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PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation 192114 and 191821. The 2567 was electronically sent on 3/14/25.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		

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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(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with 15 residents included in the sample. Based on observation, record review and interview, the facility failed to complete a resident centered comprehensive care plan for one Resident (R) 14, regarding non-pharmacologic interventions for pain.

Findings included:

- Review of Resident (R)14's electronic medical record (EMR) revealed a diagnosis of chronic pain (physical suffering or discomfort caused by illness or injury).

The "Significant Change Minimum Data Set" (MDS), dated 12/25/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She received as needed (PRN) pain medication and non-pharmacological interventions (interventions

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not based on medication) for pain. She rated the worse pain in the past five days to be five out of 10 on the one to10 pain scale (scale used to rate pain with zero being no pain and 10 being the worse pain possible). She received opioid medication (a class of drugs healthcare providers prescribe to manage moderate to severe pain) during the assessment period.

The "Pain Care Area Assessment" (CAA), dated 12/25/24, did not trigger for further development.

The "Quarterly MDS," dated 11/20/24, documented the resident had a BIMS score of 13, indicating intact cognition. She received PRN pain medication and non-pharmacological interventions for pain and received opioid medication during the assessment period.

The care plan for pain, revised 01/02/25, lacked staff instruction on non-pharmracologic interventions for pain.

Review of the resident's EMR revealed the following physician orders:

Gabapentin (prescription medication used to treat neuropathic pain), 100 milligrams (mg), by mouth (po), at bedtime (HS), for a diagnosis of restless leg syndrome (RLS-a brain, nerve and sleep condition that causes a strong, nearly irresistible urge to move your legs that ' s at least partially relieved by movement), ordered 08/12/24.

Review of the resident's "Medication Administration Record" (MAR) revealed the resident received the Gabapentin in February and March, as ordered.

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Norco (an opioid medication combination of hydrocodone (an opioid medication) and acetaminophen (a non-opioid pain reliever) which works in the brain to change how a person's body feels and responds to pain), 5-325 mg, po every (Q) six hours, PRN, for pain, ordered 08/12/24.

Review of the resident's MAR revealed the resident received the Norco seven times from 02/01/25 through 02/28/25, for pain rated between five and nine on the one to 10 pain scale and four times from 03/01/25 through 03/05/25 for pain rated six to nine on the one to 10 pain scale, with effective results.

Tylenol (acetaminophen) extra strength (ES), 500 mg, po, Q 6 hours, PRN, for pain, ordered 08/12/24.

Review of the resident's MAR revealed the resident received the tylenol medication 15 times from 02/01/25 through 02/28/25, for pain rated one to seven on the one to 10 pain scale and seven times from 03/01/25 through 03/05/25 for pain rated five to eight on the one to 10 pain scale, with effective results.

During an observation on 03/03/25 at 10:44 AM, the resident sat a recliner in her room with her feet elevated on the footrest. The resident had facial grimacing, indicating pain.

On 03/03/25 at 10:44 AM, the resident stated she always had back pain, which did not affect her sleep or day to day activities. She stated she was unaware of any pain interventions other than the pain medications available to help ease her pain.

On 03/05/25 at 08:47 AM, Certified Nurse Aide

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F 656	Continued From page 4 (CNA) N stated the resident had back pain. When the resident has pain, she will let the nurse know the resident needs pain medication. On 03/05/25 at 08:57 AM, Administrative Nurse D confirmed the resident lacked non-pharmacologic pain interventions on her care plan to help ease her back pain. The facility policy for "Baseline Care Plans", revised 11/15/17, included: The facility will implement interventions to assist the resident to achieve their goals. The facility failed to complete a comprehensive resident-centered care plan to include non-pharmacologic pain interventions.	F 656		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents with 15 residents sampled, including one resident reviewed for pain. Based on observation, interview and record review, the facility failed to offer non-pharmaceutical interventions for pain for one Resident (R)17, who has chronic pain. Findings included: - Review of Resident (R)14's electronic medical	F 697		

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record (EMR) revealed a diagnosis of chronic pain (physical suffering or discomfort caused by illness or injury).

The "Significant Change Minimum Data Set" (MDS), dated 12/25/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She received as needed (PRN) pain medication and non-pharmacological interventions (interventions not based on medication) for pain. She rated the worse pain in the past five days to be five out of 10 on the one to 10 pain scale (scale used to rate pain with zero being no pain and 10 being the worse pain possible). She received opioid medication (a class of drugs healthcare providers prescribe to manage moderate to severe pain) during the assessment period.

The "Pain Care Area Assessment" (CAA), dated 12/25/24, did not trigger.

The "Quarterly MDS," dated 1120/24, documented the resident had a BIMS score of 13, including intact cognition. She received PRN pain medication and non-pharmacological interventions for pain and received opioid medication during the assessment period.

The "Care Plan" for pain, revised 01/02/25, instructed staff to know the resident was able to call for assistance when she was in pain and was able to request pain medication.

Review of the resident's EMR revealed the following physician orders:

Gabapentin (prescription medication used to treat neuropathic pain), 100 milligrams (mg), by mouth

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(po), at bedtime (HS), for a diagnosis of restless leg syndrome (RLS-a brain, nerve and sleep condition that causes a strong, nearly irresistible urge to move your legs that's at least partially relieved by movement), ordered 08/12/24.

Review of the resident's Review of the resident's "Medication Administration Record" (MAR) revealed the resident received the medication in February and March, as ordered.

Norco (an opioid medication combination of hydrocodone (an opioid medication) and acetaminophen (a non-opioid pain reliever) which works in the brain to change how a person's body feels and responds to pain), 5-325 mg, po every (Q) six hours, PRN, for pain, ordered 08/12/24.

Review of the resident's MAR revealed the resident received the medication seven times from 02/01/25 through 02/28/25, for pain rated five to nine on the one to 10 pain scale and four times from 03/01/25 through 03/05/25 for pain rated six to nine on the one to 10 pain scale, with effective results.

Tylenol (acetaminophen) extra strength (ES), 500 mg, po, Q 6 hours, PRN, for pain, ordered 08/12/24.

Review of the resident's MAR revealed the resident received the medication 15 times from 02/01/25 through 02/28/25, for pain rated one to seven on the one to 10 pain scale and seven times from 03/01/25 through 03/05/25 for pain rated five to eight on the one to 10 pain scale, with effective results.

On 03/03/25 at 10:44 AM, the resident sat in the

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F 697	Continued From page 7 recliner in her room with her feet elevated on the footrest. The resident had facial grimacing, indicating pain. On 03/03/25 at 10:44 AM, the resident stated she had back pain, which did not affect her sleep or day to day activities. She stated she was unaware of any pain interventions other than the pain medications available to help ease her pain. On 03/05/25 at 08:47 AM, Certified Nurse Aide (CNA) N stated the resident had back pain. When the resident had pain, she would let the nurse know the resident needed pain medication. On 03/05/25 at 08:57 AM, Administrative Nurse D confirmed the resident lacked non-pharmacologic pain interventions to help ease her back pain. The facility policy for "Pain Care", effective 05/10/17, included non-pharmacological measures should be used along with pharmacological measures for maximum pain relief. The facility failed to initiate non-pharmacologic pain interventions to help this resident with chronic pain.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		

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by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on observation, record review and interview, the facility failed to display accurate, publicly accessible, and identifiable staffing information, on a daily, for the 38 residents who reside in the facility.

Findings included:

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F 732	Continued From page 9 - Review of the facility's "Daily Staffing Sheets", from 02/01/25 through 03/03/25, revealed the total hours and actual hours worked by staff was not completed on the daily staffing sheets. On 03/05/25 at 02:00 PM, Administrative Nurse D stated she was unaware the daily staffing sheets needed to include the total hours and actual hours worked. The facility policy for "Posting Direct Care Daily Staffing Numbers", undated, included information for the shift staffing for each staff shall include the total number of nursing staff working for the posted shift and the actual time worked during the shift for each category. The facility failed to properly complete the daily staffing sheets for the residents of the facility.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		

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psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents with 15 residents sampled including five residents reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to monitor five Residents (R) 26, and R 34, regarding failure to monitor the side effects

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of psychotropic (drugs that affect the brain and central nervous system, altering mood, thoughts, emotions, and behavior) and antipsychotic (drugs that treat psychotic symptoms like hallucinations and delusions) medications and the failure to obtain a stop date for R 18's antianxiety (drugs that treat anxiety disorders) medication, Ativan.

Findings included:

- Review of Resident (R)26's electronic medical record (EMR) revealed a diagnosis of major depressive disorder (major mood disorder which causes persistent feelings pf sadness).

The "Annual Minimum Data Set" (MDS), dated 11/13/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. He received antipsychotic (drugs that treat psychotic symptoms like hallucinations and delusions) and antidepressant (a type of psychotropic drugs that affects the brain and central nervous system, altering mood, thoughts, emotions, and behavior) medication during the assessment period.

The "Psychotropic Drug Care Area Assessment" (CAA), dated 11/13/24, documented staff would administer his medications and monitor for adverse side effects and to report any concerns to his physician.

The "Quarterly MDS," dated 02/12/25, documented the resident had a BIMS score of zero, indicating severe cognitive impairment. He received antipsychotic and antidepressant medications during the assessment period.

The "Care Plan", revised 02/12/25, instructed

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staff to monitor for adverse side effects and report any concerns to the physician.

Review of the resident's EMR revealed the following physician orders:

Mirtazapine (an antidepressant medication), 15 milligrams (mg), by mouth (po), at bedtime (HS), for a diagnosis of MDD, ordered 02/27/25.

Sertraline (an antidepressant medication), 2.5 milliliters (ml), po, every day (QD), for a diagnosis of MDD, ordered 02/27/25.

Olanzapine (an antipsychotic medication), 5 mg, po, at HS, for a diagnosis of MDD, ordered 02/27/25.

Review of the resident's EMR lacked monitoring of any side effects for the resident's antipsychotic and/or antidepressant medications.

On 03/05/25 at 08:57 AM, Administrative Nurse D stated staff did not monitor for side effects of antipsychotic and antidepressant medications for more than 72 hours after the medication was started.

The facility policy for "Antipsychotic Medications", effective 09/21/21, included: The charge nurse will monitor for resident behaviors and signs and symptoms of adverse consequences of antipsychotic medication every shift, and document in the resident's record.

The facility failed to monitor for adverse side effects for this dependent resident who received antidepressant and antipsychotic medications.

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- Review of Resident (R)34's electronic medical record (EMR) revealed a diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Admission Minimum Data Set" (MDS), dated 09/09/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She did not receive antidepressant (a type of psychotropic drugs that affects the brain and central nervous system, altering mood, thoughts, emotions, and behavior) medication during the assessment period.

The "Mood State Care Area Assessment" (CAA), dated 09/09/24, documented staff would observe for changes in the resident's mood and to report any concerns to the physician.

The "Quarterly MDS," dated 12/10/24, documented the resident had a BIMS score of 15, indicating intact cognition. She received antidepressant medication during the assessment period.

The "Care Plan", revised 12/11/24, instructed staff to monitor for and report any adverse side effects from the antidepressant medication to the physician.

Sertraline (an antidepressant medication), 50 milligrams, by mouth (po), every morning (QAM), for a diagnosis of depression, ordered, 09/28/24.

Review of the resident's "Medication Administration Record" (MAR), revealed the resident received the antidepressant medication, as ordered.

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	175489	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 758	Continued From page 14 On 03/05/25 at 08:57 AM, Administrative Nurse D stated staff did not monitor for side effects of antidepressant medication for more than 72 hours after the medication was started. The facility policy for "Antipsychotic Medications", effective 09/21/21, included the charge nurse will monitor for resident behaviors and signs and symptoms of adverse consequences of antipsychotic medication every shift, and document in the resident's record. The facility failed to monitor for adverse side effects for this dependent resident who received antidepressant and antipsychotic medications.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		

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F 812	Continued From page 15	F 812		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility.

Findings included:

- On 03/03/25 at 08:03 AM during an initial tour of the main kitchen, refrigerator, freezer, and dry food storage areas, the following areas of concern were observed:

Observation of the storage room revealed:
One undated bag of tortilla chips left open to air and laying on the counter.
One undated bag of coconut flakes loosely rolled shut on a shelf.
One undated, open box of baking soda box with discoloration and water damage to the box.
One undated, open box of baking soda.

Observation of the refrigerator revealed open and undated items including a bottle of soy sauce, large jug of barbeque sauce, lage jug of ketchup, large jug of salad dressing, large jug of picante sauce, large tub of beef base, and a large tub of chicken base.

Observation of the freezer revealed an undated box of chicken fried steak with the bag inside left open to air.

Observation of the walk-in refrigerator revealed:
Individual portions of deserts, which included various cakes and pies left uncovered and

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F 812	Continued From page 16 undated. A large bag of shredded mild cheddar cheese left open and undated. A large bag of cubed Monterey Jack cheese, and a large bag of Colby Jack cheeses were opened and not dated. In the kitchen serving area there were bags of open cereal that were undated. During an interview on 03/06/25 at 08:03 AM, Dietary Manager BB revealed she expected staff to label, and date opened food items. Dietary Manager BB stated that the above concerns identified with dry storage and freezer storage, which included undated and unsealed items were unacceptable and she stated she would throw out the appropriate items. Dietary Manager BB verified that if food was not labeled with a date there was no way for staff to know how long it had been opened and when to throw it out. The facility's undated policy "Food Safety- Use and storage of food and beverage brought in for residents, food procurement" revealed that education on safe food handling would be provided to all staff who may provide foods or fluids to residents of the facility. The education would include the requirement for covered containers or secure wrapping for foods, proper labeling and dating of each item, and leftover foods to be used within three days or discard. The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 17 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment for the residents of the facility, in two of four resident halls.

Findings included:

- During an initial tour of the facility on 03/04/25 at 01:25 PM, revealed the following areas of

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F 880	Continued From page 19 concern on hall 400: 1. One hall had three resident private bathrooms with incontinent products resting directly on the bathroom floor and lacking a barrier. 2. One hall had a trash can for disposal of Enhanced Barrier Precautions (EBP) outside of a resident room with disposed personal protective equipment (PPE) coming out of the partially covered trash can. 3. One resident room had multiple items on the closet floor. 4. The medication room had one box, which contained approximately 75 cards of assorted medications to be returned to the pharmacy resting directly on the floor and lacking a barrier. The facility policy for "Infection Control", revised 06/22, included: The facility shall have an infection control program to provide a safe, sanitary, and comfortable environment for the residents.	F 880		