

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2024
NAME OF PROVIDER OR SUPPLIER Linwood Village Nursing & Retirement Apts		STREET ADDRESS, CITY, STATE, ZIP CODE 530 South Linwood Avenue Cushing, OK 74023	

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)
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>41318</p> <p>Based on record review, observation, and interview, the facility failed to ensure two trash dumpster's were covered.</p> <p>The Daily Census, dated 02/09/24, documented 52 residents resided in the facility.</p> <p>Findings:</p> <p>A Disposal of Garbage policy, dated 01/02/24, documented containers and dumpster's were to be kept covered when not being used.</p> <p>On 02/09/24 at 10:16 a.m., two outside trash dumpster's were observed. Both dumpster's were observed to have an open lid. One black glove, one black sock, two clumps of paper towels, plastic spoons and forks were observed around the dumpster's.</p> <p>On 02/09/24 at 10:26 a.m., the Administrator stated the dumpster's were suppose to be closed after staff took out the trash.</p>

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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