STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265055	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kabul Nursing Homes Inc	1000 Main Street Cabool, MO 65689

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview, and record review, the facility failed to follow physician's orders for one resident (Resident #17) out of one sampled resident. The facility failed to to follow physician's orders for one resident (Resident #20) out of 20 sampled residents. The facility failed to obtain a physician's order, evaluate and assess the resident's abilities and provide education for self-care of a colostomy (a surgical procedure where the colon is diverted to an artificial opening in the abdomen) for one resident (Resident #31) out of two sampled residents. The facility also failed to obtain a physician's order and provide trapeze (a bar above the bed designed to assist the patient with a means of self-help to change positions in bed) assessments for one resident (Resident #34) out of one sampled resident. The facility census was 43. The facility did not provide a policy for bed alarms. The facility did not provide a policy for colostomy care. The facility did not provide a policy for trapezes. 1. Review of Resident #17's medical record showed: - Diagnosis of Alzheimer's disease (type of dementia that affects memory, thinking, and behavior); - An order for a bed alarm to the bed when in bed to alert the staff of the resident attempting to get up unassisted and to check the placement and function every shift, dated 11/28/23; - Care Plan, last revised 05/02/24, showed the resident to be checked on every two hours. The resident with memory problems and used a bed alarm to let staff know when he/she moved; Observation on the resident on 06/25/24 at 8:02 A.M., and 2:15 P.M., showed the resident lay in bed with a bed alarm on the bed and turned off. During an interview on 06/27/24 at 10:30 A.M., Certified Nursing Assistant (CNA) I said the bed alarm should be turned on anytime the resident was in the bed. During an interview on 06/27/24 at 1:15 P.M., the Director of Nurses (DON) said the bed alarm should be turned on when the resident was in bed. All physician orders should be followed. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 1:20 P.M., the Administrator said all physician orders should be followed. 2. Review of Resident #20's medical record showed: - Diagnoses of ulcerative colitis (a chronic, inflammatory bowel disease that causes inflammation in the digestive tract) and colostomy status; - An order to change the colostomy wafer or bag or both as needed, dated 05/16/24. Review of the resident's Treatment Administration Record (TAR), dated 05/01/24 through 05/31/24, showed: - An order to change the colostomy wafer or bag or both as needed, dated 05/06/24; - No documentation the colostomy wafer or bag or both were changed. Review of the resident's TAR, dated 06/01/24 through 06/28/24, showed: - An order to change the colostomy wafer or bag or both as needed, dated 05/06/24; - No documentation the colostomy wafer or bag or both were changed. Observation on 06/27/24 at 10:10 A.M., showed the resident changed the colostomy wafer and bag with Registered Nurse (RN) C in the room to assist. During an interview on 06/25/24 at 10:52 A.M., RN B said the resident had a colostomy, and the resident completed the changing of the colostomy bag and wafer him/herself with staff set up and assist as needed. During an interview on 06/27/24 at 10:30 A.M., the resident said he/she changed the colostomy wafer and bag with the assist of staff. During an interview on 06/27/24 at 2:45 P.M., RN C said the resident changed his/her colostomy wafer and bag with staff present and assistance provided as needed. During an interview on 06/27/24 at 3:01 P.M., the DON said she would expect the resident's colostomy care to be documented. During an interview on 06/28/24 at 9:03 A.M., the Administrator said there should be documentation to show the colostomy care was performed. 3. Review of Resident #31's medical record showed: - An admitted [DATE]; - Diagnoses of intraspinal abscess and granuloma (the swelling and irritation and the collection of infected material, pus, and germs in or around the spinal cord) and colostomy; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of an assessment for the self-care of the colostomy; - The resident's care plan, dated 04/19/24, showed the resident will perform his/her own colostomy care. Review of the resident's Physician Order Sheet (POS), dated June 2024, showed: - An order for the colostomy, dated 02/16/24; - An order to change the colostomy wafer or bag or both as needed every shift, every day and night shift, dated 02/21/24; - No documentation of an order for the resident to self-perform the colostomy care. During an interview on 06/27/24 at 4:42 P.M., the DON said resident did his/her own colostomy care and asked for help or supplies from staff when needed. The facility did not complete assessments for colostomy self-care and there was no documentation the resident received education for the colostomy care. During an interview on 06/26/24 at 8:35 A.M., the resident said he/she did his/her own colostomy care. The nursing staff provided the supplies and help if needed. During an interview on 06/28/24 at 8:44 A.M., the Assistant Director of Nursing (ADON) said the resident had a colostomy and did his/her own care. Staff watched over the resident depending on their abilities. The staff provided the supplies and education but did not document it. The resident never had self-care assessments completed in the past but it should be implemented quarterly. 4. Review of Resident #34's medical record showed: - admitted [DATE]; - Diagnoses of acquired absence of the right leg below the knee, morbid (severe) obesity due to excess calories, type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to insulin is impaired) with diabetic neuropathy (nerve damage) lower abdominal pain, unspecified. - No order for a trapeze; - No documentation of a trapeze assessment. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 05/17/24, showed: - Cognition intact; - Substantial/maximal assistance for roll left to right. Review of the resident's care plan, dated 02/21/24, showed for Activities of Daily Living (ADLs) the resident used an overbed trapeze to assist with positioning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the resident showed: - On 06/25/24 at 10:13 A.M., a trapeze attached to the top of resident's bed and the resident used the trapeze to assist staff in his/her position change and care; - On 06/26/24 at 8:45 A.M., and 06/27/24 at 10:32 A.M., the resident lay in bed with the trapeze attached to the top of the resident's bed. During an interview on 06/25/24 at 10:13 A.M., the resident said he/she used the trapeze to help reposition him/herself in the bed, and to help staff when they needed to transfer or change him/her. No staff completed an assessment for use of the trapeze, or gave any education. When the nurse came in and talked to him/her, the nurse asked if a trapeze would help the resident move around in the bed, and they agreed to try it. During an interview on 06/27/24 at 12:40 P.M., RN C said there was not documentation of a trapeze assessment and there was not an order for the trapeze. RN C talked to the resident in his/her room, and they discussed the use of a trapeze. The resident agreed it would help him/her move while in bed. During an interview on 06/27/24 at 1:11 P.M., the DON said there should be an order for a trapeze and an assessment should be completed for the resident to use the trapeze. During an interview on 06/28/24 at 9:09 A.M., the Administrator said there should be education and an assessment completed for the resident to use a trapeze. There should be an order for the trapeze to assist in bed mobility. 46521 47445

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 26 opportunities with three errors made, for an error rate of 11.54%. This practice affected three residents (Resident #2, #20, and #29) of the seven sampled residents. The facility census was 43. Review of the facility's policy titled, Medication Administration, last reviewed 04/25/24, showed: - Medication will be administered safely and accurately to residents for whom they are prescribed in accordance with current standards of practices; - Staff will observe the seven rights in giving each medication: right resident, right time, right medication, right amount, right method/route, right documentation, and right to refuse treatment; - Read medication label three times before administering medications: first when comparing the label with the Medication Administration Record (MAR) or Treatment Administration Record (TAR), second when pulling the medication from the drawer, and third when preparing to administer the medication to the resident. 1. Review of Resident #2's medical record showed: - Diagnosis of gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region); - An order for ondansetron (antinausea medication) 4 milligram (mg) one tablet three times a day as needed, dated 08/25/22. Observation on 06/26/24 at 8:45 A.M., of the resident's medication administration showed: - Certified Medication Technician (CMT) F documented the resident's ondansetron 4 mg tablet was administered to the resident; - CMT F opened the drawer of the medication cart, removed the ondansetron 4 mg tablet medication from the cart, and did not compare the ondansetron medication against the order; - CMT F administered the ondansetron 4 mg tablet to the resident; - CMT F failed to compare the medication to the medication order prior to administering the medication. 2. Review of Resident #20's medical record showed: - admitted [DATE]; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnosis of depression (a serious medical illness that negatively affects how you feel, the way you think and how you act); - An order for fluoxetine (an antidepressant) 40 mg capsule daily, dated 02/06/24. Observation on 06/26/24 at 8:49 A.M., of the resident's medication administration showed: - CMT F began to prepare the resident's medication for administration; - CMT F could not find the resident's fluoxetine 40 mg medication in the medication cart; - CMT F documented the resident's fluoxetine 40 mg as not administered due to not in the building; - CMT F did not notify the resident's nurse the resident didn't take the fluoxetine 40 mg scheduled dose. During an interview on 06/26/24 at 8:50 A.M., CMT F said he/she didn't give the fluoxetine because the resident didn't have any right now and he/she would have to order it. 3. Review of Resident #29's medical record showed: - An admitted [DATE]; - Diagnosis of stroke and hemiplegia (paralysis of one side of the body); - An order for Lyrica (medication that treats nerve pain) 75 mg capsule twice a day, dated 02/06/23. Observation on 06/26/24 at 9:04 A.M., of the resident's medication administration showed: - CMT F opened the narcotic drawer of the medication cart, removed the resident's Lyrica 75 mg medication from the cart, and did not compare the Lyrica medication against the order; - CMT F administered the Lyrica to the resident; - CMT F failed to compare the medication to the medication order prior to administering the medication. During an interview on 06/27/24 at 12:28 P.M., Registered Nurse (RN) B said if a pill was dropped on top of the medication cart, he/she would give it since it was a clean surface. If a medication wasn't in stock, then the pharmacy should be contacted and notified the medication was needed as soon as possible. A CMT should notify the nurse when a medication was not administered so if the facility's emergency kit had that medication, it could be removed and administered. During an interview on 06/27/24 at 12:34 P.M., CMT F said if a medication was not on the medication cart, then he/she or the nurse would order it. The resident's medications should be checked against the resident's orders. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 12:45 P.M., the Administrator said if a medication was out of stock, then the nurse should be notified and if it was in the emergency kit, it should be removed and administered. The pharmacy should be called and notified of the medication being out. Medications should be triple checked before being administered. During an interview on 06/27/24 at 1:00 P.M., the Director of Nursing (DON) said if a medication wasn't in the medication cart, then the nurse should be notified and could remove it from the emergency kit if needed. A CMT should let the nurse know the medication wasn't administered and why. When passing medications, the seven rights should be followed and the medications should be compared against the medication orders.

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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. 45693 Based on observation, interview and record review, the facility failed to store medications in a safe and effective manner when staff left the medication cart unlocked and unattended. This had the potential to affect all residents. The facility census was 43. Review of the facility's policy titled, Medication Administration, last revised 04/25/24, showed: - Medication will be administered safely and accurately to residents for whom they are prescribed in accordance with current standards of practices; - Medication carts must be kept locked when not in use or in plain sight. 1. Observation on 06/26/24 at 11:17 A.M., of the insulin administration for Resident #31 showed: - Licensed Practical Nurse (LPN) D locked the medication cart, entered the resident's room, and performed the blood sugar reading; - LPN D exited the room, unlocked the medication cart, got the resident's insulin pen from the medication cart, and failed to lock the medication cart; - At 11:18 A.M., LPN D entered the resident's room with the medication cart facing the hallway, unlocked and unattended. The medication cart sat to the side of the resident's door out of sight of staff; - LPN D administered the resident's insulin; - LPN D exited the room and returned to the unlocked medication cart at 11:19 A.M. 2. Observation on 06/26/24 at 11:22 A.M., of the insulin administration for Resident #95 showed: - At 11:22 A.M., LPN D entered the resident's room with the medication cart facing the hallway, unlocked and unattended. The medication cart sat to the side of the resident's door out of sight of staff; - LPN D performed the resident's blood sugar reading; - LPN D exited the room and got the resident's insulin pen from the medication cart; - At 11:24 A.M., LPN D entered the resident's room with the medication cart facing the hallway, unlocked and unattended with the top drawer cracked open one inch. The medication cart sat to the side of the resident's door out of sight of staff; - LPN D administered the resident's insulin; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN D exited the room and returned to the unlocked medication cart at 11:26 A.M. During an interview on 06/27/24 at 12:34 P.M., Certified Medication Technician (CMT) F said the medication cart should always be locked when left unattended. During an interview on 06/27/24 at 12:28 P.M., Registered Nurse (RN) B, said the medication cart should always be locked when left unattended. During an interview on 06/27/24 at 12:45 P.M., the Administrator said anytime a medication cart was left unattended, it should be locked. During an interview on 06/27/24 at 1:00 P.M., the Director of Nursing (DON) said anytime a medication cart was left unattended, it should be locked.

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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. 37575 Based on observation, interview, and record review, the facility failed to maintain adequate infection control practices to prevent the transmission of infection by failing to ensure proper infection control practices during a medication pass when the staff touched medication with their bare finger and allowed medication to touch the top of the unclean medication cart for two residents (Resident #2 and #20) out of seven sampled residents. The facility failed to ensure the appropriate placement of an indwelling catheter (a flexible tube inserted into the bladder to drain urine) tubing and drainage bag for two residents (Resident #24 and #95) out of three sampled residents. The facility failed to maintain proper infection control practices during incontinent care for one resident (Resident #34) out of four sampled residents. The staff also failed to wear gloves during the procedure of insulin administration that involved a possibility of blood contact for one resident (Resident #95) out of two sampled residents. The facility census was 62. Review of the facility's policy titled, Medication Administration, last revised 04/25/24, showed do not touch the medication with your hands. Review of the facility's policy titled, Hand Hygiene, last review date 06/19/24, showed: - Handwashing is the single most effective measure to reduce the risk of transmission of organisms from one person to another or from one site to another on the same resident. Pathogens (bacteria, virus, or other microorganism that can cause disease) can contaminate the hands of a staff person during direct contact with a resident or contact with contaminated equipment and environmental surfaces within close proximity of the resident; - In this facility, hand hygiene is performed by washing hands with soap and water or using alcohol based hand rub (ABHR); - Hands should be washed in the following situations: Before and after contact with a resident; Before and after use of gloves; Wash hands if they come into contact with blood and/or body fluids containing blood or are visibly soiled. 1. Observation of Resident #2's medication administration 06/26/24 at 8:45 A.M., showed: - Certified Medication Technician (CMT) F did not clean the medication cart or place a clean barrier on top prior the medication administration; - CMT F opened the ondansetron 4 mg medication package, dropped the tablet on top of the unclean medication cart, used a spoon and the medication package to pick up the tablet to put it into a medication cup, and administered the unclean tablet to the resident. 2. Observation of Resident #20's medication administration on 06/26/24 at 8:50 A.M., showed: - CMT F opened the bottle of JuiceFestiv Daily Veggie (a multivitamin) medication; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CMT F poured multiple capsules into the medication bottle lid; - CMT F touched one capsule inside of the medication bottle lid with his/her bare finger to hold it while pouring the other capsules back into the bottle; - CMT F put the capsule into a medication cup and administered the unclean capsule to the resident. During an interview on 06/27/24 at 12:34 P.M., CMT F said medication shouldn't be touched with his/her bare finger and it shouldn't touch the top of the cart that hadn't been cleaned. Review of the facility's policy titled, Personal Care-AM and PM Cares, last revised 04/25/24, showed: - If gloves become soiled, remove, wash hands or use hand sanitizer, and reapply clean gloves; - Remove one glove and cover the resident. Remove the other glove, wash or sanitize hands before further straightening of the resident clothing and bedding. 3. Observation on 06/25/24 at 10:13 A.M., of incontinent care for Resident #34 showed: - Certified Nurse Assistant (CNA) G performed hand hygiene and put on gloves; - CNA G removed the resident's brief soiled with fecal material; - CNA G, with the same soiled gloves, cleaned the fecal material from the resident's buttocks and rectal area; - CNA G, with the same soiled gloves placed a Hoyer (a mechanical lift) pad under the resident, attached the pad to the Hoyer lift, touched the foley catheter tubing, touched the foley catheter drainage bag, touched the pillow, touched the doorknob to the bathroom, touched a clean blanket on a shelf, made up the resident's bed with clean linens, touched and placed a clean draw sheet on the bed, opened the closet door, opened the cabinet drawers, touched and placed a clean incontinent pad on the bed, and the clean bed blankets. During an interview on 06/25/24 at 10:40 A.M., CNA G said incontinent care for residents should start with sanitizing his/her hands, putting on gloves, change the gloves when moving from dirty to clean care, and wash his/her hands before leaving a resident's room. During an interview on 06/27/24 at 2:45 P.M., Registered Nurse (RN) C said hand hygiene should be done before going into a resident's room, should change gloves and perform hand hygiene after incontinent care, should change gloves and perform hand hygiene if gloves were visibly soiled, should perform hand hygiene when care was completed, and should perform hand hygiene when leaving a resident's room. When moving from dirty to clean care, gloves should be changed and hand hygiene should be completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 3:01 P.M., the Director of Nursing (DON) said hand hygiene should be performed prior to entry to residents' room and putting on gloves. If contact with urine or fecal material, staff should perform hand hygiene and change gloves prior to placing a new brief or incontinent pad. When moving from dirty to clean care, staff should perform hand hygiene and change gloves. During an interview on 06/28/24 at 9:09 A.M., the Administrator said when staff go in a resident's room, they should wash or sanitize their hands. Before starting a procedure, they should wash hands, put on gloves. After completing the procedure, they should dispose of the gloves and wash their hands again. Staff should change gloves and perform hand hygiene when moving from dirty to clean care. Review of the facility's policy titled, Catheter Care, last reviewed 04/25/24, showed: - Maintain the position of the drainage bag below the level of the bladder; - Do not rest the drainage bag on the floor; - Ensure the drainage bag is securely attached to the bed frame; - The policy did not address the placement of the tubing. 4. Observations of Resident #24 showed: - On 06/25/24 at 11:22 A.M., and 06/27/24 at 2:18 P.M., the resident sat in a wheelchair in his/her room and the catheter tubing lay under the wheelchair in the floor; - On 06/25/24 at 12:28 P.M. the resident propelled him/herself down the hall and the catheter tubing drug the floor; - On 06/25/24 at 03:54 P.M., and 06/27/24 at 12:59 P.M., the resident sat in a wheelchair at the dining room table and the catheter tubing lay under the wheelchair in the floor; The facility failed to maintain adequate infection control practices by ensuring the resident's catheter tubing did not lay on the floor. 5. Observations of Resident #95 on 06/25/24 at 10:46 A.M., and 11:22 A.M., showed the resident lay in bed with the catheter drainage bag and tubing lay in the floor at the foot of the left side of the bed. During an interview on 06/27/24 at 02:18 P.M., CNA A said the catheter drainage bag and tubing should not be on the floor. During an interview on 06/27/24 at 2:34 P.M., CNA J said the catheter tubing and drainage bag should not be on the floor. During an interview on 06/27/24 at 2:36 P.M., CNA H said the catheter drainage bag and tubing should not be on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265055	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kabul Nursing Homes Inc	1000 Main Street Cabool, MO 65689

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 2:38 P.M., RN B said the catheter tubing and drainage bag should not be on the floor. During an interview on 06/27/24 at 2:40 P.M., Licensed Practical Nurse (LPN) E said catheter drainage bags and tubing should not touch the floor. During an interview on 06/27/24 at 2:47 P.M., the DON said she would expect the catheter drainage bags and tubing never touch the floor. Review of the facility's policy titled, Insulin Administration, last revised 04/25/24, showed: - To provide guidelines for the safe administration of insulin to residents with diabetes; - Wash hands, put on gloves, and remove insulin from the storage; - Check the expiration date, ensure the insulin matches the physician order and dose; - Draw up the amount in the syringe; - Select an injection site, clean the site with alcohol and allow to air dry; - Lightly grasp a fold of skin and insert the needle at a 90 degree angle; - Depress the plunger and remove the needle after waiting 6-10 seconds; - Dispose of the needle in a sharps container, remove gloves, and wash hands. 6. Observation on 06/26/24 at 11:21 A.M., of Resident #95's insulin administration showed: - LPN D sanitized hands and put on gloves; - LPN D entered the resident's room and obtained a blood sugar; - LPN D exited the room, removed the gloves, obtained the resident's insulin pen; - LPN D entered the resident's room, did not perform hand hygiene, did not put on gloves, cleaned the resident's arm with alcohol, and administered the resident's insulin; - LPN D exited the resident's room and removed the needle from the insulin pen without gloves on; - LPN D put the insulin pen back in the medication cart. During an interview on 06/27/24 at 12:28 P.M., RN B said if medication was dropped on top of the medication cart, he/she would give it since it's a clean surface. Should really try not to touch medications with bare fingers. Gloves should be worn when administering insulin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 12:45 P.M., the Administrator said gloves should be worn with insulin administration. Medications shouldn't be touched with bare fingers. Also, if medication touched the top of the medication cart, it should be wasted. A new medication should be obtained or the physician notified if it's was going to be missed. During an interview on 06/27/24 at 1:00 P.M., the DON said gloves should be worn when administering insulin or anytime there was a chance of coming into contact with blood. Medications shouldn't be touched with bare fingers, and if it was, it should be wasted. A new medication should be obtained if possible and if not, then the physician should be notified that the dose was being missed and why. 45693 47445

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, and interview, the facility failed to provide a safe environment for the residents and staff by not removing miscellaneous items on top of the overbed light fixtures. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 43. The facility did not provide a policy regarding a safe environment. 1. Observation on 06/25/24 at 10:04 A.M., of room [ROOM NUMBER] showed three 12 inch (in.) stuffed animals on top of the light fixture on the wall near the window and three stuff animals on the light fixture near the door. 2. Observation on 06/25/24 at 10:15 A.M., of room [ROOM NUMBER] showed one 8 in. x 10 in. picture frame on top of the light fixture above the bed next to the window. 3. Observation on 06/28/24 at 8:20 A.M., of room [ROOM NUMBER] showed four 10 in. and four 6 in. stuffed animals on top of the light fixture above the head of the resident's bed next to the door. During an interview on 06/25/24 at 12:15 P.M., the resident in room [ROOM NUMBER] said the wall fixture above the bed had been decorated for months. During an interview on 06/28/24 at 8:25 A.M., Housekeeper K said normally the room lighting was checked to see if the wall fixture was working. He/She wiped the top off on the fixture and nothing should be left stacked on top of it. If a resident had put something on top of the wall fixture, it was set to the side or somewhere safe. The resident was told if items were moved so they know it was not lost. During an interview on 06/28/24 at 8:30 A.M., Housekeeper L said the resident room lighting was checked during cleaning and there shouldn't be anything stacked on the wall fixtures. Items were removed if they were found stacked on the fixture and the residents were informed it was a fire hazard. The resident was made aware the items were moved to a safe location in the room. During an interview on 06/28/24 at 9:40 A.M., the Maintenance Director said the residents should not be stacking things on the wall fixtures. The Certified Nursing Assistant (CNA) and housekeeping staff members should check for items placed on light fixtures and clear them off when necessary. During an interview on 06/28/24 at 9:46 A.M., the Director of Nursing said lighting should not be used as shelving in the residents' rooms, CNA and housekeeping staff should check for items stacked on fixtures and other concerns when they were in the rooms. During an interview on 06/28/24 at 9:48 A.M., the Administrator said wall mounted light fixtures should not be used as shelving in the residents' rooms. 46521