilateral grab bars at the head of the bed. He stuck his left arm through the grab bar on the right side of the bed. He had a red discolored area with scarring on his lower arms with a transparent adhesive dressing on his left lower arm. The dressing was dated 09/15/24. The edges of the wound were approximated six to seven inches with clotted brown blood approximately six to seven inches in length. Certified Nurse Aide (CNA) M entered the room and repositioned the resident towards the wall. On inquiry, she reported the resident had a table in the dining room where he sits alone, and he bumped his arm on the table and the facility changed his table. CNA M confirmed the care plan provided the staff with guidance on how to give care to the resident. Identified causes of injury should have an immediate intervention addressed in the care plan to prevent further injuries. On 09/18/24 at 01:45 PM, the resident sat in the wheelchair at the nurse's station. The left top of his right hand had a clear dressing dated 09/15/24. The left hand with red area with intermittent blue areas that extended approximately two inches above his wrist to the knuckles. Administrative Nurse E verified the date of the dressing as 09/15/24. On 09/19/24 at 11:12 AM, Administrative Nurse E confirmed the above findings. Upon review of the resident's electronic medical record (EMR) revealed the lack of a physician's order or on R3's Treatment Administration Record (TAR) for the existing skin tear. He reported the staff that identified the existence of the skin tear should have assessed the area to include measurements, initiated an immediate intervention to prevent further injury and updated the care pan to guide the staff in providing care to prevent further injury and promote healing. Administrative Nurse E stated the staff failed to provide the expected care and follow-up related to the resident with repeated skin tears as they should. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 01:57 PM, CNA O reported the skin tear on his hand was due to hitting it on the dining room table and staff removed the table. On 09/19/24 at 09:02 AM, Administrative Nurse D stated when a resident received a skin tear, the nurse should assess and initiate an investigation to determine the cause and/or contributing factors. The immediate intervention should be implemented to prevent further injury. The physician should be notified, and the Nurse should put an order in the EMR, open a risk event, then determine a root cause. Staff reported the dining room had a metal strip underneath and he hit his hand on it. An intervention should be documented in the care plan. He hit his arm on the table which caused a skin tear, so staff turned the table around, but he continued to use the same table. She verified the facility failed to update the care plan to alert the staff of a change in resident care to prevent further skin care. On at 09/19/24 09:18 AM, CNA OO verified she saw the resident sustain the existing skin tear on his left hand. She reported the resident was in the dining room sitting at the old style 60s type table with metal trim around the edge of the table. She reported she attempted to obtain his blood pressure and he hit his hand under the table which caused a skin tear. On 09/19/24 at 11:19 AM, Administrative Nurse D verified a small table with the metal edge/trim remained in the dining room and should be removed to prevent injury to residents of the facility. She confirmed the resident had reoccurring skin tears due to the resident use of the table. The facility should have removed the table and communicated with the staff by updating the care plan. Administrative Nurse D reported the nurse should have put an order in for treating the skin tear to make nursing staff was aware of the treatment and follow-up care. The facility policy Wound Prevention and Management, dated 2018, documentation included the staff develop interventions to providing guidelines for optimal care to promote healing for residents with all identified kin alteration. The plan of care will address problems, goals, and interventions directed towards prevention skin integrity concern. The facility failed to ensure R3 received treatment and care to provide adequate treatment and monitoring of one cognitively impaired, dependent resident's skin condition, to ensure resolution of multiple reoccurring skin areas and prevention of further injury.

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NAME OF PROVIDER OR SUPPLIER Medicalodges Pittsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 S Rouse Street Pittsburg, KS 66762	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 29 residents with 14 residents selected for review which included one resident reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a safe and secure environment to prevent the elopement (when a cognitive impaired resident leaves the facility without the knowledge or supervision of staff) of cognitively impaired Resident (R)31. On 08/29/24 at 10:05 AM, R31, who the facility assessed as at high elopement risk, had dementia and poor safety awareness, exited the facility unsupervised and without staff knowledge. R31 ambulated approximately 248 feet, across a lawn, two parking lots, and a two-way egress street, to arrive at a dentist office. The staff from the dentist office phoned the facility at 10:15 AM to inquire if R31 was a resident of the facility. This deficient practice placed this resident in immediate jeopardy. Findings included: - Review of Resident (R)31's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and major depressive disorder (major mood disorder with severe psychotic symptoms (any major mental disorder characterized by a gross impairment in reality testing). The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS documented the resident had continuous inattention and disorganized thinking and verbal behaviors directed toward others. The MDS included R133 wandered daily which put the resident at risk for wandering into potentially dangerous places. The resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression). The Falls Care Area Assessment (CAA), dated 11/27/23, assessed the resident with dementia (progressive mental disorder characterized by failing memory, confusion) and impaired cognition which put him at risk for falls and injury. The resident had wandering behaviors and inattention and difficulty following verbal commands with impairment to recall and communication. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of 00, with fluctuating inattention, and disorganized thinking and daily wandering. The Quarterly MDS dated [DATE], assessed the resident with daily wandering and continuous inattention and disorganized thinking. The Care Plan reviewed 05/30/24, instructed staff to evaluate the resident for exit seeking behaviors and determine the resident needs (looking for bathroom, hunger, boredom), redirect him from exit seeking behavior, and place the resident on safety checks if needed. Staff were to encourage the resident to attend activities to keep busy and review behaviors to determine triggers for exit seeking behavior. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Clinical Health Review dated 11/21/23, assessed the resident with an elopement score of 24 (a score over 13 indicated high risk). The Clinical Health Review dated 05/22/24, assessed the resident with an elopement score of 13. The Clinical Health Review dated 08/24/24, assessed the resident with an elopement score of 21. On 08/29/24 at 10:15 AM, a Nurse's Note revealed Licensed Nurse (LN) G received a phone call from a dentist office to inquire if the facility had a missing resident and described the resident. LN G instructed staff to start a building search and LN G went to the dentist office and brought the resident back to the facility. LN G evaluated the resident and found no injury. LN G instructed maintenance staff to check the doors and alarms. Wunderground.com documented the temperature on 08/29/24 at 10:05 AM was 88 degrees Fahrenheit with no precipitation and approximately nine mile per hour wind speed from the south. During an observation of the area on 09/17/24 at 09:30 AM, revealed all doors which would have included the exit door R133 possibly exited from, revealed R31 would have to walk across lawns, two parking lots and a two-way egress street to reach the dentist office. The facility is bordered on two sides by four lane roads with a 35 mph (mile per hour) speed limit. During an interview on 09/17/24 at 09:00 AM, CNA O stated the resident would wander about the facility but never exited the door, prior. CNA O stated the resident often sat in a recliner near the front door. During an interview on 09/17/24 at 08:30 AM, LN G revealed staff did not know which door the resident exited, as no alarm sounded. LN G stated R31 often went to exit doors and looked out, but never had left the facility. LN G stated the exit doors have a touch pad key code and alarm when held open. LN G stated she did not hear an alarm go off when R31 exited the building and Certified Nurse Aide (CNA) N reported she saw the resident seated in the recliner near the front door at approximately 10:05 AM. During an interview on 09/17/24 at 08:00 AM, Maintenance Staff U revealed he checked all the facility exit doors on 08/29/24. Maintenance Staff U found the alarm on the exit door, by the staff break room, alarmed after approximately one minute of opening. This door led to a patio area where staff smoked, and staff used the exit to take trash out to a dumpster. The adjacent area contained grass, and eventually a parking lot. Maintenance Staff U stated the other doors alarmed after approximately 15-30 seconds upon opening and functional checks were performed weekly. Maintenance Staff U stated on 08/29/24 after the elopement, the door alarm company inspected all the doors to ensure they were working properly and set the doors with a 5 to 15-second alarm time upon opening. Maintenance Staff U stated signs were posted to ensure the door closed completely upon exiting the facility. During an interview on 09/17/24 at 08:30 AM, Administrative Nurse D revealed the resident probably exited the building from the door by the back patio, which maintenance found had an approximate one-minute delay in the alarm sounding. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The facility Resident Elopement Policy and Procedure revised 12/2022, instructed staff to identify residents at risk and develop an individualized care plan based on the risk. Staff were to investigate and report instances of potential elopement and have a process to monitor security of the premises on a routine basis.

The facility failed to ensure R31 remained free of accident hazards when the resident exited the facility, walked approximately 248 feet, across two parking lots and a two-lane egress street, in 88-degree Fahrenheit weather. The facility did not know the resident exited the building for approximately 10 minutes, when a dentist office notified the facility of the presence of R133 in their office.

On 09/17/24 at 05:52 PM, Administrative Staff A was provided a copy of the immediate jeopardy (IJ) template and informed the failure to ensure the safety of R31 when he left the facility, unsupervised and without staff knowledge, placed R31 in immediate jeopardy.

The immediate jeopardy first existed on 08/29/24 at 10:15 AM, when R 31 left the facility unsupervised and without staff knowledge.

The facility identified and implemented the following corrective actions following R31's return to the facility:

On 08/29/24 at 10:30 AM, LN G completed a full body assessment of R31 upon return to facility.

On 08/29/24 at 10:30 AM, resident placed on 1:1 (one staff assigned to monitor the resident continuously) monitoring for the remainder of the investigation.

On 08/29/24, maintenance and door alarm company provide door alarm testing.

On 08/29/24, LN G notified R31's responsible party and his physician of his elopement.

On 08/29/24 at 02:44 PM, Administrative Nurse D documented an alert in the electronic software of any care plan changes.

On 08/29/24 at 02:45 PM, Administrative Nurse D notified the State Agency via email of the elopement.

On 08/29/24, Administrative Nurse D reviewed the Medication Administration Record and progress notes 24-72 hours that led up to R31 leaving unsupervised and without staff knowledge, to determine if other risk factors were present.

On 08/29/24 at 04:00 PM, Administrative Nurse D reviewed all residents for elopement risk, for accuracy, and updated the elopement book and care plans as needed.

On 08/29/24, the facility provided Mandatory Elopement Policy training to all staff.

On 09/03/24, Quality Assurance Performance Improvement (QAPI) meeting held with the medical director regarding the elopement.

On 09/03/24 at 02:00 PM, all staff completed the mandatory Elopement Policy Training.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor validated the implementation of the above corrective measures completed on 09/03/24 at 02:00 PM, prior to entrance of the Health Resurvey. Therefore, the deficient practice was deemed past noncompliance at a J scope and severity.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 28560 The facility reported a census of 29 residents. Based on interview and record review, the facility failed to provide annual performance reviews for certified nurse aides and certified medication aides as required. Findings included: - Review of the Certified Nurse Aide (CNA)/Certified Medication Aide (CMA) employee records revealed the following areas of concern: CNA Q employee record revealed a hire date of 06/08/23 and lacked a signed evaluation. CNA O employee record revealed a hire date of 03/14/23 and lacked a signed evaluation. CNA/CMA NN employee record revealed a hire date of 08/24/06 and lacked an evaluation. CNA P employee record revealed a hire date of 08/18/1999 and lacked an evaluation. CNA MM employee record revealed a hire date of 01/12/23 and lacked an evaluation. Interview, on 09/19/24 at 08:30 AM, with Administrative Nurse D, confirmed the above and stated she would have expected annual evaluations on each certified staff member to be completed in a timely manner and at least annually. The facility did not provide a policy for completion of annual evaluations. The facility failed to ensure certified nursing staff received annual evaluations to ensure competency and identification of training needs as required.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 28560 The facility reported a census of 29 residents. Based on interview and record review, the facility failed to complete the Daily Staff Posting to include the total and actual hours worked by direct care staff as required. Findings included: - Review of the Daily Staffing Sheet dated 09/12/24 through 09/18/24, revealed lack of actual hours worked for licensed and certified nursing staff. Interview, on 09/19/24 at 12:33 PM, with Business Office Staff EE, revealed she logged the actual hour worked from the time clock and posted it on a Daily Staff Posting. Business Office Staff EE stated this had not been done since 06/11/24. Interview on 09/19/24 at 01:00 PM, with Administrative Nurse D, revealed she fills in the Daily Staffing sheet to ensure adequate staff, but the business office filled in the actual hours worked based on the time clock. The facility's Benefits Improvement Protection Act (BIPA) Nurse Staff Posting revised 12-2019, instructed the charge nurse for the shift was to fill in the total hours worked on the shift at the end of the shift. The business office personnel were to verify and record the actual hours worked utilizing payroll data. The facility failed to calculate the total and actual hours worked by direct care staff on the Daily Staffing Sheet and/or on the Daily Staff Posting as required.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 29 residents with 14 residents sampled, including five residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to monitor one Resident (R)11 for use of antipsychotic medications (drugs used to treat psychosis-related conditions and symptoms). Findings included: - Review of Resident (R)11's electronic medical record (EMR) revealed a diagnosis of schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. He received antipsychotic medication (drugs used to treat psychosis-related conditions and symptoms) during the assessment period. The Psychotropic Drug Care Area Assessment (CAA), dated 01/11/24, documented the resident received antipsychotic medications daily. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 14, indicating intact cognition. He received antipsychotic medications during the assessment period. The care plan, revised 06/13/24, instructed staff the resident received antipsychotic medications. Review of the resident's EMR, revealed the following Dyskinesia Identification System scores (DISCUS-an assessment tool that monitors for tardive dyskinesia (TD-an involuntary movement disorder) in residents who take antipsychotic medications) which revealed a score of zero, indicating no involuntary movements: 09/17/24, 01/10/24 and 10/10/23. Review of the resident's EMR, revealed the following physician's order: Risperidone (an antipsychotic medication), 1 milligram (mg), by mouth (po), twice daily (BID), for schizophrenia, ordered 08/06/24. Review of the resident's EMR revealed the following recommendations made by Consultant Staff GG: On 05/13/24, Consultant Staff GG made a recommendation for the facility to complete a DISCUS (a tool used to evaluate the severity of dyskinesia [inability to execute voluntary movements]) assessment at least Q six months, due to the resident's use of antipsychotic medication. Consultant Staff GG documented the facility last completed a DISCUS assessment on 01/10/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/13/24, Consultant Staff GG made a recommendation for the facility to complete a DISCUS assessment at least every (Q) six months, due to the resident's use of antipsychotic medication. Consultant Staff GG documented the facility last completed a DISCUS assessment on 01/10/24. On 09/19/24 at 11:36 AM, Administrative Nurse D stated she was currently working on Consultant Staff GG's recommendations. Admistrative Nurse D confirmed staff should complete the DISCUS assessments every six months and the resident had not had one completed for over eight months. The facility lacked a policy regarding the completion of DISCUS assessments. The facility failed to monitor this resident, who received antipsychotic medications, for use of his antipsychotic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36881 The facility reported a census of 29 residents. Based on observation, interview, and record review, the facility failed to prepare, store, and serve food under sanitary conditions, to the residents of the facility. Findings Included: - During a facility tour on 09/19/24 at 09:59 AM, with Administrative Staff A, revealed the following concerns in the ice room: 1. The wood shelving unit utilized to stack dishes and glasses with loose chunks of dirt on the shelves where plates and glasses were stored upside down in direct contact with the shelving. On 09/19/24 at 10:00 AM, Administrative Staff A confirmed the above findings and verified the ice machine/storage room needed housekeeping and maintenance to clean and repair the room to ensure a safe and sanitary environment for residents and staff of the facility. He reported he was not aware of who was responsible for the cleaning and if the dishes and/or glasses were utilized for food service. He verified the ice room was where staff provided ice for the residents of the facility. On 09/19/24 at 10:10 AM, Dietary staff BB reported she thought housekeeping was responsible for cleaning the ice room, the dietary staff do not clean or maintain that area. She stated the kitchen and nursing staff get ice for the residents and staff from the ice room and dietary staff often use plates and glasses stored for holiday dinners as does activities staff. The facility stored excess dishware in the ice machine room. On 09/19/24 at 10:15 AM, Housekeeping staff W stated dietary staff was responsible for the cleaning of the ice machine room and was not on the housekeeping cleaning schedule. Additionally, on 09/19/24 at 11:20, the following concerns were identified during the environmental tour with Housekeeping Staff V and Maintenance staff U: 1. An opened box of 1000 foam cups stored directly on the floor of the southeast storage room. 2. An opened box of 1000 Hot/cold insulated bowls stored directly on the floor of the southeast storage room. 3. An opened box of 1000 cup lids stored directly on the floor of the southeast storage room. On 09/19/24 at 11:20 AM, Maintenance Staff U reported dietary staff should store supplies used for food service off the floor on appropriate racks to ensure sanitary conditions for food service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/19/24 at 11:37 AM, Dietary staff BB verified the above findings. She reported the shipment of dietary supplies arrived the previous day and the dietary staff tried to get the supplies out of the kitchen. She stated the staff should have stored the boxes of plates, cups, and lids on racks to maintain sanitation for the use with food service. The undated facility policy Dietary Services lacked address of storage for dietary supplies and dishware to ensure sanitary food service. The facility failed to prepare, store, and serve food under sanitary conditions, to the residents of the facility.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 28560 The facility reported a census of 29 residents. Based on interview and record review, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on four dates between 07/01/23 and 09/30/23, and six dates between 10/01/23 and 12/31/23. Findings Included: - Review of the Payroll Base Journal (PBJ) Staffing Data Report for Fiscal year (FY), Quarter 4, 2023 (07/01/23 and 09/30/23) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates: On 07/01/23 , Saturday (SA), On 07/15/23, SA, On 07/30/23, Sunday (SU), On 07/31/23, Monday (MO), Review of the Payroll Base Journal (PBJ) Staffing Data Report for Fiscal year (FY), Quarter 1, 2024 (10/01/23 and 12/31/23) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates: On 10/13/23, Friday (FR), On 11/25/23, Saturday (SA), On 12/03/23, Sunday (SU), On 12/14/23, Thursday, (TH), On 12/27/23, Wednesday, (WE), and On 12/31/23, SU, On 09/19/24 at 01:41 PM, interview with Administrative Nurse D revealed as far as she knew, the PBJ was submitted correctly and stated the facility had 24-hour licensed nurse coverage and did not know why the PBJ indicated the above dates in question. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy for Benefits Improvement Protection Act (BIPA) Nurse Staff Posting, revised 12-2019, instructed staff to post the actual hours worked for licensed and unlicensed nursing staff. The facility lacked a policy for submission of the PBJ to CMS. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., Payroll Base Journal (PBJ), related to licensed nursing staffing information when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on four dates between 07/01/23 and 09/30/23 and six dates between 10/01/23 and 12/31/23.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 28560 The facility reported a census of 29 residents. Based on interview and record review, the facility failed to track and trend infections to prevent the spread of infections amongst the residents. Findings included: - Review of the Infection Control logbook, revealed the tab for August 2024 and September 2024 lacked data. The Tab for June 2024 contained documentation's of two wound infections, three urinary tract infections and two oral infections. The logbook lacked culture reports to determine causative organisms for the infections. Interview, on 08/18/24 at 02:30 PM, with Administrative Nurse E, revealed he documented the infections on the facility on a map of the resident rooms to determine trends by type of infections. He stated the facility did have an electronic monitoring program but did not know the components of the program or how to load the data. Administrative Nurse E stated the facility experienced a COVID outbreak in July 2024, when four residents tested positive for COVID, and then staff developed COVID also. The facility had no cases of COVID at this time. Interview, on 09/19/24 at 09:00 AM, with Administrative Nurse D revealed she would expect the staff to track and trend infections in the facility and utilize the electronic data collection tool in the facility system. The facility policy Antibiotic Use Protocol, dated 11/2023 and Antibiotic Stewardship instructed staff to monitor for infections and provide the necessary instruction to staff for management of residents with infections. The facility failed to monitor infections in the facility to determine trends in causative organisms and types of infections to prevent the spread of infections.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Medicalodges Pittsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 S Rouse Street Pittsburg, KS 66762	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 28560 The facility reported a census of 29 residents. Based on interview and record review, the facility failed to ensure staff adhered to the principles of antibiotic stewardship through monitoring for the appropriate use of antibiotics prescribed for residents to prevent antibiotic resistance and spread of multidrug resistant organisms within the facility. Findings included: - A physician's order, dated 07/26/24, instructed staff to administer to Resident (R)5 Cefdinir (an antibiotic that treats a wide range of bacteria) 300 milligrams, (mg) twice a day for five days for Health Maintenance. Interview, on 08/18/24 at 02:30 PM, with Administrative Nurse E, revealed he lacked training in the facility's computerized infection monitoring system. Interview, on 09/18/24 at 12:43 PM, with Administrative Nurse D, revealed the R5 had COVID in July 2024, and was in acute care for pneumonia and subsequently returned to the facility with the order for the antibiotic. Administrative Nurse D confirmed the lack of completion of the computerized infection monitoring system and lack of antibiotic stewardship for the residents of the facility. The facility policy Antibiotic Use Protocol, dated 11/2023 and Antibiotic Stewardship dated 11/23, instructed staff to monitor for infections and provide the necessary instruction to staff for management of residents with infections. Staff to monitor antibiotic use in the facility. The facility failed to provide ongoing antibiotic stewardship to ensure appropriate antibiotic use for the residents of the facility to prevent antibiotic resistance and the spread of multi drug resistant organisms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36881 The facility reported a census of 29 residents. Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary environment for residents and staff of the facility. Findings included: - During facility tour on 09/19/24 at 09:59 AM, with Administrative Staff A revealed the following concerns in the ice room: 1. The floor covered with black grime build up at the entrance directly in front of the ice machine, throughout the floor. 2. The wood shelving unit utilized to stack dishes and glasses with loose chunks of dirt on the shelves where plates and glasses were stored upside down in direct contact with the shelving. 3. Used crumpled paper towels laid directly on the floor. 4. The walls had missing paint on the edges of the wall. 5. The floor was unsanitizable due to missing paint/sealant directly in front of the ice machine. On 09/19/24 at 10:00 AM, Administrative Staff A confirmed the above findings and verified the ice machine/storage room needed housekeeping and maintenance to clean and repair the room to ensure a safe and sanitary environment for residents and staff of the facility. He reported he was not aware of who was responsible for the cleaning and repair of the ice room/storage area as there were multiple new staff additions in each. On 09/19/24 at 10:10 AM, Dietary staff BB reported she thought housekeeping was responsible for cleaning the ice room, the dietary staff do not clean or maintain that area. She stated the kitchen and nursing staff get ice for the residents and staff from the ice room and dietary staff often use plates and glasses stored for holiday dinners as does activities. Additionally, the facility stored excess dishware in the ice machine room. On 09/19/24 at 10:15 AM, Housekeeping staff W stated the dietary staff was responsible for the cleaning of the ice machine room and was not on the housekeeping cleaning schedule. The facility lacked a policy to address the maintenance and cleaning of the ice machine/storage room. The facility failed to ensure a safe and sanitary environment for residents and staff of the facility.