STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495210	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD 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 04/05/22 through 04/07/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaint were investigated during the survey. VA00054752 - Unsubstantiated, VA00053946 - Substantiated with a deficiency. The census in this 180 certified bed facility was 149 at the time of the survey. The survey sample consisted of 7 current resident reviews (Resident #1 through #7) and 2 closed record reviews (Resident #8 and #9).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		5/6/22

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

Electronically Signed | 04/22/2022

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on complaint investigation, staff interviews and clinical record review, the facility staff failed to notify the resident's representative of a new order to leave out the Percutaneous endoscopic gastrostomy (PEG) feeding tube for 1 out of 3 resident's (Resident #9) in the survey sample. The findings included: The most recent Minimum Data Set (MDS) was a	F 580	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth	

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F 580	Continued From page 2 quarterly assessment with an Assessment Reference Date (ARD) of 02/22/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. Resident #9 was coded total dependence of two with toilet use, personal hygiene and bathing, total dependence of one with transfer, extensive assistance of two with bed mobility and dressing and extensive assistance of one with eating for Activities of Daily Living (ADL). The care plan with a revision date of 11/11/21 identified Resident #9 requiring tube feeding related to dysphagia (difficulty swallowing). The goal set for the resident by the staff was that the resident will remain free of side effects or complications related to tube feeding and the resident's insertion site will be free of signs and symptoms of infection through of 05/23/22. Some of the interventions/approaches the staff would use to accomplish this goal is to provide water flushes per MD orders, Registered Dietitian (RD) and Speech Therapy (ST) consult and needed. A nurse's note entered by Registered Nurse (RN) #1 on 01/18/22 (3p-11p) shift at approximately 9:30 p.m., revealed the following "Informed by the Certified Nursing Assistant (CNA) that Resident #9's PEG tube was completely pulled out with the balloon still intact. The on call physician informed with a new order to leave the PEG tube out since Resident #9 takes his medications crushed in pudding an is on a pureed diet." Review of Resident #9's clinical record did not	F 580	in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580 1. Resident #9 has discharged from the facility. 2. Current residents have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on documentation of resident representative notification of orders which alter the resident□s existing form of treatment. 4. The Unit Managers/designees will complete a random weekly review of resident representative notification of alteration in a resident□s existing form of treatment through review of physician orders. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Date of Completion 5/6/2022	

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F 580	Continued From page 3	F 580		

reveal that the resident's representative was informed that the resident's PEG tube had come out with new orders to leave the PEG tube out.

An interview was conducted with RN #1 on 04/06/22 at 3:45 p.m., who stated, "I did not notify Resident #9's representative that the resident PEG tube had come out with a new order to leave the PEG tube out. When asked if the resident's representative should have been notified of the new order to leave out Resident #9's PEG tube out, she replied, "Of course, she should have been notified."

On 04/06/22 at approximately 4:10 p.m., an interview was conducted with the Director of Nursing (DON) who were informed of the above findings. The DON said RN #1 should have informed the RP and if she was not able, then it should have been passed on to the next shift but absolutely, the RP should have been notified that Resident #9, PEG tube came out with a new order to leave the tube out."

On 04/07/22 at approximately 3:30 p.m., an interview was conducted with the Director of Nursing and Regional Director of Clinical Services who were informed of the above findings with no additional information provided.

A debriefing was held with the Administrator, Director of Nursing and Regional Director of Clinical Services on 04/07/22 at approximately 3:41 p.m., who were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled Significant Change in Condition - revised on 11/01/19. All staff

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F 580	Continued From page 4 members shall communicate any information about patient status change to appropriate licensed personnel immediately upon observation. Procedure: 4. Responsible party will also be notified of a change in condition. Complaint deficiency	F 580		
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 in good condition;	F 584		5/6/22

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F 584	Continued From page 5 §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 observation, resident and staff interview the facility staff failed to ensure resident's environment were clean and homelike. Resident #3's bed room floors were observed to be dirty a with a dried dark sticky substance. The findings included: During the initial tour on 4/5/22 at 12: 45 P.M. Resident #3 who resided in room 401 bed A on Unit 4, floors were observed to be dirty with a dried dark sticky substance. Resident #3 was re-admitted to the facility on 10/07/20 with diagnoses which included hemiplegia, insomnia, attention deficit-hyperactivity, COPD, hypertension, and heart failure. A 1/30/22 Quarterly Minimum Data Set (MDS) assessed this resident in the area of cognitive ability as scoring a 15 on the Basic Interview for Mental Status (BIMS). Resident #3 was assessed as uses a walking	F 584	F584 1. Resident #3 is provided Housekeeping and Maintenance services necessary to maintain a clean and homelike environment. 2. Current residents have the potential to be affected. 3. Housekeeping staff will be educated by the Administrator/designee on maintaining clean floors in the resident□s environment. 4. The Administrator/designee will complete a random weekly review of the resident□s environment. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Date of completion 5/6/2022	

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F 584	Continued From page 6	F 584		

cane and wheelchair for mobility. Resident is able to transfer independently.

A revised care plan dated 02/26/22 indicated: The resident is at risk for falls r/t Deconditioning, gait/balance problems; Goals: The resident will be free of injury through next review. Interventions- Keep environment free of trip hazards.

On 04/05/22 at 12:45 P.M. the floor was observed to have scuff marks, dirt, and a dark sticky substance.

On 4/6/22 at 9:33 a.m. the floor tech was observed scrubbing the floor with a buffer. The suds were observed to be dark gray. The floor tech was observed to only scrub and clean half the room.
During an interview with the floor tech on 4/6/22 at 9:53 a.m. he stated the substance on the floor was spilled coffee and chocolate. The floor tech stated, there was a work order put in over the weekend to clean the floor.

During an interview on 4/7/22 at 10:05 a.m. with Resident #3, she stated, the floor has looked disgusting for over a month. She has been complaining about the condition of the filth and gross look of the floor for weeks.

During an interview on 04/06/22 at 11:03 a.m. with the Maintenance Director he stated, the floor cleaning belongs to house keeping. The House Keeping director was out on leave during the survey.

During an interview on 04/07/22 at 3:35 p.m. with the administrator, he stated, there is no work

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F 584	Continued From page 7 order system in place. The administrator was notified that the floor tech only cleaned half of room 401 floor. The administrator stated, the floor tech should have cleaned the entire floor. A housekeeping and environmental services policy was requested during the survey. There was no policy provided prior to exit.	F 584		
F 657 SS=D	Complaint Deficiency Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		5/6/22

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F 657	Continued From page 8 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, staff interviews, clinical record review and facility documentation review, the facility staff failed to revise 1 of 9 residents (Resident #9) comprehensive person- centered care plan in the survey sample. The findings included: The facility staff failed to revise Resident #9's comprehensive person-centered care plan for to the discontinuation of a Percutaneous endoscopic gastrostomy (PEG) feeding tube. Diagnosis for Resident #9 included but not limited Cerebrovascular Accident (Stroke) and Congestive Heart Failure. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 02/22/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. Resident #9 was coded total dependence of two with toilet use, personal hygiene and bathing, total dependence of one with transfer, extensive assistance of two with bed mobility and dressing and extensive assistance of one with eating for Activities of Daily Living (ADL). The care plan with a revision date of 11/11/21 identified Resident #9 requiring tube feeding related to dysphagia (difficulty swallowing). The	F 657	F657 1. Resident #9 has discharged from the facility. 2. Current residents have the potential to be affected. 3. Nurses will be educated by the Director oof Nursing/designee on revision of the resident□s comprehensive person-centered care plan when the resident□s existing form of treatment is altered, to include discontinuation of a PEG tube. 4. The Unit Managers/designees will complete a random weekly review of resident care plans to ensure that the comprehensive person-centered care plan was revised when the existing form of treatment was altered. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the review will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Date of completion 5/6/2022	

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F 657	Continued From page 9	F 657		

goal set for the resident by the staff was that the resident will remain free of side effects or complications related to tube feeding and the resident's insertion site will be free of signs and symptoms of infection through of 05/23/22. Some of the interventions/approaches the staff would use to accomplish this goal is to provide water flushes per MD orders, Registered Dietitian (RD) and Speech Therapy (ST) consult and needed.

A nurse's note entered by Registered Nurse (RN) #1 on 01/18/22 (3p-11p) shift at approximately 9:30 p.m., revealed the following "Informed by the Certified Nursing Assistant (CNA) that Resident #9's PEG tube was completely pulled out with the balloon still intact, the on call physician informed with a new order to leave the PEG tube out since Resident #9 takes his medications crushed in pudding an is on a pureed diet."

An interview was conducted with the MDS Coordinator on 04/07/22 at approximately 1:40 p.m., who stated, "The Unit Manager's and all the nurses have access to update and revise the resident's care plan when changes are made. She said when the nurse received the order to leave out Resident's #9's PEG tube, she should have revise his care plan to reflect those changes, the use of his PEG tube should have been removed from his active care plan."

On 04/07/22 at approximately 3:30 p.m., an interview was conducted with the Director of Nursing and Regional Director of Clinical Services who were informed of the above findings. The Director of Nursing stated, "All nursing staff play in role in updating/revising the resident's care plans. She stated, "When the

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F 657	Continued From page 10	F 657		

nurse received the new order to leave out Resident #9s' PEG tube, the nurse should have revise the care plan, the use of the PEG should have been removed from his care plan."

A debriefing was held with the Administrator, Director of Nursing and Regional Director of Clinical Services on 04/07/22 at approximately 3:41 p.m., who were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled Resident Assessment and Care Planning with a revision date of 11/01/19.

Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.

Procedure:
6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment.

Definitions:
-Percutaneous endoscopic gastrostomy (PEG) - feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of

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F 657	Continued From page 11 the head and neck, or other conditions (https://medlineplus.gov). Complaint deficiency	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, staff interviews and clinical record review, the facility staff failed to ensure the necessary preventative treatment, care and services were provided to prevent the development of a stage II pressure ulcer for 1 out 3 resident's (Resident #9) in the survey sample. The findings included: Resident #9 was originally admitted the nursing facility on 09/30/20. Diagnosis for Resident #9 included but not limited Cerebrovascular Accident (Stroke) and Congestive Heart Failure. The most recent Minimum Data Set (MDS) was a	F 686	F686 1. Resident #9 has discharged from the facility. 2. Current residents have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on the provision of necessary care and services to prevent the development of pressure ulcers. 4. The Unit Managers/designees will complete a random weekly observation of residents to ensure that necessary care and services to prevent the development of pressure ulcers is provided.	5/6/22

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F 686	Continued From page 12 quarterly assessment with an Assessment Reference Date (ARD) of 02/22/22 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. Resident #9 was coded total dependence of two with toilet use, personal hygiene and bathing, total dependence of one with transfer, extensive assistance of two with bed mobility and dressing and extensive assistance of one with eating for Activities of Daily Living (ADL). The care plan with a revision date of 12/15/21 identified Resident #9 with impaired skin impairment (pressure ulcer) behind left and right ear related to oxygen tubing. The goal set for the resident by the staff will have no evidence of further skin impairment. Some of the interventions/approaches the staff would use to accomplish this goal is for Healing Partners to provide skin/wound care as needed, keep skin clean and dry, lotion to dry skin and Weekly Skin Assessment. A Braden Risk Assessment Report was completed on 10/13/21; resident scored a sixteen indicating at risk for the development of pressure ulcers. During the initial tour and throughout the survey, residents identified using oxygen via nasal cannual were observed without having the use of a preventive device/cushion covering the oxygen tubing to protect the resident from device to skin contact. Review of the Weekly Skin Integrity Evaluation	F 686	5. The results of the observation will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the observation will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Date of completion 5/6/2022	

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	495210	A. BUILDING _____ B. WING _____	C 04/07/2022

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F 686	Continued From page 13 completed on 12/15/21 by License Practical Nurse (LPN) #3 revealed the following: a new stage II pressure ulcer located behind the left and right ear, cause of pressure ulcer (device related). The tissue bed noted with 100% epithelia tissue (pink in color). Will refer to Healing Partners Wound team for further evaluation. Review of the initial Tissue Analytics evaluation completed on 12/16/21 by the Healing Partners Wound team (Wound Practitioner) indicated the following: 1. A new stage II pressure ulcer located behind the right ear measured 0.5 cm x 0.65 cm with 0.10 depth with scant amount of serosanguinous drainage and no odor. The issue is 100% epithelialization with attached edges. Under other: apply bacitracin ointment twice a day and leave open to air. Pad oxygen tubing with foam. 2. A new stage II pressure ulcer located behind the left ear measured 0.49 cm x 0.62 cm with 0.10 depth with scant amount of serosanguinous drainage and no odor. The issue is 100% epithelialization with attached edges. Under other: apply bacitracin ointment twice a day and leave open to air. Pad oxygen tubing with foam. Review of Resident #9's Treatment Administration Record (TAR) for December 2021 revealed the following treatment order: pressure ulcer behind the left and right ear - clean with normal saline or dermal wound cleanser, apply bacitracin ointment and protection gauze or dressing (start date 12/14/21). An interview was conducted with LPN #3 on	F 686		

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F 686	Continued From page 14	F 686		

04/07/22 at approximately 10:20 a.m. The LPN stated, "The pressure ulcers located behind Resident #9's left and right ear were first identified by the resident's daughter." She said the daughter informed her that Resident #9 was complaining of pain behind his ears, so she looked behind both ears and saw that there were open areas behind each ear. When asked if there were EarMates cannula cushions covering the oxygen tubing to protect the resident from device to skin contact prior to the development of his pressure ulcers, she replied, "I don't remember seeing any protective covering over the oxygen tubing prior to the development of his pressure ulcers."

An interview was conducted with the Director of Nursing (DON) and Regional Director of Clinical Service 04/07/22 at approximately 1:50 p.m. The DON said oxygen tubing can cause pressure between the tubing and the ear/skin so the following preventative measure should have been in place: protective foam dressing - something to break the pressure between the tubing and ear, and the staff could have used an oxygen mask instead of a nasal cannual.

The facility's policy titled Respiratory/Oxygen Equipment - revised on 11/01/19.
-Oxygen Therapy via Nasal Cannual, Simple Mask, Venturi Mask, and Oximizer.
4. When placing oxygen delivery device take care to avoid placing pressure on the patient's skin in contact with the system, including attention to the nares and/or ears when using a nasal cannula.

A pressure ulcer prevention policy was requested from the DON and Regional Director of Clinical

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F 686	Continued From page 15 Service 04/07/22 at approximately 1:50 p.m. The Regional Director said the facility does not have a policy on pressure ulcer prevention but did provide a policy on General Wound care/Dressing Changes. The policy was reviewed but did not contain any information on preventing pressure ulcers. Definitions -A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). -Pressure Injury - Stage 2 (Partial-thickness skin loss with exposed dermis_ Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive	F 686		

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F 686	Continued From page 16 related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). -Bacitracin is used to help prevent minor skin injuries such as cuts, scrapes, and burns from becoming infected. Bacitracin is in a class of medications called antibiotics. Bacitracin works by stopping the growth of bacteria (https://medlineplus.gov/druginfo/meds). Complaint deficiency.	F 686		
F 925 SS=D	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 observations, record review and staff interview, the facility staff failed to maintain an effective pest control program. The findings included: During an environmental inspection on Unit 4 at 1:57 p.m. on 04/07/22, live roaches were observed in room 424. The residents residing in the room were not interviewable. Two live roaches were observed on the wall of bed-B. Bait traps were observed with live roaches located under air/heating unit, under the head board of Bed A and the head board of Bed-B. A Pest sighting Log for Unit 4 indicated: On 3/6/22 a small roach was observed on the wall in	F 925	F925 1. Room 424 was treated for pests. 2. Resident rooms have the potential to be affected. 3. Facility staff will be educated by the Administrator/designee on reporting pest sightings through use of the Pest Log and storage of food items in resident areas. The Maintenance Director will provide treatment as needed and notify the pest control company as needed. 4. The Maintenance Director/designee will complete a weekly observation of resident rooms to ensure maintenance of an effective pest control program. The Administrator/designee will review the	5/6/22

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F 925	Continued From page 17 room 430. On 3/6/22 roach observered in side of the door frame of room 418. On 3/24/22 roach observed on the floor of room 424. On 3/30/22 roach observed in room 417. On 4/5/22 roaches observed in rooms 423 and 424. On 4/6/22 roach trap is full. During an interview on 04/07/22 at 2:54 p.m. with the Maintenance Director he stated, the pest control company comes out when the facility calls them regarding pest sightings. A request for a pest control policy was requested but not provided during the survey. Complaint Deficiency	F 925	Pest Log on a weekly basis to ensure that pest control is effective. 5. The results of the observation and review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the observation and review will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Date of completion 5/6/2022	