STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175530	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Homestead at Stafford	405 Grand Avenue Stafford, KS 67578

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 35 residents, the sample included 12 residents. Based on interview, observation, and record review, the facility failed to inform Resident (R) 29 and/or his representative regarding the risks related to psychotropic (alters mood or thoughts) medications. These practices had the potential to lead to uninformed decisions regarding treatment.Findings included:- Review of the Electronic Health Record (EHR) for R29 included diagnoses of unspecified psychosis not due to a substance or known physiological condition (when a person experiences psychotic symptoms but the specific cause isn't clear, and it's not linked to substance use or a known medical condition), neuroleptic induced parkinsonism (a form of drug-induced parkinsonism that occurs as a side effect of certain medications, particularly those used to treat psychiatric disorders like schizophrenia), extrapyramidal and movement disorder (movement disorders as a result of taking certain medications), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R29's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven, indicating severe cognitive impairment. The MDS indicated that R29 used a wheelchair for mobility and was dependent on staff for all care and activities of daily living (ADLs).The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 01/06/25, documented R29 was dependent on staff for care and ADLs.The Psychotropic Drug Use CAA, dated 01/06/25, documented R29 had been administered antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people) medications.R29's Quarterly MDS, dated 07/02/25, documented a BIMS score of 14, which indicated cognitively intact. The MDS indicated that R29 used a wheelchair for mobility, required supervision or touching assistance for eating, and was dependent on staff for all other care and ADLs. The MDS further indicated that R29 used antipsychotic and antianxiety medications.R29's Care Plan, dated 12/27/22, documented R29 had impaired cognitive function/dementia or impaired thought processes related to dementia. An intervention dated 12/27/24 included the administration of ordered medications with orders and for staff to communicate with R29's family regarding his capabilities and needs. R29's Care Plan, dated 10/07/24, documented R29 used antipsychotic medications related to schizophrenia, schizoaffective disorder, and dementia with an additional diagnosis of extrapyramidal movement disorder. Interventions included the administering of medications as ordered; staff were to monitor and document for side effects and effectiveness, and staff were to discuss with the medical doctor and family related to the ongoing need for use of medication.R29's EHR revealed a psychotropic consent signed and dated 02/12/25 that listed clonazepam (an antianxiety medication) 0.5 mg to be given in the morning and one mg to be given at bedtime.R29's EHR documented a new order, dated 08/06/25, for clonazepam at one milligram (mg) three times daily.R29's EHR lacked evidence R29, or his representative, received education and/or informed consent regarding the clonazepam dosage and frequency increase. During an interview on 08/19/25 at 12:00 PM, Administrative Nurse D stated that the informed consent did not have to be updated if the medication that is listed on the consent was only a dosage change.During an interview on 08/19/25 at 12:05 PM, Administrative Nurse E stated that the most current psychotropic consent for R29 was from February of this year.During an interview on 08/20/25 at 12:20 PM, Administrative Staff A stated that informed consents did not have to be documented in writing and could be done verbally. The facility policy Psychotropic Medications, dated 06/2024, documented psychotropic medications included, but were not limited to, anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications. The policy further documented that psychotropic medications were given based on a comprehensive resident assessment, and the facility ensured that residents who received these medications were not given them unless the drugs were necessary to treat a specific condition as diagnosed and documented in the clinical record.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 35 residents. The sample included 12 residents with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to provide Resident (R) 38 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital and failed to provide a written notification to the resident and/or his representative for the reason of the resident's transfer to the hospital in a language easy to understand. This placed the resident at risk of not understanding bed hold policy or the reason of the transfer. Findings included:- R38's Electronic Medical Record (EMR) revealed a diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R38's EMR documented a Progress Note which noted R38 transferred to the hospital on [DATE].R38's EMR lacked documentation of a bed hold and lacked documentation of written notification to the resident and/or his representative, which explained the reason for the transfer to the hospital.On 08/20/25 at 12:07 PM, Administrative Nurse D stated it was the expectation of the staff to have a bed hold signed when a resident transferred to the hospital. Administrative Nurse D confirmed that staff had not notified the resident and/or his representative in writing of the reason for transfer to the hospital.The facility policy for Discharge/Transfer, revised 02/22/23, included: Before the facility transfers or discharges a resident, the facility shall notify the resident and the resident's representative of the transfer or discharge in writing and in a language and manner they understand. The policy also included: Before transferring a resident to a hospital, the facility shall provide written information to the resident or resident representative, which specifies the duration of the state bed-hold policy.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 35 residents. The sample included 12 residents with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and record review, the facility failed to provide weekly wound assessments for Resident (R) 1. This deficient practice placed the resident at risk for developing pressure injuries and delayed wound healing. Findings included:- R1's Electronic Health Record (EHR) revealed a diagnosis of Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer of the left heel, chronic osteomyelitis (bone infection) of the left foot and ankle, Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) of the right foot, and Stage 2 pressure ulcer of the buttock dated 07/27/25. R1's 06/25/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitively intact. The MDS documented R1 had two Stage 1 (pressure wounds which appears reddened, does not blanche, and may be painful but is not open) pressure ulcers, two Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcers, and one Stage 4 pressure area.R1's 06/25/25 Pressure Ulcer Care Area Assessment (CAA) documented R1 had the potential for, and actual impairment to, skin integrity related to fragile skin and use of oxygen, and an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). R1 was admitted with a Stage 4 pressure ulcer to his left heel. R1's Care Plan documented R1 was admitted with a Stage 4 pressure ulcer to his left heel. A wound culture was completed during hospitalization and was positive for Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics), and was treated for osteomyelitis until 06/22/25. R1's Care Plan documented R1's MDS coded a Stage 1 pressure ulcer on his right buttock, acquired in-house 06/16/25. R1 had a Stage 1 pressure ulcer on his left buttock, acquired in-house 06/16/25; a Stage 4 pressure ulcer on his left heel; a Stage 4 pressure ulcer on his right heel, and a Stage 3 pressure ulcer on his sacral (area over the tailbone) region that were present when he arrived back at the facility. R1's Care Plan documented that staff were to provide wound care as ordered. Staff were to graph the wounds on Thursday and send them to the doctor, initiated on 03/18/25. R1's Care Plan documented R1 was to have a cushion in his wheelchair to assist with offloading pressure points while seated in his wheelchair, initiated on 03/10/25. The plan directed staff to inform family and caregivers of any new area of skin breakdown, initiated on 03/10/25. The plan directed staff to monitor, document, and report to the doctor any changes in skin status: appearance, color, wound healing, signs or symptoms of infection, wound size and stage, initiated on 03/10/25. R1's Care Plan documented staff were to turn and reposition R1 as needed to prevent pressure areas and for comfort; initiated on 03/10/25.R1's Braden Scale for Pressure Score Risk dated 06/03/25 documented R1 had a pressure risk score of 17, which indicated a low risk for pressure areas. R1's Physician Order noted an order to measure the wound on R1's buttocks on a graph every Thursday and send it to the provider; ordered on 07/11/25.R1's Physician Order noted an order to clean wound on R1's buttocks and apply Allevyn (a foam dressing primarily used for managing wounds with moderate to high levels of exudate (fluid) and supporting a moist wound healing environment every day and as needed; ordered on 07/11/25. This order was discontinued on 07/28/25. R1's Wound Graph for the left buttock documented the wound was 2 centimeters (cm) x 1.1 cm on 07/24/25. It documented the treatment was Allevyn dressing every day and as needed. R1's Wound Graph for the left buttock documented the wound was 2 cm x 1.1 cm on 07/31/25. It documented the treatment was Allevyn dressing every day and as needed. No further wound graphs for the left buttock pressure ulcer were documented in R1's EHR. R1's Skin Condition Report dated 07/24/25 thru 08/14/25 documented R1 had a buttock wound that was cleansed, dressed per order, and graphed. R1's EHR lacked evidence of an active treatment or dressing for the buttocks after 07/28/25 and lacked documentation it was graphed or that the physician was aware after 08/05/25. On 08/19/25 at 9:01 AM, R1 laid in bed on his back with the head of the bed slightly elevated. On 08/19/25 at 12:05 PM, Certified Nurse Aide (CNA) N and CNA O, entered the room to transfer the resident. CNA O exposed R1's buttocks. It was dark pink/purple and was non-blanchable (visible skin redness that persists with the application of pressure). The right buttock had a dressing that was saturated with blood. There was another dressing over the coccyx (area over the tailbone). On 08/19/25 at 01:18 PM, Administrative Nurse E donned gloves and a gown. She exposed R1's buttocks and noted both buttocks and the coccyx had a deep pink/purple color and were

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 35 residents. The sample included 12 residents, which included one resident reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to provide necessary supervision and assistance required for safe ambulation for Resident (R) 6. This placed R6 at risk for falls and fall-related injuries. Findings included:- Review of the Electronic Health Record (EHR) revealed that R6 included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), other symptoms and signs involving cognitive functions and awareness (difficulties with memory, concentration, decision-making, problem-solving, and understanding, as well as changes in behavior and communication), a need for assistance with personal care (assistance with activities of daily living [ADLs] that an individual is unable to perform independently due to illness, disability, or advanced age), and repeated falls (two or more falls within a specific time frame, typically a year or six months).The 07/23/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severe cognitive impairment. R6 required supervision or touching assistance with dressing, eating, and personal hygiene. R6 was dependent on staff for bathing ADLs.The 07/23/25 Cognitive Loss/Dementia Care Area Assessment (CAA), documented R6 had a BIMS score less than 13 and had occurrences of wandering.The 07/23/25 Urinary Incontinence and Indwelling Catheter CAA, documented R6 was frequently incontinent.The 07/23/25 Falls CAA documented R6 wandered daily and had frequent falls prior to admission.The 07/23/25 Psychotropic Drug Use CAA, documented R6 was administered an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication.R6's Care Plan dated 07/19/25 documented R6 was at high risk for wandering related to an alteration in neurological status from dementia and normal pressure hydrocephalus (NPH-fluid buildup in the brain), and R6 wore a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) bracelet on her wrist. Interventions directed staff to perform quarterly and as-needed elopement risk assessments to check the WanderGuard bracelet for placement and battery function daily.R6's Care Plan dated 07/22/25 documented R6 was a high fall risk, having scored 28 points on assessment completed on 07/17/25 due to new admission, history of falls, on high-risk medications, impaired cognition, incontinence, wandering, and impaired gait. Interventions instructed staff to follow the facility fall protocol; Physical Therapy (PT) was to evaluate and treat R6 as ordered or as needed.R6's EHR recorded an active Physician's Order dated 07/17/25 that documented R6 was to ambulate with assistance only.R6's EHR recorded an active Physician's Order dated 07/17/25, for PT and Occupational Therapy (OT) to assess and evaluate R6 due to her being considered high risk for falls on her admit fall assessment.R6's EHR recorded an active Physician's Order dated 07/17/25 that documented R6 was to ambulate with assistance only.During the survey, on 08/19/25 at 11:58 AM, R6 received a signed order that changed her ambulation from assistance only to supervision.Observed on 08/18/25 at 10:48 AM, R6 ambulated in the hall without assistance. Multiple staff walked by her without assisting her.Observed on 08/18/25 at 11:13 AM, R6 wandered the hall without assistance.Observed on 08/18/2025 at 03:31 PM, R6 stood up from a recliner in the resident common area and ambulated without assistance; multiple staff were present and did not assist her.During an interview on 08/18/25 at 10:55 AM, Certified Medication Aide (CMA) S reported that R6 does not have a walker; she was admitted with one, but she kept carrying it, so it was stopped. CMA S further reported that R6 did not have any ambulation orders and that she was allowed to ambulate freely.During an interview on 08/18/25 at 02:43 PM, Licensed Nurse (LN) G stated that R6 could ambulate alone without assistance. LN G then verified that R6 did have an order for ambulation with assistance only.During an interview on 08/18/25 at 02:47 PM, Administrative Nurse D verified that R6 had an order for ambulation with assistance only. Administrative Nurse D stated she expected staff to follow provider orders and the resident care plan.During an interview on 08/20/25 at 12:20 PM, Administrative Staff A stated that facility expectations included staff were to follow and fulfill the provider orders.The facility policy Incidents, Accidents, Falls, and Prevention, dated 01/2023, documented that it was the policy of the facility that residents would achieve the highest quality of life by providing supervision and interventions that were deemed necessary to minimize significant injuries.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 35 residents. Based on observation, record review and interview, the facility failed to display accurate, publicly accessible, and identifiable staffing information, daily, for the 35 residents who resided in the facility. Findings included: - Review of the facility's Daily Staffing Sheets, from 07/01/25 through 08/18/25, revealed the actual hours worked had not been completed on the daily staffing sheets. On 08/19/25 at 02:33 PM, Administrative Nurse D confirmed the Daily Staffing Sheets lacked the actual hours worked. The facility policy for Required Posting of Nursing Staff, revised 01/2023, included: Nursing facilities are required to post individual shift data and the total hours worked each day by licensed and unlicensed nursing staff who are directly responsible for resident care.

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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. The facility reported a census of 35 residents, one kitchen and one kitchenette. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for foodborne bacteria. This placed the residents at risk of food-borne illnesses.Findings included:- During an initial tour of the kitchen on 08/18/25 at 11:03 AM, the following areas of concern were noted: The reach-in refrigerator/freezer unit had seven of eight wired shelves with large areas of missing protective and plastic coating, making them unsanitizable.The two-door reach-in freezer had eight wired shelves with large areas of missing protective and plastic coating, making them unsanitizable.The dry storage rack by the back door had a heavy build-up of dirt on the bottom rim of the shelving unit.One red and three white plastic cutting boards were heavily gouged.The area next to the steam table had two shelves which held items such as assorted syrups and breakfast items had littered food debris.Three plastic containers used to store dry cereal had a build-up of dust on the lids. On 08/20/25 at 11:13 AM, Dietary Staff BB confirmed the areas noted needed to be cleaned. The facility policy for Reach-In Refrigerators and Freezers, undated, included: Staff shall thoroughly clean, rinse and sanitize the inside and outside of the reach-in refrigerator and freezer doors, racks, and bottom shelf monthly with a clean cloth dipped in warm detergent solution.The facility policy for Reach-In Refrigerators and Freezers, undated, included: Staff shall wash the insides of cupboards and drawers with a warm detergent solution, rinse and sanitize weekly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported a census of 35 residents. The sample included 12 residents. Based on interviews, record reviews and observation, the facility staff failed to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R)1 who had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). The facility failed to follow adequate hand hygiene and infection control practices related to catheter bags and tubing as well as sanitary storage of nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs). This deficient practice placed the residents at increased risk for infections. Findings included:- Observed on 08/18/25 at 08:35, R22 was in his recliner in his room with his nebulizer on his overbed table. The nebulizer had fluid in it, and the face mask had a greasy film on it. R22 stated staff did not rinse out his nebulizer after each use and said he did not do it either.Observed on 08/18/25 at 09:19 AM, R4's Foley urine collection bag with dignity cover laid on the floor under his wheelchair.Observed on 08/19/25 at 08:00 AM, R4 was in the dining room in his wheelchair. R4's urinary catheter urine collection bag and dignity cover rested on the floor under his wheelchair.Observed on 08/19/25 at 08:16 AM, R4 wheeled himself out of the dining room in his wheelchair and his urinary catheter and collection bag with dignity bag, dragging the floor under his wheelchair.Observed on 08/19/25 at 08:39 AM, R4 wheeled himself about the common area in his wheelchair; his urinary collection bag with a dignity cover was dragging on the floor.Observed on 08/19/25 at 10:39 AM, R1 laid in bed with the catheter bag on the floor. The Foley bag was not covered with a dignity bag. Observed on 08/19/25 at 12:05 PM, Certified Nurse Aide (CNA) N and CNA O entered R1's room. CNA N donned gloves, but no gown. CNA O did not have gloves or a gown on. CNA O pulled R1's pants and incontinence brief down to expose R1's buttock dressings. The CNAs rolled R1 to place the sling under him, then attached the lift sling to the lift. CNA N lifted R1, and CNA O removed the catheter bag and held it with her ungloved hands. CNA O transferred the catheter bag and hung it on the sling. CNA N removed R1's boots, and they lowered R1 into the wheelchair. CNA O handed the catheter bag to CNA N. CNA N placed the bag on the floor. CNA O retrieved the urinal from the bathroom, and CNA N emptied the catheter. CNA N attached the dignity bag to the wheelchair, then picked up the catheter bag off the floor and placed it in the dignity bag.Observed on 08/19/25 at 03:00 PM, R4 sat in his wheelchair in his room, his urinary collection bag with a dignity cover was resting on the floor.Observed on 08/20/25 at 08:27 AM, R4 sat in his wheelchair in the resident common area; his urinary dignity bag and tubing were resting on the floor under his wheelchair.Observed on 08/20/25 at 10:17 AM, CNA M and a hospice CNA donned gowns and gloves and entered R1's room. The CNAs transferred R1 into the bed. Licensed Nurse (LN) I entered the room. The CNAs rolled R1 to the side to expose the wounds. LN 1 attained the trash can and placed it by her. CNA M exposed R1's buttocks. LN I removed the dressing and cleaned the buttock with wound cleanser. The buttock was deep red with a purple tint. LN I applied a clean dressing without performing hand hygiene and changing gloves. LN I then applied Calmoseptine (skin protectant and moisture barrier) with the same soiled gloves. LN I removed the gown and gloves and left the room.During an interview on 08/19/25 at 08:35 AM, CNA M stated that urinary catheter bags were supposed to have been positioned below the resident's bladder and should not have rested or dragged on the floor. CNA M verified that R4's urinary dignity bag had been resting and dragging on the floor.On 08/19/25 at 12:22 PM, CNA O stated that R1 was on EBP and staff should wear the proper personal protective equipment (PPE), which included gloves and a gown when providing care for a resident with a catheter. CNA O said staff should also do hand hygiene before entering the room and after removing the PPE, and between dirty and clean areas.On 08/19/25 at 11:30 AM, LN H stated the catheter bag should not lie on the floor and stated it should be in a dignity bag.On 08/20/25 at 10:17 AM LN I stated she should have completed hand hygiene and changed gloves after removing the dirty dressing, before touching the clean dressing.During an interview on 08/19/25 at 09:37 AM, Administrative Nurse E stated that if a resident had a urinary catheter, open wound, or infection of some type, there should have been EBP PPE established. On 08/20/25 at 12:21 PM, Administrative Nurse D stated it was his expectation for all staff to use good infection control practices. He said the nebulizers should be rinsed out after each use and placed to dry, then placed in a bag. Administrative Nurse D stated all staff should wash hands or use hand sanitizer when needed; during wound dressing change, staff should change gloves and wash hands after removing the dressing, before applying a clean dressing. He said catheter bags should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175530	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Homestead at Stafford	405 Grand Avenue Stafford, KS 67578

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. The facility reported a census of 35 residents. The sample included 12 residents. Based on interviews, record review, and observation, the facility failed to ensure residents had safe and properly maintained resident care equipment. This deficient practice placed the residents at risk for infection and decreased comfort.Findings included:- Observed on 08/18/25 at 11:08 AM, the leg pad on one sit-to-stand lift (medical devices designed to assist individuals with limited mobility in transitioning from a seated to a standing position) had a large, missing chunk from the leg pad, the foam resident grips were missing pieces, and there was exposed rust on the legs. Observed on 08/19/25 at 03:15 PM, the second sit-to-stand had multiple large areas of the foot base with exposed rust, the right resident hand-hold had approximately half the foam missing, exposing metal, and the left hand-hold foam was ripped, exposing metal. During an interview on 08/18/25 at 11:08 AM, Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) M stated that the sit-to-stand (one) damage had been reported to administration at least a month ago.During an interview on 08/19/25 at 03:15 PM, CNA M stated that damage to sit-to-stand two had not been reported.During an interview on 08/19/25 at 03:20 PM, Administrative Nurse D stated that the expectation was for staff to report any equipment concerns to maintenance so that the equipment parts could be ordered, repaired, or replaced as needed.During an interview on 08/19/25 at 03:36 PM, Administrative Staff A stated that maintenance was to be notified of any necessary repairs of equipment so that parts or replacements could be ordered, and the focus with the lifts had been on the resident lings.During an interview on 08/20/25 at 08:45 AM, Maintenance U reported that he did a monthly check of equipment, and if the equipment was damaged or broken, then he began the procedure to repair or replace the equipment. Maintenance U stated that he was unaware of the full damage to sit-to-stand one and was totally unaware of any damage to sit-to-stand two. The facility policy Leisure Homestead Association Policies and Procedures Patient Lifts, dated 09/24/23, documented that malfunctions or needed repairs were to be reported and that lifts were to be inspected monthly by maintenance.