STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175484	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Home	704 S Ash Street Hillsboro, KS 67063

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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 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. Based on observation and interview, the facility failed to store and prepare food in the main kitchen and kitchenette under sanitary conditions to prevent food borne illnesses. Findings included:- The initial tour of South Kitchen on 06/08/2026 at 08:13 AM with Dietary Staff BB identified the following concerns:The reach-in freezer had built-up frost on three shelves.Two deep freezers had food stuck to the top.The table holding coffee pots and a tea machine had dried-on fluids on the white plastic legs and a buildup of dust on the wooden board behind the table.The side by side two-door refrigerator had food on the bottom and front of the bottom door.There was no trash can by the hand-washing sink.Flour and sugar containers had flour and sugar on top of the lid.The kitchen floor drain had a build-up of an unknown substance. Additionally, the tour of the Kitchenette on 06/08/2026 at 10:04 AM with Dietary Staff BB identified the following concerns:The inside of the microwave had dried food throughout.The trash can had dried food and liquids on the top and sides. On 06/10/2026 at 09:13 AM, Dietary Staff BB confirmed the above findings and reported that the identified areas should be cleaned and food should be stored and prepared in a sanitary condition to prevent foodborne illnesses. The facility policy, Sanitation of Equipment and Supplies, issued 04/2022, documentation included refrigerators shall be cleaned weekly, and freezers shall be cleaned bi-weekly. Kitchen floors shall be sanitized daily at the end of the day.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and ensure cognitively impaired Resident (R) 4 ability to safely self-administer medications prior to leaving the medications with the resident to self-administer. Findings included:- R4's Electronic Medical Record (EMR) revealed a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R4's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R4's MDS revealed he was administered an antidepressant (a class of medications used to treat mood disorders) and an opioid (a class of controlled drugs used to treat pain). R4's Cognitive Loss/Dementia, dated 05/27/2026, documented R4's cognition during this lookback period; R4 scored a 10 on his BIMs, indicating moderate impairment. R4's Care Plan, dated 06/03/2025, instructed staff to administer medications as ordered. Monitor/document for side effects and effectiveness. R4's Electronic Medication Administration Record, dated 06/09/2026, documented the following AM medications: Amlodipine (an antihypertensive, a class of medication used to treat high blood pressure) 2.5 milligrams (mg), give 1 tablet by mouth one time a day.Atorvastatin (for atherosclerosis, a buildup of fats, cholesterol, and other substances in and on the artery walls) 20 mg: give 1 tablet by mouth daily. Centrum Adult multivitamin chewable: give 2 gummies by mouth daily. Donepezil 10 mg (for cognition): give 1 tablet by mouth daily. Lexapro 5 mg (an antidepressant): give 1 tablet by mouth daily. Lisinopril 20 mg (antihypertensive): give 1 tablet by mouth daily.Pantoprazole delayed release 40 mg (gastroesophageal reflux {GERD}-backflow of stomach contents to the esophagus), give 1 tablet by mouth daily.Vitamin B12 chewable 1000 micrograms, give 2 gummies, by mouth daily.Calcium carbonate 1000mg chewable (for GERD), give 1 tablet by mouth twice a day. Oxycodone 5 mg (for pain): give 1 tablet by mouth three times a day. Senna oral tablet (for constipation): give 1 tablet by mouth three times a day. Acetaminophen 325 mg tablets (for pain): give 2 tablets by mouth every 6 hours. R4's EMR lacked self-administration of medications.On 06/09/2026 at 08:50 AM, Licensed Nurse (LN) I left two medication cups in R4's room on his stand next to his recliner. LN I reported that R4 did not want her to watch him take his medications and wanted to finish his breakfast. On 06/09/2026 at 08:52 AM, R4 leaned to his right side and picked a pill off the floor as he reported he dropped it and placed the unidentified medication into his mouth. R4 has the chewable medications in one medicine cup and several other medications in the other medication cup. On 06/09/2026 at 09:12 AM, LN I reported that she removed the remainder of R4's medications out of his room as he had not taken them yet and placed them in her medication cart. LN I reported that he had taken himself to the bathroom again as she noted the door was closed. LN I reported that she had left his medications before in his room in the past and had always gone back to make sure he took his medications. She did not feel that R4 was as confused as he used to be. She did not realize that he had dropped a pill and then picked it up and took it. On 06/10/2026 at 01:10 PM, Administrative Nurse D revealed she expected that no medications should be left in residents' rooms that were not care-planned for self-administration. The facility's policy Self-Administration of Medication, dated May 2026, documented that all residents determined to be eligible by their physician, nursing staff, and interdisciplinary team will be offered the option of dispensing their own medication. After eligibility is determined, they will receive full instructions on how to use/take the medications. A licensed nurse will complete the Medication Self-Administration Safety Screen. Partial self-administration will allow resident participation in defined aspects as noted on their care plan. Aspects could include limitations to only certain medications kept at bedside, self-administration of dispensed meds, use of lotions or creams at bedside, etc.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide privacy for Residents (R)3 and R5, while staff performed cares in their rooms. Findings included:1. R3's Electronic Medical Record (EMR) documented a diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R3's admission Minimum Data Set (MDS), dated [DATE], documented that R3 had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. He was always incontinent of bowel and bladder and dependent on staff for toileting hygiene. R3's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 05/13/2026, documented that R3 required total staff assistance with toileting and transfers. R3's Care Plan instructed staff that he required total assistance with transfers and toileting hygiene. R3's EMR under the Task tab from 05/12/2026 through 06/09/2026 (30 days) revealed R3 was always incontinent of urine and required total assistance of staff for toileting hygiene. On 06/09/2026 at 08:34 AM, Certified Nurse Aide (CNA) N and CNA P performed peri-care (the cleansing of genitals) with R3 as he lay on his bed, naked from the waist down. The blinds to the windows, which looked out over the courtyard, were open during the cares. On 06/09/2026 at 08:34 AM, CNA P stated the staff does not typically close the resident's blinds while performing cares in R3's room. 2. R5's EMR documented a diagnosis of cerebral infarction. R5's admission MDS dated 05/11/2026 documented R5 had a BIMS score of nine, indicating moderately impaired cognition. She was always incontinent of bowel and bladder and required total staff assistance with toileting hygiene. R5's Urinary Incontinence and Indwelling CAA dated 05/11/2026, documented R5 required total staff assistance with toileting hygiene. R5's Care Plan, dated 05/08/2026, instructed staff that R5 was dependent on staff for toileting hygiene. R5's EMR under the Task tab from 05/12/2026 through 06/09/2026 (30 days) revealed R5 was always incontinent of urine and required total assistance of staff for toileting hygiene. On 06/09/2026 at 08:00 AM, CNA N and CNA P performed peri-care with R5 as she lay on her bed, naked from the waist down. CNA P exited R5's room and re-entered the room by opening and closing the door, exposing R5 to staff, other residents, and workmen who were in the hall directly outside the resident's room. Staff did not cover R5 as CNA P exited and re-entered the room. On 06/09/2026 at 08:00 AM, CNA P confirmed she had exited and re-entered R5's room while she lay naked from the waist down on her bed. On 06/10/2026 at 07:51 AM, Licensed Nurse (LN) G stated the staff should cover the residents while giving care in order to prevent exposing them to others in the hall. On 06/10/2026 at 07:57 AM, Administrative Nurse D stated the staff should ensure the resident's privacy was protected by covering them when they exit and re-enter the resident's room. The facility policy Resident Rights, reviewed 01/2026, included: Each resident in the facility shall have the right and shall be afforded the right to a dignified existence.

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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** Based on observation, interview, and record review, the facility failed to provide appropriate activity of daily living (ADL) assistance to Resident (R)3 when staff did not assist him to change his soiled clothing.- R3's Electronic Medical Record (EMR) documented a diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R3's admission Minimum Data Set (MDS), dated [DATE], documented that R3 had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. He was dependent on staff for upper-body dressing. R3's Activities of Daily Living (ADL)/Rehabilitation Potential Care Area Assessment (CAA), dated 05/13/2026, documented that R3 had limitations in range of motion (ROM) on his left side and required staff assistance with dressing. R3's Care Plan, dated 05/08/2026, instructed staff that he required total staff assistance for dressing. R3's EMR under the Task tab from 05/12/2026 through 06/09/2026 (30 days) revealed R3 required substantial to maximum staff assistance with upper body dressing. On 06/08/2026 at 08:50 AM, Licensed Nurse (LN) G and Certified Medication Aide (CMA) R transferred R3 from his wheelchair to his bed. R3 wore a white T-shirt with food debris and spilled fluids on the front. Staff did not change R3's shirt before leaving the room. On 06/08/2026 at 11:25 AM, the resident sat in the dining room awaiting lunch. He continued to wear the white T-shirt with food debris and dried fluids on the front. On 06/08/2026 at 01:00 PM, CMA R confirmed she had not changed R3's dirty t-shirt before leaving his room and stated staff should change the resident's clothes when they are dirty. On 06/10/2026 at 07:57 AM, Administrative Nurse D stated it was the expectation for staff to change residents' clothes when they became dirty. The facility policy, Activities of Daily Living, reviewed 05/2026, included: The facility shall provide each resident with care and services according to the resident's individualized care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record review, the facility failed to provide Resident (R) 17 with a bilevel positive airway pressure (BiPAP- a noninvasive ventilator that helps breathing) as per physician orders. Findings included:- R17's Electronic Medical Record (EMR) revealed diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations) and Friedreich ataxia (a rare, inherited, progressive neuromuscular disease that damages the nervous system). R17's admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition. Total severity score of 0, indicating no depression. No behaviors noted. The resident required total staff dependence with bed mobility. R17's MDS documented that he had a non-invasive mechanical ventilator. R17's Functional Care Area Assessment (CAA), dated 08/19/2025, documented: R17 was admitted following a hospitalization for ankle pain and lack of a caregiver at home. R17 does have a diagnosis of Friedreich's ataxia, which is a progressive neurological disorder. The resident requires substantial/maximal to total assistance with all activities of daily living (ADLs). The goal is for R17 to improve independence and ADL abilities through the next review date. R17's Care Plan, dated 08/20/2025, instructed staff to ensure the BiPAP mask fits appropriately and that there are no other devices present underneath the mask. Lift and reposition the mask when able. R17's Care Plan, dated 08/20/2025, instructed staff to assist with applying the BiPAP mask and turning BiPAP on and off. R17's Physician Orders, documented May wear BiPAP at present settings. Staff to assist with applying at bedtime related to obstructive sleep apnea, date ordered 08/06/2025. R17's Progress Note, dated 05/10/2026 at 01:51 AM, documented that R17 voiced his BiPAP was broken tonight and needs it to be looked at, but voiced he has worn it for the last four nights, email sent to human resources. R17's Orders - Administration Note, dated 05/12/2026 at 09:50 PM, documented that R17 reported that the BiPAP equipment fell and broke. R17's Orders - Administration Note, dated 05/15/2026 at 12:06 AM, documented that R17 reported that the BiPAP equipment was broken. R17's Orders - Administration Note, dated 05/15/2026 at 11:42 PM, documented that R17 reported that the BiPAP equipment was broken. R17's Progress Note, dated 05/18/2026 at 04:25 PM, documented that staff spoke with R17 about his BiPAP not working and needing to call to get it fixed. R17 said that he had the number on his phone and that he would call them. R17's Orders - Administration Note, dated 05/18/2026 at 09:58 PM, documented the call number on BiPAP and informed the company that he had dropped/broken his machine. No contact information was found on the machine. R17's Orders - Administration Note, dated 05/22/2026 at 08:37 AM, documented a call to inform them that R17 had dropped/broken his BiPAP. The number to call is [redacted]. This nurse called and left a detailed message with a callback number. R17's Orders - Administration Note, dated 05/23/2026 through 06/09/2026, documented that BiPAP was not working and was waiting for repair.R17's EMR lacked any further documentation to contact the company that supplied the BiPAP. R17's EMR lacked documentation that the provider was updated that R17's BiPAP was not working from 05/10/2026 through 06/09/2026. On 06/10/2026 at 07:53 AM, R17 exited his room in his power chair, heading to the dining room. R17 reported that his BiPAP machine fell to the floor about a month ago, and he had called the number on the machine and was unable to get in contact with anyone. On 06/10/2026 at 07:59 AM, Licensed Nurse (LN) G reported that R17's BiPAP machine had been broken for about a month now. LN G reported that she did call a number and left a message on 05/21/2026 but had not heard back and reported that maybe Administrative Nurse D had heard back. LN G reported she was unsure if the provider was aware that R17's BiPAP was not working. On 06/10/2026 at 09:25 AM, Administrative Nurse D reported that she was aware that R17's BiPAP was not working and that the staff had called the company several times. She revealed the facility had not heard back from them. Administrative Nurse D reported that the provider was probably updated verbally of R17's BiPAP being broken and not able to use. Administrative Nurse D confirmed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the EMR lacked documentation of the company being called several times and that the provider was notified. The facility's policy BiPAP dated 05/2026 documented all use of BiPAP required specific physician orders and the ordered level of air pressure to keep the airway open during sleep may not be changed without consulting the ordering physician with resultant change in settings orders.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services necessary to care for residents' needs related to provision of enteral tube feeding and medication administration via percutaneous enteral epigastric tube feeding (PEG tube-external device inserted in the abdomen to deliver nutrition, hydration, and/or medication directly to the stomach). Findings included: - Resident (R) 7's undated physician's order (POS) documented diagnoses which included cerebral vascular accident (CVA-stroke due to interrupted blood flow to the brain), hemiplegia (paralysis of one side of the body), dysphagia (impaired ability to swallow), and dementia (decline in mental abilities severe enough to interfere with daily life). R7's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of seven, indicating severe cognitive impairment. The resident was dependent on staff for total assistance with eating. He had a feeding tube for nourishment / hydration and medication administration and received nothing by mouth (NPO). The Feeding Tube Care Area Assessment (CAA) dated 09/22/2025, documentation included R7, had a feeding tube related to the diagnosis of dysphagia following a CVA. His only source of nutrition/hydration was via a PEG tube. The goal is for R7 to remain free from complications. R7's Care Plan documentation initiated 11/30/2021, included guidance to staff as follows:R7 was dependent on a tube for feeding and water flushes.Administer medications via PEG tube.Monitor/document/report symptoms of aspiration, which include fever and/or shortness of breath, tube dislodgement, infection at tube site, removal of tube by resident, tube dysfunction or malfunction, abnormal breath/lung sounds, normal lab values, abdominal pain, distension, tenderness, diarrhea, nausea/vomiting, and dehydration.Provide local care to the PEG site as ordered and monitor for signs and symptoms of infection.R7's Medication Administration Record/Treatment Administration Record (MAR/TAR) for 05/01/2026 through 06/09/2026 was documented on 05/07/2026 at 07:00 AM. Certified Medication Aide (CMA) T administered R7's tube feeding and her medications via PEG. R7's MAR/TAR for 05/01/2026 through 06/09/2026 documented CMA S administered R7's tube feeding and her medications via PEG on 05/08/2026, 06/01/2026 and 06/04/2026 at 08:00 PM. Review of five CMA training/competencies documentation and/or administering tube feedings and/or medications revealed CMA T's most recent annual competency/skill check-off for administering PEG feeding and/or medications via PEG was on 11/05/2024 (seven months overdue). CMA S's most recent annual competency/skill check-off for administering PEG feeding and/or medications via PEG was on 03/04/2025 (three months overdue). On 06/08/2026 at 02:03 PM, Certified Medication Aide (CMA) RR reported that she administers medications and enteral feedings to R7. She reported she had completed a competency check-off but could not remember when. On 06/08/2026 at 01:50 PM, Licensed Nurse (N) G reported that R7 was not due for her tube feeding until 05:00 PM. LN G stated the CMAs administered the tube feeding and medications for R7. On 06/09/2026 at 03:20 PM, Social Service Staff X reviewed the five selected CMA's files for their competencies for administering medications and enteral feeding via PEG. She confirmed that of the five reviewed, CMA T and CMA S lacked annual competency and skills check-off as expected, and confirmed that CMA T and CMA S had administered tube feedings and medications to R7 past the required annual competency requirement. On 06/10/2026 at 09:25 AM, Administrative Nurse D reported she expected the CMAs to have annual competency completed for the delegated tasks assigned to them by the nurse. She reported that they had hired a nurse to complete staff education, but that it did not work out. She confirmed that two of the five CMAs that were reviewed did not have a current competency to administer medications and enteral feeding. The 05/2026 facility policy titled Required Training/In-services and Evaluation of CNAs/CMAs documentation included that all employees directly employed at this facility are required to demonstrate competency (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to complete work assignments prior to providing care to any resident in the facility. In-service training classes are conducted to provide employees with information concerning their position, methods, and procedures to follow in implementing assigned duties, and to provide up-to-date information that may assist the employee, as well as the organization, in providing quality health care to the residents. The facility Director of Nursing defines the competencies required of the staff providing care, treatment, and services related to techniques, procedures, technology, equipment, and skills required to provide the elders served with care, treatment, and services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interviews, observation and record review, the facility failed to implement adequate infection control practices related to respiratory equipment for Resident (R) 17 and hand hygiene during incontinence care for R7. Findings included:1. On 06/08/2026 at 09:49 AM, R17 was in his room in bed. His bilevel positive airway pressure (BiPAP- a noninvasive ventilator that helps breathing) mask lay directly on the floor on the left side of his bed. R17 reported that he has no place to put the BiPAP mask when he takes it off. On 06/09/2026 at 08:20 AM, R17's BIPAP mask was noted on the floor next to his bed. On 06/10/2026 at 07:55 AM, Certified Nurse Aide (CNA) L reported that she does not do anything with the BiPAP machines; the Certified Medication Aides and Licensed Nurses (LN) take care of them. CNA L reported the mask should not be on the floor, though. On 06/10/2026 at 07:59 AM, LN G reported that R17's BiPAP machine had been broken for about a month now. LN G reported that the mask should not be on the floor, that is should be placed in a bag, and reported that since he has not worn the BiPAP, the staff probably have not noticed the mask on the floor. LN G verified there was no bag in his room to place the mask. 2. On 06/09/2026 at 01:07 PM, CNA L provided R7 with incontinent care with the assistance of CNA LL. R7 was assisted with the removal of his soiled brief of urine and bowel movement by CNA L. She removed her gloves, washed her hands, and applied new gloves. CNA LL handed CNA L the cleansing wipes. CNA L wiped the bowel movement off R7's buttocks. CNA L did not perform hand hygiene and used the same gloves to cleanse R7's urinary meatus and groin. On 06/09/2026 at 01:22 PM, CNA L reported that she should have cleansed R7 better on his front private area she then reported that she should have removed her gloves, performed hand hygiene, and applied new gloves after she cleansed the buttocks that had bowel movement them before she cleansed his front. On 06/09/2026 at 01:24 PM, LN I reported that the staff should cleanse the front of the resident's peri area completely before they wash the buttocks, she reported that the staff should remove the gloves and perform hand hygiene before cleansing the peri area after cleansing the bowel movement from a resident. On 06/10/2026 at 09:50 AM, Administrative Nurse E (Infection Preventionist) reported that she expected the staff to remove gloves and wash hands prior to cleansing the resident's peri area after they cleansed the bowel movement from the buttocks. Administrative Nurse E reported that the mask from a BIPAP should be placed in a bag when not in use, and being on the floor was not acceptable. The facility's policy BiPAP dated May 2026 documented in the morning, clean mask or pillows. Perform daily cleaning of the apparatus. Do not clean any parts of the system with alcohol, cleaning solutions containing alcohol, bleach, or any strong sanitization chemicals. Allow masks or pillows to air dry on a clean barrier. The facility's policy Incontinent Care dated May 2026 documented that when a resident is found to be incontinent of urine or bowel, direct care staff will provide incontinence care using standard precautions and cleansing wipes to cleanse the perineal area and replace the incontinence containment product. The facility's policy Infection Control, dated January 2026, documented that all staff have a responsible for following hand hygiene protocols of this facility and are able to demonstrate competency in hand hygiene annually.

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Salem Home	704 S Ash Street Hillsboro, KS 67063

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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of garbage and refuge properly in a closed dumpster to prevent pests and odors, and related contamination. Findings included:- During the initial kitchen tour on 06/10/2026 at 09:13 AM, three dumpsters had piled, bagged trash which prevented the lids from closing and securing the garbage and refuge. On 06/10/2026 at 09:13 AM, Dietary Staff BB confirmed the dumpster lids were open and should be closed to contain trash and debris. The facility policy, titled Dumpster Policy, issued 05/2024, included dumpster lids must be closed after each use to help control pests, odors, and weather-related contamination.