STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175361	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOPSIDE MANOR INC	**208 W 2ND STREET GOODLAND, KS 67735**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 38 residents. The sample included 12 residents with one reviewed for skin integrity. Based on observation, record review, and interview, the facility failed to report to the state agency Resident (R) 19's skin tear of unknown origin. - R19's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers and locomotion, and required a wheelchair for mobility. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/28/20, directed staff to assist the resident with all transfers. The Pressure Ulcer Skin CAA, dated 05/28/20, indicated the resident had fragile skin and directed staff to weekly assess the resident's skin. The Care Plan, dated 05/21/20, stated the resident had a skin tear on her left lower extremity. The care plan directed staff to weekly monitor and document the size and healing of the skin tear, identify potential causative factors of the skin tear, and use caution during transfers and bed mobility to prevent the resident from receiving further skin tears. Certified Nurse Aide (CNA) N's written statement, dated 05/21/20 at 06:00 AM, documented a staff member entered the resident's room and found the resident in her wheelchair with blood on her lower left leg and a bloody tissue in the trash can. The Nurse's Note, dated 05/21/20 at 6:30 AM, recorded staff sent the resident to the emergency department to evaluate her left lower leg. The Skin Observation Report, dated 05/27/20, recorded the skin tear on the resident's left lower leg measured eight centimeters (cm) x four cm, staff treated the skin tear with normal saline and wrapped with a kerlix dressing (woven gauze roll used for both primary and secondary dressings). Review of the resident's Skin Assessments lacked any further assessments of the skin tear. The Wound Care Clinic Physician Order, dated 07/26/20 directed staff to clean the left lower leg wound area with normal saline, apply [MEDICATION NAME] gel (a medication to treat removal of necrotic wound tissue and aids in wound healing) to the skin tear, place vaseline gauze (fine mesh that prevents skin from tearing during dressing changes and promotes wound healing) over area, wrap in kerlix dressing, and change dressing every other day. Review of the resident's Treatment Administration Record from May - August 2020, lacked any further measurements or assessments of the skin tear after the treatment started, but indicated the dressing was changed every other day as ordered. On 08/03/20 at 01:10 PM, observation revealed R19 sat in a small low wheelchair in the living room area with a dressing on her left lower leg. On 08/05/20 at 01:45 PM, observation revealed R19 lying in bed. Administrative Nurse D, Nurse Consultant (NC) GG and Licensed Nurse (LN) H entered the resident's room, applied gloves, removed the dressing from R19's left lower leg, and revealed a 0.5 cm blister. On 08/05/20 at 01:45 PM, LN H stated the dressing change to the resident's left lower leg was ordered to be changed every other day. LN H stated the skin tear healed but the physician wanted the facility to continue with the dressing until the resident's next appointment. On 08/05/20 at 12:40 PM, Administrative Nurse D stated there was not an investigation done on the resident's skin tear of unknown origin, but CNA N, who found the resident with blood on her leg completed a written statement. Administrative Nurse D verified the facility did not report the incident to the state agency. On 08/05/20 at 12:45 PM, NC GG verified the 05/27/20 assessment (6 days after the skin tear was found) was the last documented assessment of the skin tear to the resident's left lower leg. NC GG stated she expected the Licensed Nurse to assess the area and document weekly. NC GG also stated the facility should have reported the skin tear of unknown origin to the state agency. The facility's Abuse, Investigation and Reporting policy dated July 2017, documented for investigating the individual conducting the investigation will as a minimum, review the resident's medical record to determine events leading up to the incident, interview staff members who have had contact with the resident during the period of the alleged incident and report to the state agency. The facility failed to report R19's left lower leg skin tear of unknown origin to the state agency, placing the resident at risk for further harm.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 38 residents. The sample included 12 residents with one reviewed for skin integrity. Based on observation, record review, and interview, the facility failed to investigate Resident (R) 19's skin tear of unknown origin. - R19's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers and locomotion, and required a wheelchair for mobility. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/28/20, directed staff to assist the resident with all transfers. The Pressure Ulcer Skin CAA, dated 05/28/20, indicated the resident had fragile skin and directed staff to weekly assess the resident's skin. The Care Plan, dated 05/21/20, recorded the resident had a skin tear on her left lower extremity. The care plan directed staff to weekly monitor and document the size and healing of the skin tear, identify potential causative factors of the skin tear, and use caution during transfers and bed mobility to prevent the resident from receiving further skin tears. Certified Nurse Aide (CNA) N's written statement, dated 05/21/20 at 06:00 AM, documented a staff member entered the resident's room and found the resident in her wheelchair with blood on her lower left leg and a bloody tissue in the trash can. The Nurse's Note, dated 05/21/20 at 06:30 AM, recorded staff sent the resident to the emergency department to evaluate her left lower leg. The Skin Observation Report, dated 05/27/20, recorded the skin tear on the resident's left lower leg measured eight centimeters (cm) x four cm and staff treated the skin tear with normal saline and wrapped with a kerlix dressing (woven gauze roll used for both primary and secondary dressings). Review of the resident's Skin Assessments lacked any further assessments of the skin tear. The Wound Care Clinic Physician Order, dated 07/26/20 directed staff to clean the area with normal saline, apply [MEDICATION NAME] gel (a medication to treat removal of necrotic wound tissue and aids in wound healing) to the skin tear, place vaseline gauze (fine mesh that prevents skin from tearing during dressing changes and promotes wound healing) over area, wrap in kerlix dressing, and change dressing every other day. Review of the resident's Treatment Administration Record from May - August 2020, lacked any further measurements or assessments of the skin tear after the treatment started but indicated the dressing was changed every other day as ordered. On 08/03/20 at 01:10 PM, observation revealed R19 sat in a small low wheelchair in the living room area with a dressing on her left lower leg. On 08/05/20 at 01:45 PM, observation revealed R19 lying in bed. Administrative Nurse D, Nurse Consultant (NC) GG and Licensed Nurse (LN) H entered the resident's room, applied gloves, and removed the dressing from R19's left lower leg, and revealed a 0.5 cm blister. On 08/05/20 at 01:45 PM, LN H stated the dressing change to the resident's left lower leg was ordered to be changed every other day. LN H stated the skin tear healed but the physician wanted the facility to continue with the dressing until the resident's next appointment. On 08/05/20 at 12:40 PM, Administrative Nurse D stated there was not an investigation done on the resident's skin tear of unknown origin, but CNA N found the resident with blood on her leg and completed a written statement. No other statements or investigating was completed for the incident. On 08/05/20 at

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

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.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 12:45 PM, NC GG verified the 05/27/20 assessment (6 days after the skin tear was found) was the last documented assessment of the skin tear to the resident's left lower leg. NC GG stated she expected the Licensed Nurse to assess the area and document weekly. NC GG also stated the facility should have completed an investigation on the skin tear of unknown origin. The facility's Abuse, Investigation and Reporting policy dated July 2017, documented for investigating the individual conducting the investigation will as a minimum, review the resident's medical record to determine events leading up to the incident, interview staff members who have had contact with the resident during the period of the alleged incident. The facility failed to investigate R19's left lower leg skin tear of unknown origin, placing the resident at risk for further harm.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 38 residents. The sample included 12 residents with one reviewed for skin integrity. Based on observation, record review, and interview, the facility failed to complete continued assessments and documentation of Resident (R) 19's skin tear. - R19's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers and locomotion, and required a wheelchair for mobility. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/28/20, directed staff to assist the resident with all transfers. The Pressure Ulcer Skin CAA, dated 05/28/20, indicated the resident had fragile skin and directed staff to weekly assess the resident's skin. The Care Plan, dated 05/21/20, recorded the resident had a skin tear on her left lower extremity. The care plan directed staff to weekly monitor and document the size and healing of the skin tear, identify potential causative factors of the skin tear, and use caution during transfers and bed mobility to prevent the resident from receiving further skin tears. Certified Nurse Aide (CNA) N's written statement, dated 5/21/20 at 06:00 AM, documented a staff member entered the resident's room and found the resident in her wheelchair with blood on her lower left leg and a bloody tissue in the trash can. The Nurse's Not, dated 05/21/20 at 06:30 AM, recorded staff sent the resident to the emergency department to evaluate her left lower leg. The Skin Observation Report, dated 05/27/20, recorded the skin tear on the resident's left lower leg measured eight centimeters (cm) x four cm and staff treated the skin tear with normal saline and wrapped with a kerlix dressing. (woven gauze roll used for both primary and secondary dressings). Review of the resident's Skin Assessments lacked any further assessments of the skin tear. The Wound Care Clinic Physician Order, dated 07/26/20 directed staff to clean the area with normal saline, apply [MEDICATION NAME] gel (a medication to treat removal of necrotic wound tissue and aids in wound healing) to the skin tear, place vaseline gauze (fine mesh that prevents skin from tearing during dressing changes and promotes wound healing) over area, wrap in kerlix dressing, and change dressing every other day. Review of the resident's Treatment Administration Record from May - August 2020 lacked any further measurements or assessments of the skin tear after the treatment had started but indicated the dressing was changed every other day as ordered. On 08/03/20 at 01:10 PM, observation revealed R19 sat in a small low wheelchair in the living room area with a dressing on her left lower leg. On 08/05/20 at 01:45 PM, observation revealed R19 lying in bed. Administrative Nurse D, Nurse Consultant (NC) GG and Licensed Nurse (LN) H entered the resident's room, applied gloves, removed the dressing from R19's left lower leg, and revealed a 0.5 centimeter (cm) blister. On 08/05/20 at 01:45 PM, LN H stated the dressing change to the resident's left lower leg was ordered to be changed every other day. LN H stated the skin tear healed but the physician wanted the facility to continue with the dressing until the resident's next appointment. On 08/05/20 at 12:40 PM, Administrative Nurse D stated staff did not complete ongoing documentation of the skin tear. On 08/05/20 at 12:45 PM, NC GG verified the 05/27/20 assessment (6 days after the skin tear was found) was the last documented assessment of the skin tear to the resident's left lower leg. NC GG stated she expected the Licensed Nurse to assess the area and document weekly. The facility's Skin Tear policy, dated September 2013, recorded the documentation of interventions and assessment of skin tear is to be done on a weekly basis. The facility failed to continually assess and document R19's left lower leg skin tear, placing the resident at risk for infection.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 38 residents. The sample included 12 residents with one reviewed for skin integrity. Based on observation, record review, and interview, the facility failed to keep Resident (R) 19's environment free from accident hazards when the resident obtained a skin tear of unknown origin. - R19's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers and locomotion, and required a wheelchair for mobility. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/28/20, directed staff to assist the resident with all transfers. The Pressure Ulcer Skin CAA, dated 05/28/20, indicated the resident had fragile skin and directed staff to weekly assess the resident's skin. The Care Plan, dated 05/21/20, stated the resident had a skin tear on her left lower extremity. The care plan directed staff to weekly monitor and document the size and healing of the skin tear, identify potential causative factors of the skin tear, and use caution during transfers and bed mobility to prevent the resident from receiving further skin tears. Certified Nurse Aide (CNA) N's written statement, dated 05/21/20 at 06:00 AM, documented a staff member entered the resident's room and found the resident in her wheelchair with blood on her lower left leg and a bloody tissue in the trash can. The Nurse's Note, dated 05/21/20 at 6:30 AM, recorded staff sent the resident to the emergency department to evaluate her left lower leg. The Skin Observation Report, dated 05/27/20, recorded the skin tear on the resident's left lower leg measured eight centimeters (cm) x four cm, staff treated the skin tear with normal saline and wrapped with a kerlix dressing (woven gauze roll used for both primary and secondary dressings). Review of the resident's Skin Assessments lacked any further assessments of the skin tear. The Wound Care Clinic Physician Order, dated 07/26/20 directed staff to clean the left lower leg wound area with normal saline, apply [MEDICATION NAME] gel (a medication to treat removal of necrotic wound tissue and aids in wound healing) to the skin tear, place vaseline gauze (fine mesh that prevents skin from tearing during dressing changes and promotes wound healing) over area, wrap in kerlix dressing, and change dressing every other day. Review of the resident's Treatment Administration Record from May - August 2020, lacked any further measurements or assessments of the skin tear after the treatment started, but indicated the dressing was changed every other day as ordered. On 08/03/20 at 01:10 PM, observation revealed R19 sat in a small low wheelchair in the living room area with a dressing on her left lower leg. On 08/05/20 at 01:45 PM, observation revealed R19 lying in bed. Administrative Nurse D, Nurse Consultant (NC) GG and Licensed Nurse (LN) H entered the resident's room, applied gloves, removed the dressing from R19's left lower leg, and revealed a 0.5 cm blister. On 08/05/20 at 01:45 PM, LN H stated the dressing change to the resident's left lower leg was ordered to be changed every other day. LN H stated the skin tear healed but the physician wanted the facility to continue with the dressing until the resident's next appointment. On 08/05/20 at 12:40 PM, Administrative Nurse D stated there was not an investigation done on the resident's skin tear of unknown origin, but CNA N, who found the resident with blood on her leg completed a written statement. Administrative Nurse D verified the facility did not report the incident to the state agency. On 08/05/20 at 12:45 PM, NC GG verified the 05/27/20 assessment (6 days after the skin tear was found) was the last documented assessment of the skin tear to the resident's left lower leg. NC GG stated she expected the Licensed Nurse to assess the area and document weekly. NC GG also stated the facility should have reported the skin tear of unknown origin to the state agency. The facility's Skin Tears policy, dated September 2013, documented the purpose of the policy is to guide the prevention and treatment of [REDACTED]. The policy directed staff to document any complications related to the area, interventions implemented or modified to prevent additional abrasions, investigate and report skin abrasions, and document weekly measurements and treatments on the skin report. The facility failed to keep R19's environment free from accident hazards when the resident obtained a skin tear to her lower left leg, placing the resident at risk for further harm.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) The facility had a census of 38 residents. The sample included 12 residents with three reviewed for nutrition. Based on observation, record review, and interview, the facility failed to develop and implement effective nutritional interventions for one of two sampled residents, Resident (R) 6, who had a weight loss of 12.6 pounds (lbs) in six months. Findings included: - R6's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS recorded the resident required set up help with supervision, encouragement, and cueing with eating. The Nutrition Care Area Assessment (CAA), dated 12/05/19, did not trigger. The Nutrition Care Plan, dated 05/13/20 documented the resident at risk for potential nutritional problems due to [MEDICAL CONDITION] (progressive mental deterioration characterized by confusion and memory failure), did not eat well, and weight loss. The care plan documented on 03/04/20 the resident received a nutritional supplement, invited the resident to food-related activities, offered food and beverages of choice to encourage intake, and provided setup and supervision in the dining room. The facility's Vital Signs form documented the following weights: 01/29/20 - 133.2 lbs 02/04/20 - 131.6 lbs 03/04/20 - 129.6 lbs 04/14/20 - 126.4 lbs 05/05/20 - 125.4 lbs 06/08/20 - 123.6 lbs 07/08/20 - 123.4 lbs 07/20/20 - 120.6 lbs (loss of 12.6 lbs or 9.5 % in 6 months) The Physician Order, dated 07/10/20, directed staff to administer the resident a regular diet, regular texture and regular consistency. The resident had no nutritional supplements ordered. The Consultant Dietician Note, dated 12/03/19, documented the resident weighed 133.5 lbs., caloric needs 1515 calories, protein needs 61 grams, and fluid needs 1515 (ml) milliliters. The note documented the resident's oral intake 26-100%, fluid intake 1360 ml, and received a house supplement four times a day. Review of R6's Electronic Medical Record (EMR) lacked a completed dietary assessment by the Registered Dietician after 12/03/2019, and the resident continued to lose weight. On 08/06/20 at 09:10 AM, Administrative Staff A and Nurse Consultant (NC) GG verified the resident had a weight loss of 12.6 lbs in six months, contacted the Registered Dietician, and had him reassess the resident's nutritional needs and interventions. The facility's Nutritional (Impaired)/Unplanned Weight Loss policy, dated December 2017, documented nursing staff would monitor and document the weight and dietary intake of residents in a format which permits comparison over time. The staff would report to the physician any significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. The staff and physician would identify pertinent interventions based on identified causes and overall residents' condition, prognosis, and wishes. The physician would authorize appropriate interventions, staff and physician will review and consider existing dietary restrictions and modify consistency diets. The facility failed to timely implement effective interventions to prevent weight loss for R6, who lost 12.6 pounds in six months, placing the resident at risk for continued weight loss and inadequate nutrition.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** Based upon document review, and staff interview the facility is not inspecting and maintaining their rated door assemblies in compliance with NFPA 80. This deficient practice could prevent the ability of the facility to properly confine smoke and prevent fire from spreading to other zones. This deficient practice would affect all residents, visitors, and staff in 5 of 5 smoke zones. The facility has a capacity of 45 beds and at the time of survey the census was 35. Findings include: During the survey conducted on 1/8/2020 the following deficiency is noted: 1. During document review at 12:11 PM, it is observed that there is no documentation for any annual inspection on the rated door assemblies in the facility. Staff A was present and acknowledged the finding. NFPA Standard: NFPA 80 2010 5.2.1 Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. 5.2.3.1 Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 5.2.4.2 As a minimum, the following items shall be verified: (1) No open holes or breaks exist in the surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and non combustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7 (6) The self-closing device is operational; that is, the active door completely closes when operated from the open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. 3.3.95 Qualified Person. A person who, by possession of a recognized degree, certificate, professional standing, or skill, and who by knowledge, training, and experience, has demonstrated the ability to deal with the subject matter, the work, or the project.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full time Certified Dietary Manager for the 38 residents who resided in the facility and received their meals from the facility kitchen. Findings included: - On 08/03/20 at 11:20 AM, observation during the initial kitchen tour revealed dietary staff served the noon meal to the residents. On 08/03/20 at 11:40 AM, observation revealed the posted noon meal menu included chicken alfredo, green beans, roll with butter, banana pudding with whip topping, and drink of choice. Residents could choose what they wanted prior to the meal being served or they could choose from an alternate menu. On 08/03/20 at 11:50 AM, Dietary Staff (DS) BB stated she was not certified. DS BB stated she had worked as the dietary manager for a few months and enrolled in the dietary manger program. DS BB verified four residents received a pureed diet and three residents received a mechanical soft diet. On 08/06/20 at 10:30 AM, Administrative Staff A verified DS BB was not certified and was currently enrolled in a certified dietary manager online course. Upon request, a Certified Dietary Manager/Food Service Director job description/policy was not provided. The facility failed to employ a full time Certified Dietary Manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 38 residents in the facility who received their meals from the facility kitchen, placing the residents at risk for inadequate nutrition.
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 had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment in the facility kitchen. Findings included: - On 08/05/20 at 12:10 PM, observation in the kitchen's dishwashing area revealed four 12 inch (in) x 12 in ceiling mounted air flow registers, one located between the stove and food serving window, and three located above the stove, covered with brownish/gray lint that coated the grills. Continued observation revealed two 12 in x 12 in steel return air grills, directly above the clean dish washing area, with brownish, rust colored lint coating the grills. On 08/05/20 at 12:30 PM, observation in the kitchen revealed two 18 in x 36 in fluorescent overhead lights located in front of the overhead grill hood and stove, the plastic light covers were cracked with an approximately six in by two in missing area and the covers had a brown coating on the inside with brownish black debris under the coverings. On 08/05/20 at 01:00 PM, Dietary Staff (DS) BB and Administrative Staff A verified the ceiling mounted air flow registers with brownish/gray lint, return air grill with brownish rust colored lint, and missing/cracked fluorescent light covers. Administrative Staff A verified the registers needed cleaned and the fluorescent light covers should be replaced. The facility's Cleaning and Sanitation of Dining and Food Service Areas policy, dated 2013, documented the food service would maintain the cleanliness

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. A cleaning schedule would be posted for all cleaning tasks, and staff will initial the task as completed. All staff will be held accountable for cleaning assignments. The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 38 residents who received meals from the facility kitchen.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment in the facility kitchen. Findings included: - On 08/03/20 at 12:00 PM, observation during the initial kitchen tour revealed the food preparation area with all of the 16-inch (in) x 16 in square ceramic floor tiles with grout (paste for filling spaces between wall or floor tiles) between the tiles. The tiles were discolored with brownish black grime (dirt ingrained on the surface) and grime build up along the exterior of the kitchen floor that connects to the baseboards. On 08/05/20 at 01:00 PM, Dietary Staff (DS) BB and Administrative Staff A verified the brown grease and grime build up on the floor and stated it should be cleaned and would look for a product to clean the grout. The facility's Sanitation policy, dated October 2008, documented the food service area shall be maintained in a clean and sanitary manner, and all kitchen areas shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. The policy documents the kitchen surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The facility failed to provide a safe, functional, sanitary, and comfortable environment in the facility kitchen.