STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/17/19 through 12/19/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. The census in this 222 certified bed facility was 213 at the time of the survey. The survey sample consisted of 8 current Resident reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		1/16/20

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

Electronically Signed | 12/26/2019

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and facility document review, it was determined that facility staff failed to ensure a clean, comfortable and homelike environment for three of eight residents in the survey sample, Resident #8, #3, and #4. The findings included: 1. For Resident #8, her room was found to have several dried up water rings on the ceiling. Resident #8 was admitted to the facility on 12/26/13 and readmitted on 7/30/14 with diagnoses that included but were not limited to Bipolar disorder and Schizophrenia. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/19. Resident #8's was coded as being moderately impaired in cognitive function scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam.	F 584	1. Resident #8 that had stained ceiling tiles were replaced on 12/17/19. Resident #3, broken tile under sink was replaced on 12/17/19. Resident #4 room was cleaned, swept, mopped by housekeeping on 12/17/19. 2. All residents have the potential to be affected. The facility conducted a facility room audit to identify areas that need maintenance repair work to both floor and ceiling tiles and /or housekeeping. To be completed 12/27/19 3. Maintenance staff will be educated by Executive Director on audit sheets to identify rooms needing repair to maintain a clean comfortable, home like environment to complete on 12/27/19. Housekeeping will have re-educated on proper housekeeping techniques by Housekeeping supervisor to maintain a clean comfortable, home like environment to be completed by 1/10/20.	

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F 584	Continued From page 2 On 12/17/19 at 10:53 a.m., an observation was made of Resident #8's room. Several dried up water rings were observed to her ceiling. On 12/17/19 at approximately 2:00 p.m., OSM (other staff member) #2, the Director of Maintenance was asked to provide all work orders for Resident #8's room in the past year. On 12/17/19 at 2:21 p.m., OSM #2 could not provide work orders related to the above observation. When asked how he is made aware of resident rooms or equipment needing repair, OSM #2 stated that staff will usually submit a work order request. OSM #8 stated work order requests were located at each nursing station. OSM #2 stated that he does not make regular rounds on rooms;that he will go into a room if a concern or complaint is voiced by staff or residents. On 12/17/19 at 2:23 p.m., OSM #2 followed this writer to Resident #8's room. OSM #2 confirmed that there were several water rings on the ceiling. OSM #2 stated that the water rings was caused by condensation from the AC unit. OSM #2 stated it may have been there since the summer. OSM #2 stated he was not aware of Resident #8's ceiling by staff. When asked if water stains on the ceiling was a homelike environment, OSM #2 stated it was not. On 12/18/19 at 11:53 a.m., an interview was conducted with Resident #8. When asked if the water stains had bothered her, Resident #8 stated, "Not really." But then stated, "Well, maybe a little bit."	F 584	4. The Executive Director and/or designee will complete an audit on the facility grounds and resident rooms daily x 4 weeks then weekly x 4 weeks to ensure a clean comfortable homelike environment. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.	

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On 12/18/19 at the end of day meeting at approximately 4:00 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services were made aware of the above concerns. ASM #1 stated that they did not have a policy regarding the above concerns.

2. For Resident #3, his room was found to have a large gouge (missing tile piece) on the floor underneath his bed approximately (12 x 12 inches).

Resident #3 was admitted to the facility on 8/21/17 and readmitted on 5/1/28 with diagnoses that included but were not limited to chronic obstructive pulmonary disease abnormalities of gait, and muscle weakness. Resident #3's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 11/12/19. Resident #3 was coded as being moderately impaired in cognitive function scoring 10 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

On 12/17/19 at 10:35 a.m., tour of the facility was conducted. On 12/17/19 at 10:58 a.m. Resident #3's room was observed. Resident #3's room was observed to have a large gouge in the floor underneath his bed. The gouge was the size of one full tile piece (12 x 12 inches). The gouge was located directly under the bed leg.

On 12/17/19 at approximately 2:00 p.m., OSM (other staff member) #2, the Director of Maintenance was asked to provide all work orders for Resident #3's room in the past year.

On 12/17/19 at 2:21 p.m., OSM #2 could not

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F 584	Continued From page 4	F 584		

provide work orders related to the above observation. When asked how he is made aware of resident rooms or equipment needing repair, OSM #2 stated that staff will usually submit a work order request. OSM #2 stated work order requests were located at each nursing station. OSM #2 stated that he does not make regular rounds on rooms;that he will go into a room if a concern or complaint is voiced by staff or residents.

On 12/17/19 at 2:22 p.m., OSM #2 followed this writer to Resident #3's room. OSM #2 confirmed that a gouge was present to Resident #3's floor roughly the size (12 x 12 inches). OSM #2 stated that the gouge was caused by facility staff not lowering the bed prior to moving it. OSM #2 stated that if the bed is lowered all the way to the floor, it can move back and fourth on its wheels. OSM #2 stated he was not aware of Resident #3's room.

On 12/18/19 at approximately 3:53 p.m. an interview was conducted with Resident #3. Resident #3 stated that the gouge in the floor did not bother him.

On 12/18/19 at the end of day meeting at approximately 4:00 p.m., ASM (administrative staff member) #1, the Executive Director, ASM #2, the Director of Clinical Services were made aware of the above concerns. ASM #1 stated that they did not have a policy regarding the above concerns.

3. For Resident #4, her room was found to have dried up sticky food debris and trash on the floor next to her bed.

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Resident #4 was admitted to the facility on 8/10/2016 with diagnoses that included but were not limited Alzheimer's disease, difficulty walking, difficulty walking. Resident #4's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/27/19. Resident #4 was coded in Section G (Functional Status) as requiring limited assistance from staff with meals.

On 12/17/19 at 10:45 a.m. an observation was made of Resident #4's room. Resident #4's bed was up against the wall, but her bed was pulled out. On the floor next to her bed and closest to the wall, the following was observed:

Dried up yellow substance stuck to the floor.
Dried up bright orange substance stuck to the floor.
Dried up black substance in pieces that looked like rotting food debris stuck to the floor.
One milk carton and one juice carton.

The floor was also observed to be sticky. This writer's shoes stuck to the floor.

On 12/17/19 at 11:15 a.m., a roach was observed on its back (antennas still moving) across the hall from Resident #4's room.

On 12/17/19 at 11:24 a.m., a housekeeper was observed in the hallway (OSM (other staff member) #8. OSM confirmed that there was a roach in the hallway. When asked if roaches were a common sighting, OSM #8 stated that she doesn't see too many during the day. OSM #8 swept up the roach. OSM #8 was then asked to follow this writer into Resident #4's room. OSM #8 confirmed that there was dried up sticky debris on

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the floor next to Resident #4's bed. OSM #8 also confirmed the black debris pieces on the floor and the milk and juice carton. OSM #8 stated that she cleans the residents' rooms every day so the mess; which she stated was food debris, must have just happened after breakfast. When asked if there was a housekeeper at night, OSM #8 stated that they did not have a housekeeper at night so the mess could have also happened after dinner the day prior (12/16/19). OSM #8 stated that she did not get to Resident #4's room yet that morning to clean the room. When asked why her food would be on the side of the bed nearest to the wall, OSM #8 stated that Resident #4 sometimes ate meals in bed and has been known to frequently spill food. When asked if the food substances would be dried up and stuck to the floor if a spill had just occurred after breakfast, OSM #8 stated, "It can happen." OSM #8 then stated, "Maybe the floors need to be replaced."

On 12/17/19 at 12:45 p.m., a second observation was made of Resident #4's floor next to her bed closest to the wall. The floor was cleaned and spotless.

On 12/17/19 at 4 p.m., an interview was conducted with OSM #3, the Director of Housekeeping and Laundry. OSM #3 stated that six housekeepers were usually on the schedule for the day shift. OSM #3 stated that resident rooms and bathrooms were cleaned on a daily basis. When asked what cleaning entailed, OSM #3 stated, "Sweeping, mopping, wiping down surfaces, high dust and low dusting." When asked how often staff clean rooms every day, OSM #3 stated that staff will do a complete clean in the morning and then conduct a walk through around the building after lunch. OSM #3 stated

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that staff will clean as needed at this time. When asked if he expects his staff to clean and mop under and behind beds, OSM #3 stated that he did. When asked if there was a housekeeper on evening shift, OSM #3 stated he had a housekeeper from 2-10 p.m. who will also sweep, mop and dust resident rooms. When asked if a resident spills food on the ground after meals, if the food debris/liquids would be dried up and stuck to the floor if the spill was recent, OSM #3 stated, "Things like that can happen." When asked what time breakfast was served, OSM #3 stated that breakfast was served anywhere from 7:15-7:45 a.m.

On 12/18/19 at approximately 1:40 p.m., an interview was conducted with OSM #10, the 2-10 p.m. housekeeper. OSM #10 stated that during his shift he will clean the main areas of the facility such as the lobby and dining room. OSM #10 also stated that if staff alert him of a spill or mess in the residents' rooms, he will also clean that up. When asked if nursing staff have access to cleaning supplies, OSM #10 stated that he will give them cleaning supplies if they tell him what the spill is. OSM #10 could not recall being made aware of a spill in Resident #4's room the evening of 12/16/19.

On 12/19/19 at 9:45 a.m., an interview was conducted with CNA (certified nursing assistant) #4, Resident #4's CNA the morning of 12/17/19. When asked if Resident #4 ate meals in bed, CNA #4 stated that Resident #4 sometimes ate her meals sitting up in bed. When asked if she had a history of spilling food items, CNA #4 stated that sometimes she did spill food on the floor. When asked what time breakfast was served to Resident #4, CNA #4 stated that breakfast that

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F 584	Continued From page 8 morning was served to all residents at approximately 7:45 to 8 a.m. CNA #4 stated that he couldn't remember if he was the one who picked up Resident #4's breakfast tray that morning but that he did not recall seeing food on the floor when she was finished with her breakfast. When asked the process if he were to walk into a room and see food debris/liquids on the floor, CNA #4 stated that nursing staff can pick up food debris and wipe up anything off the ground but that housekeeping would also be alerted if it was anything that could make the floor sticky. On 12/19/19 at the end of day meeting, ASM #1, the Executive Director, and ASM #2, the Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit.	F 584		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 687	1. Resident #5 received podiatry services 12/20/2019.	1/16/20

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F 687	Continued From page 9 was determined that facility staff failed to provide podiatry services for one of eight sampled residents, Resident #5. The findings included: Resident #5 was admitted to the facility on 2/16/18 with diagnoses that included but were not limited to Schizophrenia, unspecified lack of coordination, muscle weakness, amputation of left leg. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/19/19. Resident #5 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assist with personal hygiene. On 12/17/19 at 10:45 a.m., tour of the facility was conducted. At approximately 11:32 a.m., an observation was made of Resident #5's room. Resident #5 was observed lying on his bed without covers or a sock to his right foot. His toenails were visible to this writer. Resident #5's toenails were yellow and thickened. His fourth toenail was long approximately 1 inch in length and curved upward. When asked if he received podiatry services at the facility, Resident #5 stated that it had been awhile since he was seen by anyone regarding is toenails. Resident #5 stated his toenails had not been cut for some time, but could not recall how long. Resident #5 stated he has not asked the staff to see podiatry but that no one has also offered to either cut his nails or have the podiatrist see him. Review of the podiatry list and visits from the past six months failed to evidence that Resident #5	F 687	2. Current residents have the potential to be affected. Current residents will be assessed for need of podiatry services completed 12/26/2019. Residents requiring podiatry services will be offered services completed with Podiatrist on 12/31/2019 3. The SDC and or designee will educate on assessing residents for podiatry services and ensuring podiatry services are received as needed completed 12/27/2019. 4. The Unit managers or designee will audit ten residents every week to ensure podiatry services were obtained as needed for two months. Then monthly for four months. The results will be reported to the Quality Assurance Performance Committee by the DCS for 3 months for further compliance and/or revision.	

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was put on the list to be seen.

There was no evidence in Resident #5's clinical record that he refused podiatry services.

On 12/17/19 at 2:30 p.m., an interview was conducted with CNA (certified nursing assistant) #3. When asked who was responsible for providing toenail care, CNA #3 stated that she believed the nurses were responsible for providing toenail care or podiatry. CNA #3 stated that the nursing aides provided fingernail care if the resident was not a diabetic.

On 12/17/19 at 2:50 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, Resident #5's nurse. When asked who was responsible for providing toenail care, LPN #1 stated that CNAs can provide toenail care if the resident is not diabetic or if the resident's toenails are not thickened. When asked when toenail care would be provided, LPN #1 stated that toenail care would be provided as needed or during shower days. When asked who was responsible for providing toenail care if the residents were diabetic or had thickened nails, LPN #1 stated that these residents would be put onto the podiatry list to be seen by the podiatrist. When asked how often the podiatrist made visits, LPN #1 stated that the podiatrist comes in monthly and will see his normal scheduled residents that month and any resident that needs to be seen per nursing request. LPN #1 stated that nurses put the residents on the podiatry list. When asked if she frequently worked with Resident #5, LPN #1 stated that she does. When asked if he had recently been seen by podiatry or was put on the list to be seen, LPN #1 stated that she was not sure. When asked if Resident #5 was diabetic,

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LPN #1 stated that he was not. When asked if she knew what his toes to his right foot looked like, LPN #1 stated that she did not see his toes that day.

On 12/17/19 at 3:10 p.m., LPN #1 followed this writer to Resident #5's room. Upon walking in, LPN #1 glanced at Resident #5's toes and stated, "Oh (Name of Resident #5) can I put you on the podiatry list?" Resident #5 stated yes. LPN #1 confirmed that the toenails to his right foot were long, yellow and thickened and the fourth toe was pointed upward. LPN #1 stated that his toenails should have been noticed before now; especially upon a skin assessment. LPN #1 stated that skin assessments were conducted weekly.

Review of Resident #5's latest skin assessment dated 11/26/19, failed to show any information regarding his toenails.

On 12/17/19 at the end of day meeting (4:00 p.m.), ASM (administrative staff member) #1, the Executive Director, and ASM #2, the Director of Clinical Services were made aware of the above concerns.

Facility policy titled, 'Podiatry Services," documented in part, the following: "Podiatry Services are available to residents in need of services other than routine care. Procedure: Podiatry Services are provided via one of the following mechanisms: The center maintains a list of local podiatrists who will accept referrals to their office.
The center maintains a contract with a podiatrist who agrees to see referrals at the Center. Any member of the team may ask the attending physician to request a podiatric consult. Once the

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	495273	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 12 consult order is written or transmitted verbally to the Licensed Nurse, the charge nurse will make the referral. The consulting podiatrist will complete the physician consultation form and/or podiatry assessment and return it to the charge nurse for filing in the medical record..."	F 687		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to maintain an effective pest control program. The findings included: On 12/17/19 at 11:15 a.m., a roach was observed on its back (antennas still moving) across the hall from a resident's room that was observed to have food debris on the floor. On 12/17/19 at 11:24 a.m., a housekeeper was observed on the hallway (OSM (other staff member) #8. OSM #8 confirmed that there was a roach in the hallway. When asked if roaches were a common siting, OSM #8 stated that she doesn't see too many during the day and that she does not work at night. OSM #8 swept up the roach and threw it in the trash. On 12/17/19 at 12:30 p.m., a walk through of the kitchen area was conducted with another surveyor, OSM #6, the Dietary manager and	F 925	1. Pest Control Company was at the facility and treated building on morning of 12/17/19 as scheduled services. Pest Control Company was called back to the facility after sightings and treated hallway outside of room #148, upon finding pest on 12/17/19. Pest was already dead in kitchen and was swept up by dietary staff. 2. All residents have the potential to be affected. Pest control company available to treat facility. 3. Pest Control Company and facility will schedule a meeting to investigate alternative professional treatment options pest control for the building and in the kitchen. Pest Control Company is scheduled 2 times week and as needed visits to maintain a pest control. Pest Control Company will treat kitchen 1 time a week to maintain pest control. Staff to be re-educated on logging items in pest control book. 4. Pest log will be reviewed by Maintenance or Executive Director 2	1/16/20

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F 925	Continued From page 13 OSM #4 the assistant dietary manager. Three dead roaches were found underneath the kitchen sink (first sink upon entering the kitchen from dining area). When asked if roaches were a constant problem in the kitchen, OSM #4 stated that he didn't see too many in the kitchen. When asked how often the kitchen was sprayed for pests, OSM #4 stated that he was not sure. One dead roach was then observed underneath the dishwasher, and another dead roach was found next to the convection oven. OSM #6 stated that the roach found next to the oven was a "waterbug." When asked OSM #6 if roaches in the kitchen were sanitary, he stated that it was not. OSM #6 was asked to provide a "Summary of Service" report from the last time pest control sprayed in the kitchen. On 12/17/19 at approximately 1:00 p.m., OSM #6 presented this writer with the "Summary of Service" (from pest control company) showing that the last time the kitchen was sprayed was on 11/29/19. Review of the facility sighting log revealed that on 12/2/19 large roaches were documented as being seen in the facility kitchen. Further review of the facility sighting log from the past two months (December and November 2019) revealed roaches were seen on the following dates and units: 11/6/19; in the rehabilitation office on the second floor. 11/11/19; on unit 1A in one (1) resident room. 11/25/19; on unit 2A in three (3) resident rooms. 11/26/19; in the social services office across from the dining room.	F 925	times a week for concerns times 4 weeks. The maintenance director and/ or designee will conduct a facility grounds audit for pest sightings daily x 4 weeks then weekly x 4 weeks. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.	

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F 925	Continued From page 14	F 925		

12/2/19; on unit 2B in two (2) resident rooms.
12/3/19; on unit 2A in (1) resident room.
12/17/19; on unit 2B in (1) resident room.

Further review of the "Summary of Service" reports (September 2019 through December 2019) from the pest control company revealed the facility was sprayed twice a week for pests.

On 12/17/19 at 1:07 p.m., an interview was conducted with OSM (other staff member) #5, the pest control technician. When asked how often he comes into the facility to spray for pests, OSM #5 stated he will spray inside the facility twice a week (Tuesdays and Thursday) and the facility kitchen once a month. OSM #5 stated that one treatment lasts up to 90 days. OSM #5 stated that he will visit more often if there is an increase in pests sightings. OSM #5 stated that each nursing station has a sighting book where they can document when there is any pest sighting. When asked if the facility's pest control program was effective if there were still sightings of roaches, OSM #5 stated that his main goal was to control the number of sightings; that there was never total elimination. OSM #5 also stated that he will make recommendations at each visit of problem areas or things to fix that could potentially attract roaches/pests. OSM #5 stated that he did not make any recommendations for the 12/17/19 routine visit. OSM #5 stated that he did not see any active (live) roaches that day. OSM #5 was told about this writer's above observation in the hallway. OSM #5 stated that the live roach may have come out to try to get way from the chemicals.

On 12/17/19 at 1:34 p.m., an interview was conducted with OSM #7, the dishwasher who was

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responsible for cleaning the kitchen. OSM #7 told this writer that he had swept up two dead roaches underneath the sink the day prior (12/16/19). OSM #7 stated that the three dead roaches found that day (12/17/19) underneath the sink had to have been new and recently died. OSM #7 stated that he will see roaches from time to time in the kitchen and that the pest control company is made aware. OSM #7 stated that he wasn't sure what happens after they are made aware.

Further review of the "Summary of Service" reports (September 2019 through December 2019) revealed it was recommended by the pest control company for the facility to clean up debris (trash) in the linen rooms and kitchen; and vegetation on the outside of the building to prevent pests/rodents.

On 12/18/19 at the end of day meeting; ASM (administrative staff member) #1, the Executive Director and ASM #2, the Director of Clinical Services; were made aware of the above concerns.

Facility policy titled, "Pest Control" documents in part, the following: "The facility will maintain a pest control program, which includes inspection, reporting, and prevention."