STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265326	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Republic Nursing & Rehab	901 East Hwy 174 Republic, MO 65738

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff) included accurate nutritional and weight loss information for one resident (Resident #28). The facility census was 82. Review of the facility provided document titled, MDS and Care Planning Guidelines, dated 10/01/15, showed the following information: -It is the policy of the facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) Manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. 50237 1. Review of Resident #28's face sheet showed the following information: -admitted [DATE]; -Diagnoses included chronic kidney disease-stage 3 (kidneys have mild to moderate damage and are less able to filter waste and fluid out of the body), Type 2 diabetes mellitus (a disease that occurs when your blood sugar is too high), and schizophrenia (a serious mental disorder in which people interpret reality abnormally). Review of the resident's quarterly (and most recent) MDS, dated [DATE], showed the resident weighed 156 pounds with no significant weight loss identified. Review of the resident's weights showed the following: -On 12/11/23, the resident weighed 156 pounds; -On 01/01/24, the resident weighed 142 pounds (a 14 pound (8.97%) weight loss). Review of the resident's significant change MDS, dated [DATE], showed the following: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff documented the resident's weight as 142 pounds; -Staff did not identify significant weight loss present. Review of the resident's weights showed the following: -On 01/08/24, the resident weighed 140.2 pounds; -On 01/09/24, the resident weighed 140 pounds; -On 01/15/24, the resident weighed 137.4 pounds; -On 01/19/24, the resident weighed 136.2 pounds; -On 01/22/24, the resident weighed 134 pounds; -On 01/29/24, the resident weighed 134.2 pounds. Review of the Registered Dietitian's note dated 01/30/24, at 8:49 A.M., showed the resident's current weight as 134 pounds, a 5.5% loss in the last month, and an overall loss of 13% loss in the last 6 months. Review of the resident's care plan, reviewed/revised 03/07/24, showed monitor the resident's weight per physician order and as needed. The resident had recent abnormal weight loss due to not eating. During an interview on 03/14/24, at 3:30 P.M., the MDS Coordinator said she looks back on quarterly nutrition reports for weights. The Dietary Manager in the kitchen and the dietitian run reports that she uses when collecting information for the MDS. Restorative is responsible for obtaining weekly and monthly weights. He/she did a significant change MDS on 01/05/24 and agrees that the resident's weight was 142 pounds. During an interview on 03/14/24, at 4:26 P.M., with the Administrator and DON, they said if a resident has weight loss, it should be addressed in morning meetings. The facility has weekly weight loss meetings and they discuss weights in those meetings. The MDS Coordinator is present during those meetings. They have a weekly weight variance report they review. If a resident has a significant weight loss, it should be marked on the MDS. The resident has had a significant weight loss since December 2023/January 2024 and it should have been reflected on the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37358 Based on record review and interview, the facility failed to complete a comprehensive and individualized care plan, including interventions, to address the use of antianxiety medications for one resident (Resident #56) and receipt of hospice services for one resident (Resident #89). The facility had a census of 82. Review of the facility's policy titled, Care Plan Comprehensive, dated March 2015, showed the following: -The interdisciplinary care plan team, with input from the resident, family, and/or legal representative. will develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain; -The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to, the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff); -Assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition; -The interdisciplinary care plan team is responsible for the periodic review and updating of care plans when a significant change in the resident's condition has occurred, at least quarterly or when changes occur that impact the resident's care. 1. Review of Resident #56's face sheet (a general information sheet) showed the following: -admitted [DATE]; -Diagnoses included unspecified dementia (a set of symptoms that over time can affect memory, problem-solving, language and behavior), psychotic and mood disturbance (disorders-a group of illnesses affecting thinking, communicating, understanding and behaviors), and anxiety (a feeling of worry, nervousness or unease). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Diagnoses included anxiety; -Resident had severely impaired cognition. Review of the resident's March 2024 Physician Order Sheet (POS) showed the following: -An order, dated 12/14/23, for buspirone (an antianxiety medication) 10 milligrams (mg), one tablet by mouth at bedtime; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 12/14/23, for buspirone 5 mg, one tablet by mouth, once a day, scheduled at 8:00 A.M. Review of resident's progress notes showed the following: -On 02/20/24, at 2:09 P.M., the resident's Nurse Practitioner (NP) reviewed resident's medication record and verified continuation of current orders for psychotropic medications with dose reduction clinically contraindicated without improvement in anxiety, behaviors, and insomnia or current therapy. The dose reduction may cause destabilization and exacerbation of symptoms with decline in function. Resident to continue Buspar (buspirone) 5 mg by mouth every morning, and Buspar 10 mg by mouth daily at bedtime. -On 03/07/24, at 10:27 A.M., received new order to increase buspirone to 7.5 mg by mouth daily at 8:00 am due to dementia with agitation; Review of resident's March 2024 POS showed the following orders: -An order, dated 03/07/24, for buspirone 7.5 mg, one tablet by mouth, once a day at 8:00 A.M. Review of resident's progress notes showed the following: -On 03/08/24, at 10:19 A.M., psychotic medication change made to increase 8:00 A.M. buspirone to 7.5 mg daily; -On 03/10/24, at 3:54 A.M., change of dosage continued to be monitored with no behaviors noted. Review of the resident's current care plan, last revised on 03/11/24, showed staff did not address the resident's use of psychotropic medications. During an interview on 03/14/24, at 4:40 P.M., the Director of Nursing (DON) the use of psychotropic medications should be care planned. 2. Review of Resident #89's face sheet showed the following: -Most recent admitted [DATE]; -Diagnoses included anxiety, type II diabetes mellitus (diabetes characterized by high blood sugar, insulin resistance, and a lack of insulin, occurring when cells resist the normal effect of insulin), acute/chronic respiratory failure (difficulty to breathe on own) with hypoxia (deficiency in the amount of oxygen reaching tissues), hypertension (high blood pressure)and disorientation (losing one's sense of direction). Review of resident's progress note dated 02/24/24, at 2:19 P.M., showed hospice present for admission to the services and obtain permission from family for continuity of care. Review of resident's significant change MDS, dated [DATE], showed hospice care had been added. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's February 2024 POS showed an order, dated 02/26/24, for hospice evaluation and services. Review of the resident's current care plan showed staff did not address hospice services on the resident's care plan. During an interview on 03/14/24, at 4:40 P.M., the DON said the resident's care plan should have included hospice services. During an interview on 03/14/24, at 4:50 P.M., the Administrator said hospice evaluations hospice will evaluate a resident and then the MDS/Care Plan Coordinator will add it to the care plan. 3. During an interview on 03/13/24, at 10:28 A.M., the MDS/Care Plan Coordinator said the following: -He/she had been working at the facility since October 2023; -He/she was trained until February 2024 and then took over the MDS duties; -He/she had not done care plans until this past week; -He/she thinks the person who trained him/her had not done the care plans either; -He/she was told by the one training him/her that nurses do the care plans; -He/she just realized in the past week or two that he/she was supposed to be doing them. 4. During an interview on 03/14/24, at 4:40 P.M., the DON said the following: -The MDS/Care Plan Coordinator is responsible for adding information to the care plans; -He/she would expect to see concerns like behaviors and hospice to be care planned; -Nurses do not enter information on the care plan; -If something new comes up, a change in condition, the nurses communicate with the MDS/Care Plan Coordinator. 5. During an interview on 03/14/24, at 4:50 P.M., the Administrator said the following: -The MDS Coordinator would be the one to add anything to care plans; -Corporate came and trained the MDS/Care Plan Coordinator for a week and every couple of weeks since then; -This would include any significant changes like behaviors or hospice.

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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** 45176 Based on observation, interview, and record review, the facility staff failed provide care per standards of practice when staff failed to obtain a physician's order for hospice and update the resident's care plan to reflect admission to hospice for one resident (Resident # 6). The facility census was 82. Review of the facility's policy titled, Physician's Orders, dated March 2015, showed the following: -Physician's orders must be signed by the physician and dated when such order was signed; -Current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors. Review of the facility's policy titled, Care Plan Comprehensive, dated March 2015, showed the following: -The interdisciplinary care plan team, with input from the resident, family, and/or legal representative, will develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain; -Assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition; -The interdisciplinary care plan team is responsible for the periodic review and updating of care plans when a significant change in the resident's condition has occurred, at least quarterly or when changes occur that impact the resident's care. 1. Review of Resident #6's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/07/24, showed an admitted [DATE]. Review of the resident's face sheet showed the resident was admitted to hospice on 08/02/23. Review of the resident's current Physician Order Sheet showed staff did not document an order for hospice services. Review of the resident's care plan, updated on 03/11/24, showed staff did not address the resident receiving hospice services. During an interview on 03/14/24, at 9:45 A.M., Licensed Practical Nurse (LPN) H said the following: -Nurses add orders when received from the doctor; -Residents require an order for hospice; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she looked in the electronic record and found on the resident's face sheet that indicated the resident was on hospice, but he/she could not locate an order for hospice; -He/she said the resident should have an order since the resident is on hospice; -He/she knows hospice would be included on a resident's care plan and should be listed on the resident's care plan. During an interview on 03/14/24, at 9:55 A.M., Certified Med Tech (CMT) I said the following: -If a resident is on hospice, he/she doesn't believe they need an order; -The resident is on hospice; -The resident's care plans are located in their closets and in the electronic health records (EHR); -He/she doesn't know if the care plan would list whether a resident is on hospice. During an interview on 03/14/24, at 10:05 A.M., Certified Nurse Aide (CNA) J said the following: -He/she can see some of the resident's care plan on the EHR; -When a resident is on hospice, it's listed on their care plan; -The resident is on hospice so this should be on his/her care plan. During an interview on 03/14/24, at 10:15 A.M., LPN K said the following: -Nurses receive the orders and the nurse that receives the order is responsible for putting that into the resident's EHR; -Residents on hospice should have an order in their records; -The resident is on hospice; -He/she looked in the resident's record and said the resident does not have a current order for hospice; -The resident should have an order for hospice; -He/she said the MDS Coordinator is responsible for care plans; -He/she doesn't know if hospice would be listed on the resident's care plan. During interviews on 03/14/24, at 10:22 A.M., 10:30 A.M., and 3:30 P.M., the MDS Coordinator said the following: -He/she knows now that he/she is responsible for completing and updating the care plans; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was told in the beginning that the nurses are doing the care plans; -He/she is told by the nurses or morning meetings when there needs to be updates to care plans; -Resident's should have an order for hospice services; -Hospice should be included on the resident's care plan. During an interview on 03/14/24, at 4:46 P.M., the Administrator and Director of Nursing (DON), said the following: -Care plans are in the resident's closets; -Staff are asked about input for resident care plans; -Nurses do not enter care plans, they communication with the MDS Coordinator, and he/she looks over notes every day and go over these in the morning meeting; -Hospice should be listed on the care plan; -MDS Coordinator is responsible for completing the care plans.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31464 Based on observation, interview, and record review, the facility failed to ensure residents' environment remained as free of accident hazards as possible when staff failed to care plan transfer method and failed to obtain therapy's assessment and recommendations of how to safely transfer one resident (Resident #1) who was non-weight bearing and when staff failed to ensure access to smoking materials were limited to residents assessed able to keep them when two residents (Resident #36 and #66) kept smoking materials in an unsecured manner. The facility census was 82. 1. Review of a facility policy entitled Transfer Activities (Nursing Guidelines Manual, March 2015) showed the following: -Purpose to transfer the resident from bed to chair, toilet or tub safely; -Obtain assistance of another individual if necessary for safe transfer; -Depending upon the amount of assistance required, the nurse may either support the resident on his/her affected side or stand in front of the resident. Support may be provided by use of a waist belt; -Do not support the resident under the arms as this prevents the resident from using his/her unaffected extremity. Do not allow resident to put arms around your neck; -If resident is unable place resident in sitting position. Place yourself with your legs apart and your knees flexed, facing the resident; grasp the resident around the waist, supporting his/her back. Assist to a standing position by straightening you knees and supporting the resident's knees inside your knees; step toward the chair, supporting the resident in the same manner, until resident is positioned in front of the chair. Review of Resident #1's face sheet (gives basic profile information) showed the following information: -admitted [DATE]; -Diagnoses included cerebral palsy (a group of conditions that affect movement and posture), muscle weakness, muscle wasting and atrophy (partial or complete wasting away of a part of the body), and anxiety disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 12/19/23, showed the following information: -Severely impaired cognition; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on another person for mobility using a wheelchair, personal hygiene/showers, activities of daily living (ADLs - dressing, grooming, bathing, eating, and toileting), dressing, movement from lying to sitting on the side of the bed, and transfers from bed/chair; -Required assistance to roll from side to side and to move from sitting to lying down. Record review of the resident's care plan on 03/13/24 showed the care plan did not address how staff should transfer the resident safely. Observation on 03/13/24, at 11:25 A.M., showed the resident lay on his/her bed, yelling out. and crying. Certified Nurse Aide (CNA) A said the resident had just been changed and redressed. CNA A assisted the resident to sit up on the side of the bed. The resident's feet did not reach the floor. CNA A told the resident that he/she was going to transfer the resident over to his/her wheelchair for lunch. The CNA A said the resident was not able to stand and the resident refused to allow staff to put a gait transfer belt on him/her and said, We just do it like this. CNA A faced the resident and leaned over toward the resident, instructing the resident to put his/her arms around the CNA's neck. The resident did so. The CNA held the resident around the waist, picked him/her up, turned and placed the resident in the wheelchair. The resident then stopped crying. The resident's feet did not touch the floor during the transfer. CNA A said, We get it done quickly, because he/she hates to be touched. Observation on 03/14/24, at 11:30 A.M., showed the resident lay on his/her bed, crying. CNA A assisted the resident to sit up on the side of the bed. The resident's feet did not reach the floor. CNA A told the resident that he/she was going to transfer the resident over to his/her wheelchair for lunch. CNA B stood on the opposite side of the resident's bed, several feet away from the bed, and did not touch the resident. CNA A faced the resident and leaned over toward him/her. The resident put his/her arms around the CNA's neck to hold onto the CNA. CNA A put his/her arms around the resident's waist, picked him/her up, turned and placed the resident in the wheelchair. The resident then stopped crying. The resident's feet did not touch the floor during the transfer. Review of the resident's care plan,updated 03/13/24, showed the following: -Start date 03/13/24 for resident does not tolerate a gait belt being used for transfers. He/she is a one person assist for transfers. -Resident will be safely transferred without the use of a gait belt. -Staff will transfer resident without a gait belt. If staff does not feel safe transferring with one assist, they will get a second staff member to assist with the transfer. During an interview on 03/14/24, at 1:05 P.M., Certified Occupational Therapy Assistant (COTA) C and the Director of Therapy Services said the following: -Staff nurses would request an evaluation on admission or if a resident had a fall or other changes. -They would assess the resident and make recommendations for restorative therapy or for transfer abilities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Both staff said a resident must be able to bear weight in order to do a gait belt assist to transfer; otherwise, the resident should be transferred using a Hoyer (mechanical) lift. -F a resident won't tolerate the lift or gait belt, staff should request an evaluation and recommendations by the therapy department. -Neither COTA A nor Director of Therapy Services had been asked to assess the resident. They were not aware of how staff was transferring the resident and said one staff picking up the resident was probably not safe. During an interview on 03/13/24, at 11:37 A.M., CNA B said he/she transferred the resident just like CNA A just did; the resident puts his/her arms around my neck, facing me, and I lift her from bed to the shower chair and back. CNA B said the resident cannot bear weight on his/her legs. During an interview on 03/14/24, at 3:18 P.M., Certified Medication Technician (CMT) D said the facility started a new mini care plan that is posted on each resident's closet door. It shows basic assist needs, including how they transfer. CMT D did not know how staff transferred the resident. During an interview and observation, in the resident's room on 03/14/24, at 3:25 P.M., CNA E said he/she transferred the resident by having the resident put his/her arms around the CNA's neck. The CNA then picked up the resident and put him/her in the wheelchair or back to bed. CNA E sometimes staff pick up the resident from the side, cradling him/her with one arm under the resident's back and one arm under the knees. Then they lift the resident from bed to chair or back to the bed. CNA E pointed out the new mini care plan on the outside of the resident's closet door. The form contained a line marked Transfers, which had been written as one person assist, without clarification on the procedure. During an interview on 03/14/24, at 3:29 P.M., with Registered Nurse (RN) F and Licensed Practical Nurse (LPN) G, the RN said the facility just started new summary care plans that week that are posted on the front of the residents' closet doors showing assist needs and how the resident transfers. RN F and LPN G both said on admission the nurse assesses the resident to determine their transfer ability and assist needs. If the resident's status changes at any point, the nurse can ask the therapy department to evaluate the resident and write a recommendation regarding mobility and transfers. LPN G said the resident is a one person transfer without a gait belt. The resident holds on around the CNA's neck, and the CNA picks up the resident and moves him/her. If the resident is unfamiliar with a staff member, he/she gets more upset, so they use two people (one whom the resident knows) for the transfer. RN F and LPN G did not know if therapy had ever evaluated the resident or given a recommendation regarding transfers. RN F said the resident cannot bear weight on her legs. They just do a bear hug lift to transfer the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/14/24, at 4:40 P.M., with the Administrator and the Director of Nursing (DON), the DON said the facility recently started posting brief care plans on the residents' closet doors showing staff the residents' basic care and assist needs. If the aides note a change in a resident's mobility or transfer ability, they should tell the nurse. The nurse will request a therapy evaluation and recommendations. If a resident is not able to bear weight on their legs, staff should use a Hoyer lift or a slide board for transfers. If the resident will not allow the mechanical lift, staff should use a gait belt if it is tolerated. The resident likes to grab around the aide's neck and hang on while they lift him/her, because it makes her feel safe. The Administrator and DON were unsure whether or not therapy was involved. Someone besides the aides should make the determination on how to transfer a resident. Therapy should be involved in an assessment and care planning for transfers. The DON said the resident's care plan, updated yesterday, showed the resident's intolerance of gait belt use and specifies a one person assist and two if a staff doesn't feel safe. 50185 2. Review of the facility's smoking policy, dated March 2015, showed the following information: -Prior to, or upon admission, residents shall be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility can accommodate smoking preferences; -Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues; -The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision; -Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking according to the facility smoking schedule; -The staff will review the status of a resident's smoking privileges periodically and consult as needed with the DON and the attending physician; -Independent smokers shall be permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. Residents may only keep disposable safety lighters. All other forms of lighters, including matches shall be prohibited; -Residents with independent smoking privileges may not give smoking articles to other residents with restricted smoking privileges; - Residents without independent smoking privileges may not have of keep any types of smoking articles, including cigarettes, tobacco, etc. except when they are under direct supervision. -The facility may check periodically to determine if the residents have any smoking articles in violation of smoking policies. Staff shall confiscate any such articles and shall notify the charge nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(The facility policy did not address how to ensure smoking supplies were secured from other residents not deemed as safe to have access to cigarette supplies.) 3. Review of Resident #36's annual MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Staff indicated the resident used tobacco at that time. Review of the resident's smoking risk assessment, dated 02/13/24, showed the following information; -Resident smokes cigarettes hourly; -No problem smoking in unauthorized areas; -No problem with carelessness of smoking supplies; -No problem smoking cigarettes from ash trays; -No problem inappropriately providing smoking materials to others; -No problem with begging or stealing smoking materials from others; -No problem with general awareness and orientation; -No problem with general behavior and interpersonal interaction; -Ambulates with minimal problem using rollator walker; -No problem with capability to follow safe smoking guidelines; -Assessed as safe smoker- follow facility policy. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -The resident used a walker; -Independent with mobility. -Staff did not indicate the resident's tobacco use status. Review of the resident's care plan, last revised on 03/07/24, showed the following information: -Resident currently smokes cigarettes independently; -The resident has a history of running out of cigarettes and having no more money to buy more; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She tries to bum or buy cigarettes from peers/staff and/or borrow money to purchase more cigarettes; -Smoking times have changed to no smoking between 10:00 P.M. to 6:00 A.M. If not following times, notify charge nurse; -Educate the resident that he/she should not ask staff/peers to use their own money to purchase his/her cigarettes and suggest that he/she do a better job at watching his/her consumption throughout the month, so the resident does not run out; - Explain to the resident where designated smoking areas are located. Remind as needed. Observation and interview, on 03/14/24, showed the following: -At 8:39 A.M., the resident lay in bed, resting with eyes closed, facing away from his/her walker. One pack of cigarettes and disposable lighter lay on top of the resident's rollator walker; -At 11:18 A.M., the resident lay in bed awake. One pack of cigarettes and disposable lighter continue to be in same placement (on top of walker); -At 12:41 P.M., the resident left his/her room using the rollator walker. The pack of cigarettes and disposable lighter continue to lay on top of walker. The resident said about four to five residents smoke. All of them can go out independently. Staff does not accompany them at this time. If a resident is physically and mentally able, they can go alone. The facility is strict about their smoking rules. During an interview on 03/14/24, at 8:55 A.M. Certified Nursing Assistant (CNA) Q said the resident smokes independently. During an interview on 03/14/24, at 9:24 A.M., CMT R said the resident is independent with smoking. The resident was supervised when he/she came back from last emergency room visit due to being in a wheelchair, and not being able to get out the door on his/her own. 4. Review of Resident #66's face sheet showed the following: -Most recent admitted [DATE]; -Diagnoses included unspecified dementia (a set of symptoms that over time can affect memory, problem-solving, language and behavior) and chronic obstructive pulmonary disease (COPD - persistent respiratory symptoms like progressive breathlessness and cough), and acute respiratory disease (shortness of breath, wheezing, spasm, persistent cough, blood in sputum affecting the lungs, bronchus and respiration). Review of the resident's annual MDS, dated [DATE], showed the following: -Diagnosis of anxiety; -Cognitively intact; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Current tobacco user Review of the resident's smoking assessment, dated 03/01/24, showed the following: -Resident smokes cigarettes; -Resident smokes hourly; -Smoking in unauthorized area is marked as a minimal problem; -Careless while smoking is marked as a minimal problem; -Smokes cigarettes from ash trays marked as no problem; -Begs or steals smoking materials from others is marked as no problem; -General awareness and orientation/ability to understand safe smoking requirements is marked as a minimal problem; -General behavior and interpersonal interaction shows no problem; -Mobility is marked as a minimal problem; -Capability to follow facility safe smoking guidelines is marked as a minimal problem; -Assessed as safe smoker - follow facility policy. Review of the resident's care plan, last revised 03/06/24, showed the following: -Resident is currently a smoker; -Resident is found to be safe and independent with smoking; -Resident is able to keep smoking materials with him/her. Observation and interview on 03/13/24, at 2:10 P.M., showed the following: -Resident laying down, flat on his/her back with his/her arms folded behind his/her head and wearing glasses; -Two packs of cigarettes and a lighter laying on the bedside table; -He/she said he/she was going to try to take a nap; -He/she said he/she is able to go out to smoke at any time and it's whenever he/she feels like having a cigarette; -He/she said some people have certain times they can go out because they need staff to help them; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she keeps his/her own cigarettes and lighters at all times; -These are kept on his/her bedside table. Observation on 03/13/24, at approximately 3:35 P.M., showed the following: -The resident was seen sleeping, facing the wall and his/her back was towards the door; -A pack of cigarettes and a lighter were lying on the bedside table. 5. During an interview on 03/14/24, at 8:55 A.M. CNA Q said there were smoke times when he/she first started working at the facility. Residents were on restriction at first. Now, all residents are independently smoking. Residents must know the code to the door and be able roll/walk themselves out to the smoking area and get back in independently. Everyone on his/her hall has had an assessment showing they are safe to smoke independently. Nurses keep cigarettes and lighters. The residents must ask the nurse for supplies when they are ready to go out. Residents receive two cigarettes every time they go out to smoke. Supplies should not be kept in the resident rooms. During an interview on 03/14/24, at 9:24 A.M., CMT R said he/she believes the process for smoking is having scheduled smoke breaks. Most smokers are with it. They are allowed to go out as they want. For the residents that require supervision, the staff will stay with them while they smoke. They also stayed with the residents during the COVID outbreak and during the cold part of winter. If residents are independent, they keep their own supplies with them. They usually keep the smoking supplies on their walkers. Supervised smokers have the nurse keep smoking supplies in the nurses' cart. When it's time to smoke, the staff accompanying the resident obtains the supplies from the nurse and staff goes with the resident to smoke. Nurses let him/her know if a resident is supervised smoking or independent. The criteria to be independent with smoking is the resident has gotta be with it and able to take themselves in and out of the building. During an interview on 03/14/24, at 2:09 P.M. CNA S said there is one resident on C-hall that wanders throughout the facility, including into other residents' rooms. During an interview on 03/14/24, at 2:09 P.M. CMT D said there are a couple residents that do wander throughout the facility and into other residents' rooms. During an interview on 03/13/24, at 2:20 P.M., LPN H, said the following; -Residents can go out to smoke any time they choose, unless they have to be supervised; -If the resident is supervised, they would have to go to the charge nurse and they will be given their cigarettes and lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/14/24, at 2:45 P.M., RN F said all smokers are currently independent smokers and they are allowed to have their supplies. Residents can go out whenever they want unless it's below freezing or too hot. Upon admission, if a resident is a smoker, they go through a period of supervised smoking until they prove themselves as capable of smoking independently. Nursing staff does the smoking risk assessments to determine if they should be independent or not. Supervised smokers cannot keep their supplies in their room. The charge nurse keeps them in the medication cart. The residents have designated smoking times and assigned staff to take them for smoking. The staff will come and get their supplies and take the residents out. There are residents that wander the facility and into other rooms. He/She is not sure how the facility ensures that the wandering residents do not gain access to the smokers' supplies. One resident is known for wandering into other resident rooms and has been accused of stealing items such as sunglasses, but he/she is not sure if the accusation is true. During an interview on 03/14/24, at 4:26 P.M., with the Administrator and DON, the DON said the process for smokers is to complete an assessment upon admission, which determines if the residents are safe to smoke independently safely. The facility also completes this assessment if there is a change of condition, or any rules have been broken. Staff will revoke their independent privileges and make them supervised smokers in those cases. Independent smokers can smoke whenever they want, pending weather. Supervised smokers are to be accompanied when they smoke and only go out during certain times. Independent residents keep their own supplies themselves. Supervised residents must keep their supplies at the nursing stations and must request their supplies. Independent smokers usually keep their supplies on them, or inside their walkers. There are no residents that wander the facility, and smokers are also very protective of their supplies. 37358

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with standards of practice when the facility failed to have a physician's diagnosis for continuous positive airway pressure (CPAP - machine that uses mild air pressure to keep breathing airways open while one sleeps) and failed to address the CPAP on the care plan or on the Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff) for one resident (Resident#83). The facility had a census of 82. Review of the facility's policy titled, MDS and Care Planning Guidelines, dated 10/01/15, showed the following information: -It is the policy of the facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) Manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. Review of the facility's titled Continuous Pressure Airway Pressure (CPAP) Administration, undated, showed the following information: -Purpose to administer continuous airway pressure to maintain open airway to the resident with obstructive sleep apnea (characterized by episodes of complete collapse of the airway or partial collapse with an associated decrease in oxygen saturation or arousal from sleep) or respiratory problems when sleeping. (The policy did not address the need for a diagnosis for CPAP use, the need to care plan CPAP use and care, or addressing the CPAP use on the resident's MDS.) 1. Review of Resident #83's face sheet (a brief information sheet about the resident) showed the following information: -admitted [DATE]; -Diagnosis included Parkinson's disease (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) without behavioral disturbance, and allergic rhinitis (inflammation (redness and swelling) of the inside of the nose). (Staff did not list a diagnosis related to obstructive sleep apnea or CPAP use.) Review of the resident's admission MDS, dated [DATE], showed staff did not indicate CPAP use by the resident on admission or while a resident. Review of the resident's Physician Order Sheet (POS), current as of 03/14/24, showed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 01/05/24, to apply CPAP at 4 cmH2O (pressure most commonly used to measure breathing on respirators) via nose mask every night at bedtime for sleep apnea. Review of the resident's nursing progress notes showed staff the following: -On 01/05/24, at 3:15 P.M., the resident had new tubing for CPAP. Staff spoke with the provider about the settings and provider informed this nurse to leave current setting and if needed verify setting with family. The resident was admitted to the facility with CPAP and used it every night per family. The family did not remember the setting. Currently setting was at 4 cmH2O. New order received to apply CPAP at 4 cmH2O via nose mask every night for sleep apnea. Review of the resident's quarterly MDS, dated [DATE], showed staff did not list a diagnosis related to obstructive sleep apnea or CPAP use. Review of the resident's POS, current as of 03/14/24, showed an order, dated 03/01/24, to change CPAP tubing and mask every three months. Review of the resident's care plan, last reviewed 03/07/24, showed the following: -The resident had a diagnosis of insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep); -Staff should provide a quiet environment; -Staff should encourage the resident to stay up during the day and sleep at night; -The resident required assistance with activities of daily living (ADL's - dressing, grooming, bathing, eating, and toileting) tasks related to cognitive deficits, dementia, chronic pain, and weakness. (Staff did not care plan related to the resident's use of a CPAP, the care of the CPAP, or or sleep apnea diagnosis.) Observation of the resident's room showed the following: -On 03/11/24, at 9:30 A.M., a CPAP machine with mask and hose connected was setting on the bedside table at the head of the resident's bed; -On 03/13/24, at 1:30 P.M., a CPAP machine with mask and hose connected was setting on the bedside table at the head of the resident's bed. Review of the resident's Medication Administration Record (MAR), current as of 03/14/24, showed staff documented the following: -CPAP at bedtime as ordered; -Change of the tubing, filters, and mask as ordered; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No diagnosis listed on the MAR of sleep apnea. During an interview on 03/14/24, at 9:50 A.M., Certified Nurse Aide (CNA) L said that he/she is able to locate each resident's special needs on their care plan in the computer. He/she worked day shift and did not have any duties assigned to CPAP use for the resident. During an interview on 03/14/24, at 9:40 A.M., Licensed Practical Nurse (LPN) K said that all resident special equipment and individual needs will be located on the MAR and care plan, this would include CPAP. He/she did not know that the resident had a CPAP because the task does not pop up on the task list for his/her shift. He/she did not know if this information should be on the MDS. During an interview on 03/14/24, at 9:58 A.M., LPN H said that resident's individual needs and services should be on the care plan, including CPAP use. Anything in the care plan should have a diagnosis for that area of care. During an interview on 03/14/24, at 3:30 P.M., the MDS Coordinator said that all specialty items should be on resident care plans and MDS, including use of a CPAP. He/she did not know until this week during the survey that that CPAP used needed to be on the care plan. He/she did not know that the resident had a CPAP. During an interview on 03/14/24, at 4:46 P.M., the Administrator and Director of Nursing (DON), said the following: -CPAP use should be listed on the care plan; -CPAP use should have a corresponding diagnosis; -CPAP use should be on the MDS; -The MDS coordinator is responsible for completing the care plans.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on record review and interview, the facility failed to ensure that one resident's (Resident #17) with Post-Traumatic Stress Disorder (PTSD - disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event) had his/her PTSD diagnosis listed in the medical record, failed to ensure the resident's PTSD was noted on the resident's care plan to include triggers and interventions, and failed to ensure staff were knowledgeable of the resident's history of PTSD. The facility census was 82. Record review of the facility assessment, updated December 2023, showed the following information: -Individualized care plans are developed for each resident to ensure each resident within the facility has their physical, mental, psychosocial, spiritual needs met. Review showed the facility did not provide a policy related to PTSD. Review of the facility's policy titled, MDS and Care Planning Guidelines, dated 10/01/15, showed the following information: -It is the policy of the facility to use the most current Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff) Resident Assessment Instrument (RAI) Manual and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. 1. Review of Resident #17's face sheet (a brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain) with other behavioral disturbance, dysphagia (difficulty or discomfort in swallowing), repeated falls, overactive bladder (condition in which the bladder squeezes urine out at the wrong time), generalized anxiety disorder, and sleep apnea (sleep disorder in which breathing repeatedly stops and starts). (Staff did not list a diagnosis related to trauma or PTSD.) Review of the resident's electronic medical record showed an emergency room noted, dated 03/15/22, that included a PTSD diagnosis from 02/01/08. Review of the resident's initial admission assessment, dated 08/31/20, showed staff did not document regarding PTSD. Review of the resident's quarterly MDS, dated [DATE], showed staff did not list the a diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, last reviewed 01/05/24, showed the following information: -Resident had behavioral symptoms and high anxiety; -Staff should redirect the resident as needed for nervousness, anxiety, and scared behavior; -Resident had experienced insomnia; -Staff should discourage daytime napping; -Staff should encourage resident to go to bed at the same time everyday and wake up at the same time everyday; -Resident had impaired decision making related to dementia; -Staff should encourage resident to verbalize feelings, concerns, and fears. (Staff did not address a diagnosis of PTSD, the resident's triggers, or interventions related to PTSD.) Review of the resident's physician progress notes, dated 02/07/24, showed the resident had a past medical history of PTSD. Review of the resident's annual MDS, dated [DATE], showed the resident's diagnoses included progressive neurological conditions, dementia, anxiety disorder, depression, and PTSD. Review of the facility provided Matrix (a form requested on survey entrance with brief details of resident care needs), completed on 03/11/24, showed the following staff identified the residents as having Alzheimer/dementia, using an anti-anxiety, anti-depressant, and anti-psychotic medications, had falls with injury and had PTSD. During an interview on 03/12/24, at 3:05 P.M., the Director of Nursing (DON) was not aware of the resident having a diagnosis of PTSD. During an interview on 03/14/24, at 9:40 A.M., Licensed Practical Nurse (LPN) K said that all resident special needs and cares should be on the care plan, including PTSD. He/she thought that PTSD would specifically have approaches needed for the resident in the care plan. He/she had received past in-services included special need training, dementia, and PTSD. He/she said that the resident's diagnosis list should accurately reflect the resident's medical history. He/she was not aware of any resident on the hall assigned with PTSD. He/she was not aware that the resident had PTSD. During an interview on 03/14/24, at 9:50 A.M., Certified Nurse Aide (CNA) L said that resident's individual needs are on resident care plan in the computer. He/she was not aware of any resident with PTSD on the assigned hall. He/she was not aware that the resident had PTSD. He/she said that staff can tell some residents have PTSD by signs they may exhibit. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/24, at 9:58 A.M., LPN H said that residents with PTSD will have a care area in their care plan and also there would be information on the computer face sheet under code status related to PTSD. He/she usually discusses resident symptoms/triggers with doctor for types of care needs. He/she said that PTSD should be in the care plan and on diagnosis list. He/she did not work with the resident and was not aware the resident had PTSD. During an interview on 03/14/24, at 11:41 A.M., the DON said that the MDS Coordinator found the PTSD diagnosis on the resident's past hospital records and from the recent provider note, dated 02/07/24, and placed it on the recent MDS. The MDS Coordinator was recently employed in that position and did not know the information should also be on the care plan. During an interview on 03/14/24, at 3:30 P.M., the MDS Coordinator PTSD should be included on the resident's care plan. He/she talks with staff and reviews medical records for the seven day look back period required for the MDS. He/she did not know that information was to be on the care plan until this week. During an interview on 03/14/24, at 4:46 P.M., the Administrator and DON, said the following: -PTSD should be listed on the resident's care plan; -There should be a diagnosis related to the PTSD for the resident; -The MDS coordinator is responsible for completing the care plans.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Republic Nursing & Rehab	901 East Hwy 174 Republic, MO 65738

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 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. 37358 Based on observation, interview, and record review, the facility failed to keep food safe from potential contamination when staff stacked clean dishware inside one another trapping moisture; the facility failed to keep dented cans separate from other canned goods; and failed to ensure dry food containers were properly sealed. This could potentially affect all the residents. The facility census was 82. 1. Review of the facility's policy titled, Dishwashing, by Nutrition and Dining Services Manual, dated May 2015, showed the following information: -Rack dishes and trays in appropriate rack; -Rack cups, bowls, and glasses upside down; -Allow items thoroughly dry before unloading racks or storing items. Review of the 1999 Food Code, issued by the Food and Drug Administration (FDA), showed the following information: -After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food; -Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Observation on 03/11/24, beginning at 8:42 A.M., showed two small metal steam table pans stacked on each other with water droplets trapped inside. Observation on 03/12/24, at approximately 1:00 P.M showed the following: -Four small metal pans for the steam table stacked on one another with water droplets trapped between pans; -Five large metal pans for the steam table stacked on one another with water droplets trapped between pans -Sixteen small plastic dessert cups stacked on one another with water droplets trapped between cups; -Eleven plastic trays stacked on one another with water droplets trapped between trays; -Ten white ceramic plates stacked on one another with water droplets trapped between plates; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Five small ceramic bowls stacked on one another with water droplets trapped between bowls. During an interview on 03/14/24, at approximately 1:35 P.M., Dishwasher M said he/she was not aware that dishes could not be stacked while wet and said that is how he/she has always done this. During an interview on 03/14/24, at approximately 1:40 P.M., Dietary Aide (DA) N said he/she said he/she was not aware that dishes could not be stacked wet. During an interview on 03/14/24, at approximately 1:55 P.M., [NAME] P said the following: -He/she did not know the dishes were being stacked while they were still wet; -If he/she had been aware, he/she would have made sure this was not happening. During an interview on 03/14/24, at approximately 4:45 P.M., the Administrator said the following: -Dishes should be air dried; -Once the dishes have air dried, they can be stacked. 2. Review of the facility's policy titled, Storage of Dry Food and Supplies, by Nutrition and Dining Services Manual, dated May 2015, showed severely dented, rusted, leaking, and bulging cans must be placed in a separate, labeled holding area for return to the distributor. Review of the 1999 Food Code, issued by the FDA, showed the following information: -Food packages should be in good condition and protect the integrity of the contents so the food is not exposed to potential contamination. -Food held for credit, such as damaged products, should be segregated and held in an area separate from other food storage. -Food packages that are damaged, spoiled or otherwise unfit for sale or use in a food establishment may become mistaken for safe and wholesome products and/or cause contamination of other foods and should be kept in separate and segregated areas. -Damaged packaging may allow the entry of bacteria or other contaminants into the contained food. Observation on 03/11/24, beginning at 8:42 A.M., showed the following canned good items to be dented or to have a compromised seal: -A 6.5 pound can of diced peaches; -A 6.8 pound can of fancy shredded sauerkraut. During an interview on 03/14/24, at approximately 1: 45 P.M., DA O said the following: -The kitchen does not keep any canned food that has dents and showed where the dented cans belong; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she was not aware of the two dented cans on the shelf. During an interview on 03/14/24, at approximately 1:55 P.M., [NAME] P said the following: -All dented cans should be separated away from the good cans; -He/she not aware of any dented cans not separated because staff are good about this. During an interview on 03/14/24, at approximately 4:45 P.M., the Administrator said dented cans should be separated and sent back to the supplier. Dented cans should not be mixed in with the canned food that was going to be consumed. 3. Review of the facility's policy titled, Storage of Dry Food and Supplies, by Nutrition and Dining Services Manual, dated May 2015, showed the following information: -Metal or plastic containers with tight fitting covers, labeled top or side, must be used for storing opened products; -Open boxes are to be effectively re-sealed; -Bulk crackers, cereal, cookies, pasta, etc. are to be stored and properly labeled in sealed containers. Observation on 03/11/24, beginning at 8:42 A.M., showed the following bags of dry food items not in any containers with bags open and exposed to the air: -One 20 pound bag of panko breadcrumbs; -One 20 pound bag of yellow corn meal; -One 50 pound bag of pinto beans. During an interview on 03/14/24, at approximately 1: 45 P.M., DA O said the following: -He/she was not aware of the bags of open food; -He/she said they should be closed up properly. During an interview on 03/14/24, at approximately 1:55 P.M., [NAME] P said the following: -He/she thought all of the dry food items were stored properly and had not realized there were open bags; -He/she said the bags should have been put into large plastic containers. During an interview on 03/14/24, at approximately 4:45 P.M., the Administrator said the following: -Dry food should be stored in a closed tight and sealed container; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Items found open during observations should have been sealed properly.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 37358 Based on observation, interview, and record review, the facility failed to ensure a sanitary environment for all residents and staff when the facility staff did not keep walls, baseboards, and vents clean in the kitchen area. The facility census was 82. 1. Observation on 03/11/24, beginning at 8:42 A.M., showed the following areas were dirty with grease, lint, and debris: -The walls and baseboards behind the ovens; -The baseboards underneath the metal, three-bin kitchen sink; -The space behind the ice machine, between the unit and wall; -The ceiling vents; -The ceiling air conditioning unit. During an interview on 03/14/24, at approximately 1:45 P.M., Dietary Aide O said he/she does do a lot of cleaning, but had not noticed the baseboards or up high like any of the ceiling vents or on the air conditioner. During an interview on 03/14/24, at approximately 1:55 P.M., [NAME] P said the following: -The baseboards, air conditioner, and ceiling vents, should be cleaned on a regular basis; -He/she said it has been done before, but it had been a long time; -He/she said it is difficult to move the heavy equipment out to get to those areas. During an interview on 03/14/24, at approximately 4:45 P.M., the Administrator said the following: -Kitchen staff are all responsible for cleaning: -Staff should be following a cleaning schedule; -The Dietary Manager is responsible for overseeing the cleaning task; -Staff should be doing the cleaning of all areas they can reach; -Maintenance is responsible for cleaning the ceiling vents and air conditioning unit.