STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458 Based on observation, interviews and record reviews, the facility failed to ensure that residents had the right to a safe, clean, comfortable, and homelike environment for 6 (Resident #2, Resident #3, Resident #4, For Resident #5, For Resident #6, and Resident #7) of 8 residents reviewed for a clean and comfortable environment. 1. The facility failed to ensure a broken windowsill in Resident #2's bedroom was repaired, and the exposed wood was repainted. 2. The facility failed to ensure Resident #3 had access to cold water when the bathroom faucet was not repaired and missing cove base trim in the bathroom was not repaired or replaced that exposed damaged dry wall and wood. 3. The facility failed to repair the cove base trim in Resident #4's bedroom that exposed damaged dry wall and wood and failed to repair the bathroom sink that had dislodged from the wall. 4. The facility failed to repair the cove base trim in Resident #5's bedroom that exposed damaged dry wall and wood and repair the damaged dry wall behind the headboard that had broken off and formed a large pile of drywall to accumulate on the floor. 5. The facility failed to clean bugs from the florescent light fixture over the top of head of the bed and repair the missing cove base trim in the bedroom that exposed damaged dry wall and wood for Resident #6. 6. The facility failed to repair the broken toilet seat after Resident #7 reported the seat was damaged and uncomfortable to sit on. These failures could place residents at risk of a decrease in quality of life and self-worth. Findings include: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's face sheet, dated 09/19/2023, revealed an [AGE] year-old male who was admitted into the facility on [DATE]. Resident #2's diagnoses included Unspecified Dementia (mild memory disturbance due to known physiological condition), Chronic (persisting) Embolism (obstruction of an artery) and Thrombosis (blood clot within a blood vessel) of left Femoral Vein (large blood vessel in the thigh), and Essential (Primary) hypertension (occurs when you have abnormally high blood pressure that is not the result of a medical condition). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 02, which indicated severe cognitive impact. During an observation on 09/18/2023 at 6:25 p.m., the windowsill in Resident #2's room, was observed to be broken along the outside of the sill in a crooked manner and unpainted wood was exposed. During an interview on 09/18/2023 at 6:28 p.m., Resident #2's family member said the board on the windowsill had been broken since Resident #2 had moved into the facility and that it made the room look in disrepair. Resident #2's family member said the resident who resided with Resident #2 moved out the week before and the bed was moved at that time. Resident #2's family member said the staff who moved the Resident #2's roommate were aware of the broken windowsill. Record review of Resident #3s face sheet, dated 09/20/2023, revealed a [AGE] year-old-female who was admitted into the facility on [DATE]. Resident #3's diagnoses included Anxiety, Chronic (persisting) Diastolic Heart Failure (condition in which the heart's main pumping chamber [left ventricle] becomes stiff and unable to fill properly), and Type II Diabetes (problem in the way the body regulates and uses sugar as a fuel). Record review of Resident #3's Quarterly MDS, 08/17/2023, revealed Resident #3 had a BIMS score of 12, which meant a moderate cognitive impairment. During an observation on 09/19/2023 at 2:31 p.m., observed Resident #3's bathroom sink, and noticed the faucet had separate knobs for cold and hot water. Observed the handle on the cold-water valve was missing. The cove base trim missing from the bottom of the wall at the floor level approximately one foot on the side wall to approximately four feet on the wall facing the toilet, exposing a black substance from water damage, chipped paint, damaged wood, and damaged dry wall. During an interview on 09/19/2023 at 2:31 p.m., Resident #3 said she had broken the faucet knob that morning. Resident #3 said she noticed half the knob was on the cartridge (screw that stands up to hold the faucet handle) and when she turned handle, the other piece broke off. Resident #3 said she told her nurse that the handle was broken but could not remember who she told. Record review of Resident #4's face sheet, dated 09/19/2023, revealed an [AGE] year-old male who was admitted into the facility on [DATE]. Resident #4's diagnoses included Malignant Neoplasm (term for cancer) of Unspecified Part of Lung, Secondary Malignant Neoplasm (new cancer that occurs as a result of previous treatment) of Bone, and Essential (Primary) Hypertension (occurs when you have abnormally high blood pressure that is not the result of a medical condition). Record review of Resident #4's Comprehensive Admission MDS, dated [DATE], revealed a BIM score of 05, which indicated severe cognitive impact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an on observation on 09/19/2023 at 10:05 a.m., the vinyl cove base trim (the piece of trim installed around the baseboard of a room that created a transition between the floor and the wall) in Resident #4's room was missing in the area by the entrance door, exposing damaged dry wall that was brown and black in color, and chipped paint. The entrance door to Resident #4's bedroom had chunks of wood missing and unpainted wood exposed. Observation in Resident #4's bathroom revealed the bathroom sink was dislodged from the wall at the back of the basin and a layer of crusty build-up around the cold-water knob. The bathroom wall had a large area of the wall near the vinyl cove base trim covered in white drywall mud and pieces of the cove base trim were pulled back exposing damaged and discolored drywall and wood covered in a black substance. The handrail near the toilet had fallen off and dislodged. During an interview on 09/19/2023 at 3:02 p.m., Resident #4's family member said the facility could do better with the repairs in the facility. Resident #4's family member said Resident #4's room was always filthy and dirty. Resident #4's family member said she visited Resident #4 every Sunday and had to ask the employees to clean his room. Resident #4's family member said she visited the facility on Sunday, 09/17/2023, and informed the CNA on duty the issue with the cleanliness. Record review of Resident #5's face sheet, dated 09/19/2023, revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #5's diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest of task), Essential (Primary) Hypertension (occurs when you have abnormally high blood pressure that is not the result of a medical condition), and Dysphagia (difficulty swallowing). Record review of Resident #5's Quarterly MDS, dated [DATE], revealed Resident #5 had a BIMS score of 00, which indicated severe cognitive impact. During an observation on 09/19/2023 at 10:20 a.m., observed the vinyl cove base trim had fallen off the bottom of the right wall near the entrance to Resident #5's bedroom approximately a foot in length, that exposed damaged drywood and chipped paint. Observed an area behind Resident #5's headboard where damaged dry wall had broken off the wall and formed a large pile of a powder substance and chunks of white drywall to accumulate on the floor under and beside the bed. During an interview on 09/19/2023 at 3:40 p.m., Resident #5's family member said she felt Resident #5's room and tray table need to be cleaned and cleared off. Resident #5's family member said overall, she would give the facility a B+ in cleanliness. Record review of Resident #6's face sheet, dated 09/19/2023, revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #6's diagnoses included Unspecified Dementia (mild memory disturbance due to known physiological condition), Unspecified Hydronephrosis (abnormal enlargement or swelling of a kidney due to dilation of the kidney calices [collects urine] and kidney pelvis), and Type II Diabetes (problem in the way the body regulates and uses sugar as a fuel). Record review of Resident #6's Quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of 14, which indicated intact cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/19/2023 at 11:00 a.m., observed the fluorescent light fixture directly above the head of Resident #6's bed contained a large amount of dead bugs inside the plastic cover and was brown in color. Observed an external electrical box with two outlets that had partially detached from the wall by the windowsill and the windowsill contained dirt debris and peeling paint around the windowpane. During an interview on 09/19/2023 at 11:00 a.m., Resident #6 said when she laid down in bed, she could see the bugs in the light fixture, and it bothered her at night. Resident #6 said she was unable to clean it herself. Record review of Resident #7's face sheet, dated 09/20/2023, revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #7's diagnoses included Unspecified Dementia (mild memory disturbance due to known physiological condition), Pulmonary Hypertension (condition that affects the blood vessels in the lungs), and Acute (recent) Kidney Failure. Resident #7's face sheet identified her as a self sufficient financial responsible party and did not have a Power of Attorney. During an observation on 09/19/2023 at 10:46 a.m., observed the bathroom of Resident #7 had an area of cove base trim missing from the wall in the corner, approximately 2 feet in length, exposing damaged drywall with a black substance, chipped paint, and damaged exposed wood. Resident #7's toilet seat hinge on the left side was broken and had come completely off the lid. The toilet seat was unstable and moved left and right on the toilet rim. During an interview on 09/19/2023 at 10:46 a.m., Resident #7 said she had reported the broken toilet seat to the nurse, housekeeping, and maintenance. Resident #7 said she had reported the toilet seat approximately 2 weeks prior because when she sat on the toilet, the seat pinched her bottom. Resident #7 could not remember the specific name of the employee she talked to but said she knew the maintenance man was aware because he came in her room and looked at the toilet. Resident #7 said the bottom of the wall in the bathroom had been exposed since she moved in. During an interview on 09/19/2023 at 10:31 a.m., Housekeeper A said at times the residents would tell her that their room did not get cleaned when she had her days off. Housekeeper A said she would tell the residents to report unclean rooms to the Housekeeping Supervisor. Housekeeper A said there was a logbook located at the nurses' station to report any issues that needed to be repaired. Housekeeper A said she would log the issue in the book and text the Maintenance Supervisor. Housekeeper A said she had seen the windowsill in Resident #2's room and said the condition of the windowsill would be an issue she would report as a work order in the maintenance logbook. During an interview on 09/19/2023 at 12:56 p.m., CNA B said if she saw an issue that needed to be repaired, she would put the issue down in the maintenance log and then tell the Maintenance Manager. CNA B said she was assigned Hall 200 but was not aware Resident #7's toilet seat was broken. CNA B said the broken toilet seat had been reported and documented in the maintenance log and she thought the issue had been addressed. Record review of the maintenance log, dated 08/21/23 through 09/09/2023, revealed Resident #7's room number had been documented on 09/04/2023 as a need of toilet. The document revealed completion date with only the Maintenance Manager's initials documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/19/2023 at 1:42 p.m., the Maintenance Director said he or the Maintenance Assistant would check the maintenance log to see if something in the building needed to be repaired several times a day. The Maintenance Director said the employee who noticed or saw the need for a repair was responsible for documenting in the maintenance logbook. The Maintenance Director said he in-serviced staff at the all-staff meetings to not call or text him because he could not keep up with verbal messages. The Maintenance Director said the staff were told to put the request for repairs in writing in the maintenance logbook. The Maintenance Director said he looked at the log in for Resident #7's toilet and observed the log said toilet. The Maintenance Director said he went into Resident #7's bathroom and did not find an issue or see the toilet seat was broken. The Maintenance Director said the log in the maintenance book did not have a space to prompt the staff to add the name of the person making the request, so he was unable to identify the employee to ask for more information. The Maintenance Director said the staff need to be descriptive when documenting a repair request. During an interview on 09/19/2023 at 2:08 p.m., the Assistant Maintenance Director said the facility could be cleaner and needed repairs in many areas including the common areas and the residents' rooms. The Assistant Maintenance Director said she was aware of the areas missing the strip of cove base trim in many of the residents' room and bathrooms, but cove base trim pulled off or fell off easy when it got old. The Assistant Maintenance Director said the housekeeping staff could be more trained on reporting what needed to be repaired and how to clean. During an interview on 09/20/2023 at 9:56 a.m., the ADON said the broken windowsill in Resident #2's room and cove base trim that had come of the bottom of the walls in areas of the facility and exposed damaged dry wall and wood was not an acceptable living environment. During an interview on 09/20/2023 at 10:41 a.m., the Administrator said the windowsill in Resident #2's room should have been fixed. The Administrator said the water faucet handle in Resident #3's bathroom should have been reported and fixed immediately. The Administrator said the environment of the facility over-all does not affect the residents' rights. The Administrator said the maintenance log policy had room for improvement. Record review of facility policy, Federal Residents Rights, not dated, revealed Safe Environment - Residents had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving supports of daily living safely. Record review of facility policy, Maintenance & Facilities, Environmental Management, not dated, revealed the policy was to establish an environmental plan to ensure a physical environment was a safe, neat, sanitary environment and met regulations to protect the health and safety of the residents, employees, and others. #3 of the policy revealed the facility would put a system in place for reporting repairs and requests (paperwork orders or TELS); #11 of the policy revealed the procedure would include identifying and reporting safety issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 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. 45458 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 2 of 4 halls (hall 200 and hall 300) reviewed for environmental conditions by failing to ensure: 1. The door and the door casing of the entrance door of the community shower room was damaged. 2. The public bathroom on Hall 300 had damage to the tile on the wall and the wall to the right of the entrance was splattered with dark spots. 3. The wall in the community shower across from the toilet was dirty and the cove base trim was pulled back exposing damage to the drywall and wood. 4. The door and the door casing of the exit door on Hall 200 that led to the smoke area was damaged. 5. A light fixture in the hallway of Hall 300 next to the emergency exit contained numerous dead bugs and was brown in color. These failures could affect resident by placing them at a risk for diminished quality of life due to the lack of a well-kept environment. Findings include: During an observation on 09/19/2023 at 9:35 a.m., the doorframe of the exit/entrance door that led into the community shower room on Hall 300 was damaged with chunks in the paint that exposed the wood, and the door frame was covered with several layers of old paint. Observation of the small bathroom in the community shower room revealed the wall across from the toilet was splattered with a white substance and the vinyl cove base trim (the piece of trim installed around the baseboard of a room that created a transition between the floor and the wall) was pulled back from the wall in several areas exposing a black substance from water damage, a strip of dried glue, chipped paint, and damaged dry wall. Observation of the sink in the community bathroom revealed a layer of crusty build-up around the faucet handles and the particles of unknown substance were observed in the sink. During an observation on 09/19/2023 at 10:10 a.m., the public bathroom located in Hall 300 had a missing tile from the wall and the wall to the right of the entrance was splattered with dark spots. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/19/2023 at 10:25 a.m., the entrance/exit door that led to the outside designated smoking area located off Hall 200 was damaged. The door frame was cracked, and large parts of the door casing boards were broken or missing, which exposed raw, unpainted wood, nails not flush with the boards, and a gap that let in air and light. Observation revealed the door sweep (metal surface mounted to the bottom of the door) was broken and twisted, did not cover the right side of the bottom of the door and let in air and light. The door, which was originally white, was stained black to grey in color in several areas and had scraps across the surface. The floor at the bottom of the baseboard was covered in a thick, dark layer of dirt. During an observation on 09/19/2023 at 11:30 a.m., the fluorescent light fixture at the end of the hallway of Hall 300 next to the emergency exit contained a large number of dead bugs, with a huge concentration of bugs carcasses at the end of the fixture furthest from the door and was brown in color. During an interview on 09/19/2023 at 12:36 p.m., CNA A said the process to make repairs in the facility was for the staff who found an issue was supposed to document the issue in the maintenance binder located at the nurses' station or to call the Maintenance Manager or Assistant Maintenance Manager. During an interview on 09/19/2023 at 1:12 p.m., CNA C said she was normally assigned to Hall 100 and Hall 200. CNA C said if she saw something in need of repair, she would write it down in the maintenance book. During an interview on 09/19/2023 at 1:42 p.m., the Maintenance Director said when something in the building needed to be repaired, the Assistant Maintenance Director and he were the only staff who were available to make repairs. The Maintenance Director said he relied on nursing staff to write down what they saw in the residents' rooms that needed to be repaired because he could not go into every room, every day, and make inspections. The Maintenance Director said the log in the maintenance book did not have a space to prompt the staff to add the name of the person making the request, so he was unable to identify the employee to ask for more information. The Maintenance Director said the staff need to be descriptive when documenting a repair request. During an interview on 09/19/2023 at 2:08 p.m., the Assistant Maintenance Director said the process for making repairs in the facility was for staff to write down issues in the maintenance book located at the nurses' station. The Assistant Maintenance Director said the staff had been in-serviced many times to be more descriptive when documenting the maintenance log, but she still had difficulty determining what the problem was. The Assistant Maintenance Director said the sinks pulled away from the wall after the resident pushed down on it and the staff were not documenting when repairs were needed. During an interview on 09/20/2023 at 9:56 a.m., the ADON said she knew there was issues that needed to be repaired because the building was older. The ADON said the sinks in the residents' bathrooms separating from the wall should be an immediate concern and immediate action taken to fix. The ADON said with building being older, she would expect minor issues. The ADON said exposed drywall at the baseboards was not an acceptable living environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Oaks Living & Rehabilitation Center	2722 Old Anson Rd Abilene, TX 79603

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/20/2023 at 10:41 a.m., the Administrator said the sinks separating from the walls in the residents' bathrooms were more cosmetic than a repair issue. The Administrator said the issue was not of immediate nature. The Administrator said the environment of the facility over-all does not affect the residents' rights. The Administrator said the maintenance log policy had room for improvement. Record review of facility policy, Maintenance & Facilities, Environmental Management, not dated, revealed the policy was to establish an environmental plan to ensure a physical environment was a safe, neat, sanitary environment and met regulations to protect the health and safety of the residents, employees, and others. #1 of the policy revealed that furnishing, equipment, and accessories would be maintained in good order; #4 revealed inspections of the buildings and equipment would be done on a schedule; #5 revealed inspections would be documented.