STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175201	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downs Care and Rehab	1218 Kansas Street Downs, KS 67437

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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. 27168 The facility had a census of 40 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to provide a clean, homelike environment when staff failed to clean the dining chairs in the dining room. This placed the residents who ate meals in the dining room at risk for impaired comfort and decreased quality of life. Findings included: - On 07/29/24 at 11:30 AM, the dining observation of the lunch meal in the main dining room included nine dining tables with 14 maroon cloth chairs, and the second dining room had two round tables and three square tables with nine maroon cloth chairs. Further observation revealed all of the chairs in both dining rooms had numerous areas of what appeared to be a liquid blackish-brown stain on the seats. They appeared unclean and dirty. On 07/31/24 at 10:30 AM, Housekeeper U verified he used a shampooer every other week to clean and deodorize the chairs but stated it did not remove the stains due to the age of the chairs. On 07/31/24 at 02:00 PM, Administrative Staff A verified housekeeping staff were to clean the dining room chairs and verified the chairs were stained and appeared unclean. Administrative Staff A stated the facility was aware of the stains and dirty-looking chair seats and said staff had tried to clean them. Administrative Staff A stated the facility was looking into getting the chairs reupholstered, but staff had not done so at that time and did not have a date to have the work completed. The facility's Safe, Clean, Comfortable, Homelike Environment, policy, dated, 09/2024, documented the residents have the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. The facility failed to provide a homelike dining experience for residents who ate meals in the dining room, by having unclean and soiled dining room chairs. This placed the residents who ate meals in the dining room at risk for impaired comfort and decreased quality of life.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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** 32358 The facility had a census of 40 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to revise one sampled resident's care plan to include guidance to staff regarding Resident (R) 25 exiting the building without staff supervision. This placed R25 at risk for impaired care due to uncommunicated care needs. Findings included: - R25's Electronic Medical Record (EMR) documented that R25 had diagnoses of attention-deficit hyperactivity disorder (ADHD-ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R25's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R25 was independent with most activities of daily living (ADLs). He required staff supervision with ambulation 50 feet (ft) with two turns or 50 ft. once standing. R25's Care Plan, revised 06/25/24, documented R25 required set-up or supervision with ADLs and directed R25 was up ad lib throughout the facility and his room without an assistive device. The care plan lacked guidance to staff on what to do if R25 exited the building unsupervised. On 07/29/24 at 03:15 PM, observation revealed R25 ambulated down the hall, from the nurse's station using a walker with a fast steady gait to his room. Once he was inside the entrance door, he left his walker by the entrance door and ambulated into the bathroom. Further observation revealed R25 ambulated out of his room using a walker with a fast steady gait down the hall to the south exit door. He opened the door and went outside (without staff supervision) and no alarm was heard at the exit door. Further observation revealed R25 ambulated through an open gate and sat on a bench outside the facility. On 07/29/24 at 01:37 PM, Certified Medication Aide (CMA) M stated all of the facility doors were unlocked but did alarm at the nurse's station whenever someone went out without putting in the code. CMA M stated when R25 exited the facility through the south exit door, it alarmed the nurse's station; staff could see him exit from the nurse's station and tried to keep an eye on him when he exited. CMA M stated staff knew R25 was allowed to exit the building unsupervised. On 07/31/24 at 12:00 PM, Administrative Nurse D verified that R25's Care Plan lacked instructions to staff regarding what to do when R25 exited the building unsupervised. Administrative Nurse D stated she discussed with the administrative team whether the facility should include instructions on the care plan related to R25 exiting the building unsupervised. Administrative Nurse D stated the facility had a few other residents who were allowed to exit the building without staff supervision. if R25 was updated, the other care plans would require updating as well so the facility determined it was not necessary. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Comprehensive Assessment Policy, revised 09/2023, documented resident's assessment would be completed within the last 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive care plan. The facility failed to revise R25's care plan to include guidance to staff regarding R25 exiting the building unsupervised. This placed the resident at risk of impaired care due to uncommunicated care needs.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 40 residents. The sample included 12 residents. Based on record review and interview, the facility failed to develop a discharge summary that included a complete recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of the resident's stay and post-discharge plan for Resident (R)42. This placed the resident at risk of receiving inadequate care. Findings included: - R42's Electronic Medical Record (EMR) revealed the resident admitted to the facility on [DATE]. R42's Admission Minimum Data Set (MDS), dated [DATE], documented R42 required limited staff assistance with activities of daily living (ADLs). The MDS documented the resident was expected to stay at the facility for three or fewer months. The Care Area Assessment (CAA, dated 04/26/24), documented the resident planned to return to the community, and the social service director would work with the family for possible home health. R42's Admission Care Plan, dated 04/17/24, documented the resident was admitted to the facility for skilled therapy including physical therapy and occupational therapy and he would have a short-term stay at the facility. The Nurse's Note, dated 05/06/24 at 10:42 AM, documented R42 was discharged from the facility to home. A review of R42's EMR lacked a discharge summary which included a complete recapitulation of her stay. On 07/31/24 at 02:30 PM, Administrative Staff A verified R42's discharge summary had an incomplete recapitulation of her stay and stated social service staff and nursing were responsible for completing the discharge summary. The facility's Discharge Summary and Plan, policy, revised 09/2023, documented that staff should complete a discharge summary when the resident is discharged that would include a recapitulation of the resident's stay at the facility and a final summary of the resident status at the time of discharge in accordance with established regulations governing the release of resident information and as permitted by the resident. The recapitulation would include, but not be limited to: diagnoses, course of the illness, treatment or therapy; pertinent lab, radiology, and consultation results; reconciliation of all pre-discharge medications with the residents post-discharge medications, for prescribed and over the counter; and a final summary paragraph that may be released to any provider with the consent of the resident or representative. The facility failed to develop a discharge summary that included a complete recapitulation of R42's stay and post-discharge plan. This placed the resident at risk of receiving inadequate care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 40 residents. The sample included 12 residents with one resident reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide necessary services to maintain good personal hygiene, including bathing, for Resident (R)37. This placed the resident at risk for poor personal hygiene and impaired dignity. Findings included: - R37's Electronic Medical Record (EMR) recorded diagnoses of adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals,) dementia (a progressive mental disorder characterized by failing memory, confusion, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R37's Admission Minimum Data Set (MDS), dated [DATE], recorded R37 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS recorded R37 required set-up and clean-up assistance from staff for most ADLs including bathing. R37's Care Plan, dated 06/21/24 indicated that R37 required limited staff assistance and supervision with ADL care. R37's Bathing/Shower Task documentation revealed the resident was scheduled to have a shower/bath once a week. The April 2024 bathing report documented the resident received a bath on the following days: 04/07/24 04/14/24 The May 2024 bathing report documented the resident received a shower on the following days: 05/15/24 (30 days with no shower). The June 2024 bathing report documented the resident received a shower on the following days: 06/05/24 (19 days with no shower) The July 2024 bathing report documented the resident received a shower on the following days: 07/10/23 resident refused to have her hair washed (13 days with no shower) 07/17/24 resident refused to have her hair washed (6 days) 07/24/24 -resident refused to have her hair washed (6 days) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The bathing report lacked documentation the resident refused her showers. On 07/29/24 at 10:45 AM, observation revealed R37 sitting in a wheelchair in her room dressed in street clothes. Her hair was uncombed and appeared greasy. On 07/30/24 at 10:00 AM, Administrative Nurse D verified the residents had scheduled shower days and the aides documented in the electronic medical record and on shower sheets. Administrative Nurse D verified the R37's EMR noted the dates she received a shower and verified the resident did not receive her shower once a week. Administrative Nurse D stated the resident did not like to get her ears wet and she would refuse showers but confirmed the facility staff were unsure of her apprehensions or why she did not want to get her ears wet and had not followed up on that. The facility's Activities of Daily Living policy, dated 09/2024, documented the facility would ensure a resident would be provided appropriate care and services including hygiene, mobility, elimination, dining, and communication. The policy documented residents who were unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene and if the resident refuses care and treatment which may contribute to a decline the staff would attempt to find the underlying cause of the refusal if related to depression, behavioral or dementia care. The facility failed to provide the necessary care and bathing services for R37, placing the resident at risk for poor hygiene and impaired dignity.

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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** 32358 The facility had a census of 40 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure an appropriate indication for the use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) or the required physician documentation for two of five residents, Resident (R) 31 and 38, reviewed for unnecessary medications. This placed the residents at risk for unnecessary psychotropic (alters mood or thought) medications. Findings included: - R31's Electronic Medical Record (EMR) documented R31 had diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R31's Quarterly Minimum Data Set (MDS), dated [DATE], documented R31 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R31 required partial to moderate staff assistance with toileting, dressing, and bed mobility. R31 required maximal staff assistance with showering and was dependent on staff for putting on and taking off footwear. The MDS documented R31 received an antidepressant (class of medications used to treat mood disorders) medication during the look-back period. R31's Care Plan, revised 06/24/24, instructed staff to monitor R31 for drug-related complications from his Seroquel (antipsychotic medication). R31 used Seroquel related to behavior management. The care plan instructed staff to administer R31's psychotropic medications as ordered by the physician and consult with the pharmacy and physician to consider a dosage reduction of the Seroquel when clinically appropriate, at least quarterly. The Physician Order, dated 02/10/23, instructed staff to administer Seroquel, 25 milligrams (mg), at bedtime related to depression. R31's EMR lacked evidence of nondrug behavioral interventions that were tried and failed before starting the antipsychotic medication and lacked a physician-documented rationale including risk versus benefits for the continued use of Seroquel. On 07/2/24 at 1:00 PM, observation revealed R31 sat in a wheelchair in his room visiting in a polite voice with a family member. On 07/31/24 at 11:22 AM, Administrative Nurse D verified the resident's Seroquel had an inappropriate indication and stated the facility staff tried to get the physicians on board with proper documentation for antipsychotic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Unnecessary Drugs Policy, revised 09/23, documented that residents would receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated. The facility failed to ensure an appropriate indication for use, or the required physician documentation for R31's Seroquel. This placed the resident at risk for unnecessary psychotropic medications. 26768 - R38's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) with agitation and heart failure lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition. The MDS documented R38 had hallucinations (sensing things while awake that appear to be real, but the mind created) and verbal and wandering behaviors. The MDS documented R38 received antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and opioid (narcotic) drugs. The Dementia Care Area Assessment (CAA), dated 05/09/24, documented R38 would not answer questions, or her answers made no sense, and the interview was completed showing severe dementia. R38 was noted to be alert and oriented to self only and wandered and paced throughout the facility. R38 displayed constant confusion with a scattered thought process, clear speech with frequent rambling, and did not always answer questions appropriately. The physician adjusted her medications which were becoming effective with less agitation noted. Risk factors of her medications included social isolation and behaviors. The Behavior CAA documented R38 wandered nearly daily and had at least one behavioral symptom. No physical aggression was noted, but she had increased verbal rambling, and some foul word use; she paced continuously while talking to herself. One evening she was in a constant state of agitation, restlessness, and irritability as evidenced by her wandering the halls, attempting to leave the facility, entering other resident's rooms, and yelling at them causing other residents to become agitated. R38 spit her crushed medications on staff, verbalized constant cursing at staff, called staff names, and yelled at staff. She scratched a Certified Nurse Aide (CNA). Staff offered drinks, snacks, activities, and television which were refused by the resident. Staff were unable to redirect or distract her. The Quarterly MDS, dated [DATE], documented R38 received antipsychotic, antianxiety, and antidepressant (class of medications used to treat mood disorders) drugs. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's Care Plan, dated 07/26/24, stated R38 had impaired cognitive function or impaired thought processes related to severe dementia with agitation. The care plan directed staff to perform behavior monitoring each shift due to the dementia diagnosis and document in detail behaviors and chart effective interventions if any. Administer medications as ordered, and monitor for effectiveness and possible adverse reactions. The care plan stated R38 used antipsychotic medications for behavior management and included the Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) for Seroquel (antipsychotic medication) which stated, not approved for dementia-related psychosis and mortality risk in elderly people on antipsychotic treatment for dementia-related psychosis. The Physician Note, dated 06/21/24, documented R38's agitation was markedly improved and R38 was calm. The note documented R38's generalized anxiety disorder improved with clonazepam. The Physician Order, dated 06/28/24, directed staff to administer clonazepam (antianxiety medication) 0.5 milligrams (mg) in the afternoon for dementia with agitation. The Physician Order, dated 06/28/24, directed staff to administer Seroquel 75 mg two times a day related to severe dementia with agitation. The Physician Order, dated 06/29/24, directed staff to administer Seroquel 50 mg in the morning for dementia with agitation. The Physician Order, dated 07/21/24, directed staff to administer clonazepam 1 mg in the morning for dementia with agitation. R38's EMR lacked physician documentation of the interventions that were attempted and failed prior to starting an antipsychotic and lacked physician documentation of the risks versus benefits for continued use of Seroquel. On 07/30/24 at 10:06 AM, observation revealed R38 wandered into the room next door to hers. She wore glasses, non-skid socks, and a Wander Guard bracelet. She was very confused. Observation revealed Licensed Nurse (LN) G administered medications crushed and in applesauce to R38 in the hallway. On 07/31/24 at 1058 AM, Administrative Nurse D verified dementia with agitation was not an approved indication for the use of the antipsychotics and the facility did not have the physician's rationale for the continued use of Seroquel and clonazepam for R38. The facility's Unnecessary Medication policy, dated 09/2023, stated residents would only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. The policy directed staff to record and document an individual's target symptoms including if the behavior was observed or identified by shift in the clinical record for antipsychotics and medications used off label to affect the target symptom. The presence or absence of side effects of antipsychotics would be recorded in the clinical record every shift. The facility failed to ensure an appropriate indication for use or the required physician documentation for the ongoing use of antipsychotic medications for R38. This placed the resident at risk for unnecessary psychotropic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 40 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to record the open or discard date on residents' insulin (a hormone that lowers the level of glucose in the blood) vials when they opened a new, multi-use insulin vial. This deficient practice placed Residents (R)13 and R30 at risk for ineffective insulin medication. Findings included: - On [DATE] at 08:53 AM, observation of the west medication cart medications with Licensed Nurse (LN) G revealed one opened and partially used insulin glargine (long-acting insulin) vial for R30 was not dated and one insulin glargine vial for R13 had been opened and was not dated. On [DATE] at 08:53 AM, LN G verified staff were to date the insulin vial when opened so they would know when the insulin was expired. On [DATE] at 01:45 PM, Administrative Nurse D verified staff were to date all insulins when opened. Medlineplus.gov, on [DATE] documented that urefrigerated vials of insulin glargine can be used within 28 days; after that time they must be discarded. Opened vials of insulin glargine can be stored for 28 days at room temperature or in the refrigerator. The facility's Insulin Administration policy, dated ,d+[DATE], directed staff to record the expiration date and time on the vial when opening a new insulin vial. The facility failed to date R13 and R30's multi-use insulin vials when opened, placing the residents at risk for ineffective insulin.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 27168 The facility had a census of 40 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full-time certified dietary manager for the 40 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 07/29/24 at 08:30 AM, observation revealed dietary staff in the kitchen prepared the breakfast meal. On 07/29/24 at 09:40 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated the facility had seven residents with mechanical soft diets and one with a pureed diet. On 07/31/24 at 02:00 PM, Administrative Staff A verified Dietary Staff BB was not certified. The facility's Food Service Staffing dated 10/2024, documented the community will employ sufficient staff with the appropriate competencies and skills to carry out the function of the food and nutrition services. The qualified Dietician would help oversee clinical nutrition and dietary services in the facility. The policy documented that if the Dietician is not full time the community would employee another qualified nutritional professional, to serve as the Dietary Manager. The person a minimum must meet one of the following qualifications: a) A certified Dietary Manager, b) A certified food service manager, c) Have similar certification in food service management and safety from a national certifying body, d) Has an associate or higher degree in food services management or in hospitality, if the course study includes food service or restaurant management from an accredited institution or higher degree, e) Has two or more years of experience in the position of dietary manager in a nursing facility setting and has completed a course of study in food safety management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illnesses, sanitization procedures, and food purchasing/receiving; and f) meets the state-established standards if applicable. The Dietary Manager would receive frequently scheduled consultations from a qualified dietician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 40 residents in the facility. This placed the residents at risk for inadequate nutrition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175201	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downs Care and Rehab	1218 Kansas Street Downs, KS 67437

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 27168 The facility had a census of 40 residents. Based on observation, record review, and interview, the facility failed to provide a safe environment in the facility kitchen. This deficient practice placed the facility residents and staff at risk for impaired safety. Findings Included: - On 07/30/24 at 12:15 PM, during kitchen follow up tour, observation revealed the following: Four 2-foot x 4 -foot fluorescent lights, located between the food preparation area and the stove area that lacked a plastic light diffuser (cover). Each fixture had two fluorescent tube glass light bulbs per fixture. Five 2-foot x 4 -foot fluorescent light, located above the dishwasher area lacked a plastic light cover. Each fixture had two fluorescent tube glass light bulbs per fixture. On 07/30/24 at 12:20 PM, Maintenance Staff U verified the overhead fluorescent light fixtures lacked a diffuser/cover and said he thought the facility had some in storage and would replace the covers as soon as he could locate them. The facility's Sanitization policy, dated 10/2024, documented the food service area shall be maintained in a clean and sanitary manner. The kitchen area would be kept clean, maintained in good repair and free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. The facility failed to provide a safe environment for the facility kitchen, placing the residents and staff at risk.