STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(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 survey was conducted 9/12/2023-9/14/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey. All six were substantiated. VA00059683-7 Allegations- S w/ def VA00059457- 5 Allegations- S w/def VA00059436-9 Allegations- S w/ def VA00059396- 11 Allegations-S w/ def VA00058937- 2 Allegations= S w/ def VA00058144- 2 Allegations = S w/o def . The census in this 180 certified bed facility was 172 at the time of the survey. The survey sample consisted of 8 resident reviews.	F 000		
F 584 SS=E	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.	F 584		10/23/23

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

Electronically Signed | 10/19/2023

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F 584	Continued From page 1 (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; §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, interview, clinical record review, and facility documentation, the facility staff failed to ensure the residents right to a clean, comfortable, and homelike environment, for four (4) residents (Residents #4, #2,# 7, and #8) in a survey sample of eight (8) residents. The findings included: For Residents #1, #2, #7, and #8, the facility staff failed to maintain a comfortable homelike environment due to the lack of effective and efficient HVAC cooling system in the building.	F 584	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 in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F584 Safe/Clean/Comfortable/Homelike	

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F 584	Continued From page 2 The following observations were made regarding Resident #1, who has Brief Interview of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. On 09/13/2023 at approximately 9:50 a.m., Resident #1 was in bed with his eyes closed, appeared to be asleep, dressed in a hospital gown, had a distinct odor of urine in the room, which was compounded by the warm humid air in the room. On 09/14/2023 at approximately 2:30 p.m., Resident #1 was observed in bed, awake, and alert. The resident was noted to have beads of sweat on his forehead and was covered in a sheet and light blanket. When asked if he was warm, he stated that he was. He stated, "It is a bit warm in here for me." When asked if he would like the room a little cooler he said, "Yes ma'am a lot cooler." The following observations were made for Resident #2 who has a BIMS score of 15, indicating no cognitive impairment: On 09/12/2023 at 3:00 p.m., an interview was conducted with Resident #2, and she was asked about the air conditioning in the building. She stated the air conditioning has been broke for years. Resident #2 said, "They use these little portable units like this one my family brought me. But unless you have one in each room, it isn't no good. These little units can cool off one room but not a whole hallway full of rooms." When asked what she did before getting the unit from her family, she stated she laid in bed hardly able to	F 584	Environment 1. Residents #1, #2, #7, and #8 still reside in the facility. For Resident #1. The temperature in his room has been adjusted by ensuring the thermostat is switched to the cooling setting. The temperature of this room now ranges from 72 to 74 degrees. For Resident #2, the temperature in her room is to her liking. No adjustments were needed at this time. For Resident #7, the portable unit has been vented and the condensation was drained to ensure it is operating efficiently. The temperature of this room now ranges from 72 to 74 degrees. For Resident #8. The temperature in her room is to her liking. No adjustments were needed at this time. 2. All residents in the facility have the potential to be affected by this deficient practice. Portable units in the facility were checked to ensure they were vented, and condensation was drained as needed to ensure they operated efficiently. The thermostat switches on the east unit were switched on to ensure the chiller was operating properly to cool the unit off. No other findings requiring adjustment of thermometers. 3. The Administrator or designee will educate the Maintenance Director on ensuring the portable units are vented and drained as needed to ensure efficient operation. Education also included ensuring the thermostat switches on the east unit were switched on to ensure the chiller was operating properly to cool off the unit. 4. The Administrator or designee will	

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F 584	Continued From page 3 breathe good because she has "respiratory issues." The unit her family gave her was a small portable air conditioner that was vented through the window and putting out cold air. The room was a comfortable temperature and not humid. The following observations were made for Resident #7, who has a BIMS score of 15, indicating no cognitive impairment. On 09/12/2023 at 3:15 p.m., Resident #7 was observed in bed dressed in only a hospital gown, and no sheet or blanket covering her. The resident's room had a PTAK unit air conditioner running as well as a portable air conditioner not vented. When asked how she was feeling she said, "Hot as Hell." When asked if the air conditioner is working, she stated that it has not worked since she arrived in May. Employee C was present and asked if the PTAK units work and he stated they were operational. When asked to check the temperature of the PTAK unit, he found it was putting out air at 77.8 degrees on its highest cool setting. When asked to check the temperature of the portable air conditioning unit that was set on its highest cool setting, it was putting out air at 75.5 degrees. When asked if that was efficient cooling, he stated that it was not. The portable air conditioner stopped running at that point, and Employee C was asked how the facility drains the condensation from the units, he stated they take them to the shower room. When asked if the unit automatically shuts off and does not work efficiently when it needs draining and he stated that it does. When asked if the unit runs cooler and more efficiently when it is vented, he stated that it did.	F 584	complete weekly inspections weekly x 4 then monthly x 2 to ensure the temperature is comfortable for the residents and within the regulatory guidelines. Any discrepancies will be immediately corrected. The findings will be reported to the QA Committee who will review and revise the action plan as needed. This plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023	

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F 584	Continued From page 4	F 584		

The following observations were made for Resident #8:

On 09/13/2023 at approximately 12:30 p.m., an interview was conducted with Resident #8 who stated the problem with the air conditioner has been brought up in resident council meetings and that residents are tired of the response, "We have to wait for corporate to get the money to fix it." She further stated, "The portable units in the hallways are not helping and the Administrator is the one who picks who can have one in their room and who can't. Well that's just not fair. If you can open your mouth and fuss you can get one but what about those poor folks who cannot speak for themselves, they just lay there and sweat." Resident #8 had a portable unit in her room vented in the window, and the room was cool and comfortable. When asked what she did before she got the portable unit she stated, "I complained a lot and sweated a lot."

On 09/12/2023 at 2:30 p.m., an interview was conducted with Employee C who was asked how long the cooling system has not been working effectively, and he stated that was before him working there over a year ago. When asked about the portable air conditioning units observed in the hallways, he stated that each unit has at least 2 of the portable air conditioning units. When asked why some of the units are properly vented to the ceiling or a window, he stated that they did not have the tubing to vent all the units. He stated the tubing to vent the air conditioning units is very expensive and corporate does not want to buy it. When asked if the units could run safely without the tubing, he stated they could. Employee C went around the building with Surveyor C and the temperatures in the building

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F 584	Continued From page 5 ranged from 64 degrees on the West wing to 78.8 degrees on the East Wing. On 09/13/2023 at approximately 11:00 a.m., an interview was conducted with the Ombudsman who stated that she submitted complaints on behalf of residents because the building is too hot and humid and smells of urine. There are a few residents that have family bring in fans or portable air conditioning units but the ones who have no family will just suffer with the temperatures. The residents who cannot speak for themselves will not get a portable unit in their room either. On 09/14/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 584		
F 657 SS=D	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	F 657		10/23/23

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F 657	Continued From page 6 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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise the care plan for one resident (Resident #6) of eight (8) residents in the survey sample. For Resident #6, the facility staff failed to review and revise the care plan after a significant weight loss from July 2022 to October 2022. The findings included: On 09/12/2023, a review was conducted of Resident #6's clinical record. Review revealed Resident # 6 was edentulous, had difficulty swallowing, and was prescribed a mechanically altered diet. According to the Monthly Weight Report, Resident #6 had a 20.0093% decrease in weight between July 2022 and October 2022. There were no monthly weights documented in July 2022 and August 2022. The weights from June 2022 to January 2023 were: 01/06/2023 - 96.1 lbs.	F 657	F657 Care Plan Timing and Revision 1. Resident #6 no longer resides in the facility. 2. All residents in the facility have the potential to be affected by this deficient practice. An audit by DON or designee was completed on all current residents to ensure residents with significant weight loss had care plan revised. No other residents were identified. 3. The Director of Nursing or designee will educate current licensed nurses on the process for documented significant weight loss requires care plan reviewed and revised. 4. Unit Managers or designee will complete weekly audits x 4 and monthly x 2 to ensure residents□ care plans are reviewed and revised for documented significant weight loss. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance	

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F 657	Continued From page 7 01/03/2023 - 95.2 lbs. - Wheelchair 11/21/2022 - 95.2 lbs. 10/11/2022 - 100.0 lbs. 10/06/2022 - 96.7 lbs. 07/07/2022 - 118.2 lbs. 06/28/2022 -116.0 lbs. - Mechanical Lift 05/11/2022 - 117.0 lbs. 03/10/2022 - 110.8 lbs. Further review of weights taken monthly to twice monthly from January 2021 of 125.5 lbs. to November 2021 of 124 lbs. showed weights that were stable with slight fluctuations in weight. The first weight calculated for 2022 was completed in March 2022. It was 110 lbs., which was an 11.243% difference from the November 2021 weight of 124 lbs. The Registered Dietitian's notes stated Resident #6 was seen on 07/18/2022 and the plan was to continue the mechanically altered diet due to dysphagia, and continue with staff assisting with feeding. "Gradual weight gain" was noted. The next Dietitian note dated 10/12/2022 documented "Nutrition Weight Change Note-significant weight loss noted and resident has dementia and weight loss is expected. Decreased oral intake noted. Ensure supplements increased to three times daily.	F 657	has been achieved. 5. Date of Compliance: 10/23/2023.	

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F 657	Continued From page 8	F 657		

Weight loss may be unavoidable."

On 09/13/2023 at 1:10 p.m., an interview was conducted with Licensed Practical Nurse C who stated the Certified Nursing Assistants were expected to report food intake to the nurses. LPN C stated the nurses review the care plans of all residents, follow the plan of care, follow the physician's orders regarding diets, weights and nutritional supplements. LPN C stated the physician should be notified to assess the residents.

On 09/14/2023 at 2:45 p.m., an interview was conducted with the Director of Nursing who stated Resident # 6 had dementia and failure to thrive. The Director of Nursing stated the expectation was for the staff to assess and monitor for significant weight loss. The Director of Nursing stated she did not see any weights for August 2022 and September 2022. When asked if the nursing staff would be expected to monitor this resident closely for weight loss due to the medical diagnoses, history, decreased food intake, and prognosis, the Director of Nursing stated, "Yes." The Director of Nursing agreed that a resident with a weight of 117 would look different at 96 pounds. There would be an obvious indication of a change in weight.

Resident #6's care plan was reviewed. It read: "Nutrition Risk R/t (related to) advanced dementia, advanced age, mechanically altered diet provided for ease of chewing/swallowing.

Goal: The resident will maintain adequate nutritional status aeb (as evidenced by) no significant weight change by next review.
Date Initiated: 01/06/2022 - Created on:

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F 657	Continued From page 9 06/12/2018 Revision on: 10/25/2022 Interventions: · Monitor/document/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Date Initiated: 07/18/2022 · Monthly Weights Date Initiated: 01/06/2022 · Provide adaptive equipment for feeding; divided plate. Date Initiated: 01/06/2022 · Provide and serve supplements as ordered. Date Initiated: 01/06/2022 · Provide staff supervision/assistance with feeding at meal times." The care plan did not address the actual significant weight loss identified in October 2022. On 09/14/2023 at 3:00 p.m., the Administrator, Director of Nursing, and Assistant Director of Nursing were notified of the findings. No further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record	F 658	F658 Services Provided Meet	10/23/23

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F 658	Continued From page 10 review, and facility documentation, the facility staff failed to ensure care and services met professional standards of quality for 1 resident (Resident #2) in a survey sample of eight (8) residents. For Resident #2, the facility staff failed to follow physician's orders to weigh Resident #2 three times per week due to a diagnosis of congestive heart failure (CHF). On 09/13/2023 at approximately 12:00 p.m., an interview was conducted with Resident #2 who was asked about her diagnosis of CHF. She stated she was diagnosed when she was in her 40's and has had to watch her diet and weight frequently and watch for swelling of her legs and feet. When asked how many times per week she is supposed to be weighed she stated 3 times per week. When asked how she gets weighed, she stated, "They are supposed to use the lift scale, but a lot of times they don't do it because they don't like getting the lift out and weighing me." A review of the clinical record revealed that Resident #2's weight was not documented from 05/11/2023 until 07/07/2023. From 07/07/2023 until 09/14/2023 the following weights are not documented as having been done: July: 07/14, 07/17, 07/28, and Aug.: 08/4, 08/14, 08/21, and 08/25 Sept.: 09/04, 09/11, and 09/13 On 09/12/2023 at approximately 1:00 p.m., an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) was conducted. They were both asked if it is the expectation of the facility that nurses will follow	F 658	Professional Standards 1. Resident #2 chart was reviewed, and weights were obtained with documentation in the clinical record to re-establish a base line weight remain stable. 2. All residents in the facility have the potential to be affected by this deficient practice. An audit by the DON or designee was completed to verify all current residents with physician orders for weights were obtained. No other residents were identified. 3. The Director of Nursing or designee will educate current licensed nurses on following physician□s orders to obtain weights with documentation in the clinical record. 4. Unit Managers or designee will complete weekly audits x 4 and monthly audits x 2 to ensure physician orders are followed for obtaining weights and documented in the clinical record. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023.	

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F 658	Continued From page 11 the physician's orders and/or clarify any orders they do not understand. They both indicated that it is the facility's expectation of all nurses. No further information was received.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure residents received the necessary services to maintain good grooming, and personal hygiene for 1 resident (Resident #1) in a survey sample of eight (8) Residents. The findings included: On 09/12/2023 at approximately 2:15 p.m., an observation was made of Resident #1 in bed with eyes closed, appeared to be resting, and did not respond to the knock on door. The room smelled of urine and feces, which was compounded by the heat and humidity of the room. On 09/13/2023 at approximately 9:50 a.m., Resident #1 was in bed with his eyes closed, appeared to be asleep, and dressed in a hospital gown. As surveyor moved closer to the resident, there was a smell of body odor, and the room had a distinct odor of urine, which was compounded by the warm humid air in the room.	F 677	F677 ADL Care for Dependent Residents 1. Resident #2 received personal hygiene to include a bed bath on 9/13/2023 with documentation. Resident #2 received a shower on his scheduled shower day of 9/14/2023 with documentation. 2. All residents in the facility have the potential to be affected by this deficient practice. An audit by the DON or designee was completed on all dependent residents to ensure no other residents were affected with hygiene, grooming and showers. No other residents were identified. 3. The Director of Nursing or designee will educate certified nursing assistants in ensuring all dependent residents receive necessary services to maintain good hygiene, personal grooming and showers as scheduled or as needed and/or bed baths as required. 4. Unit Managers or designee will complete audits weekly x 4 to ensure all dependent residents receive services to	10/23/23

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	495097	A. BUILDING _____ B. WING _____	C 09/14/2023

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PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

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F 677	Continued From page 12 On 09/14/2023 at approximately 2:30 p.m., Resident #1 was observed in bed, awake, and alert. The resident was noted to have beads of sweat on his forehead and was covered in a sheet and light blanket. When asked if he had gotten a shower today, he stated that he had not. A review of the clinical records revealed that Resident #1's last recorded shower was 08/10/2023. On 09/13/2023, an interview with Employee C was conducted at 9:55 a.m. Employee C was asked how often residents were bathed, she stated they received showers twice a week or bed bath if they prefer. She stated sometimes they refuse. When asked what the Certified Nursing Assistant (CNA) is supposed to do if a resident refuses, she indicated they are supposed to notify the nurse so she can document it in the nurses' notes and that she can try again later to get them to shower. On 09/13/2023 at approximately 11:00 a.m., an interview was conducted with the Ombudsman who stated she comes to the facility many times and finds the facility smells of urine and feces. She stated that Resident #1's wife complains that he is not bathed regularly, and it is evident by the body odor and urine smell. She stated the lack of adequate air conditioning is not helping with the body odor and incontinent smells either. A review of the policy entitled, "Shift Responsibilities for CNA," read: "2. Obtain patient assignments at the beginning of shift with / from a licensed nurse. Examples of report information includes but is not limited to patient's name, room and bed, scheduled	F 677	maintain hygiene, personal grooming, bed bath and/or showers as scheduled. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023.	

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F 677	Continued From page 13 appointments, bathing needs, special care needs etc. 3. Provide pertinent information to the oncoming shift such as tasks not completed." On 09/14/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to arrange transportation to medial appointments for 1 resident (Resident #5) in the survey sample of eight (8) residents. The findings included: For Resident # 5, the facility staff failed to ensure transportation was arranged for medical appointments. Resident #5 was admitted to the facility in July 2022. Resident #5's diagnoses included but were	F 684	F684 Quality of Care 1. Resident #5 reports having no upcoming appointments. Education provided to resident #5 to inform nurses or unit secretary for self-scheduled appointments to ensure arrangement of transportation. 2. All residents in the facility have the potential to be affected by this deficient practice. An audit by the DON or designee was completed on all current residents in the facility to ensure no other residents had missed appointments due to transportation not being arranged. No other residents were identified.	10/23/23

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F 684	Continued From page 14 not limited to heart failure, respiratory failure with hypoxia, diabetes, hypertension, and chronic kidney disease. Review of the clinical record was conducted on 09/12/2023 and 09/13/2023. On 09/13/2023 at 9:30 a.m., an interview was conducted with Resident #5. He stated it was upsetting that transportation to appointments was always a problem. Resident #5 stated he has missed several appointments in the past and did not have transportation to return to the facility at times. Resident #5 stated he needed to keep the medical appointments when they were scheduled. The facility's sign-in/sign-out sheet was reviewed. The May 2023 sign-in sheet revealed that on 05/22/2023, Resident #5 had an appointment at 2:00 p.m. and was picked up at 1:00 p.m. There was no documentation of the time of return. Additionally, the columns for Transportation Company, Return Time, and Scheduler, were not filled out for any of the entries on the sheet. On 09/13/2023 at approximately 4:00 p.m., an interview was conducted with the Administrator who stated Resident #5 often would secure his own transportation to appointments. The Administrator stated there was a scheduler on the units who arranged for transportation. The Director of Nursing (DON) stated the facility often was unaware when Resident #5 had appointments outside of the facility. The DON stated the facility used the transportation services that were approved by Medicaid. The DON stated that sometimes the transportation service did not	F 684	3. The Director of Nursing or designee will educate the unit secretary and licensed nurses in ensuring transportation is arranged for all residents who have upcoming appointments. Transportation is arranged through the residents insurance company or the family transporting the resident to their appointment(s). 4. Unit Managers or designee will complete audits weekly x 4 to ensure residents have arrangement of transportation for their scheduled appointments. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023.	

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F 684	Continued From page 15	F 684		

show up as scheduled.

Review of the progress notes revealed the following:

"Effective Date: 05/22/2023 17:38 Type: Plan of Care Note
Note Text: Resident returned from dentist. No new orders at this time. Stated "I had some teeth filled"

Effective Date: 05/19/2023 11:51 Type: Alert Note
Note Text : pt has appt (appointment) 5-22-23 at 2pm with dentist (address redacted) with pick up at 1pm

Effective Date: 05/19/2023 11:38 Type: Alert Note
Note Text : transportation did not show for pt appt today 5-19-23 with cardiologist was told they could not find a provider to accommodate his transportation for today trip #71509

Effective Date: 05/18/2023 10:31 Type: Alert Note
Note Text: pt has appt 5-19-23 at 745am with cardiologist at (address redacted) with pick up at 630am."

Review revealed that Resident #5 did not have a dental appointment on 05/2/2023. There was an appointment on 05/22/2023 at 2:00 p.m. Review of the facility's transportation records revealed Resident # 5 was picked up at 1:00 p.m. The Nursing progress notes dated 05/22/2023 at 17:36 (5:36 p.m.) stated the resident returned to the facility from the dentist. Resident #5 was gone from the facility for over 4 hours and over 3 hours after his dental appointment time. There was no documentation that the dental office called the

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F 684	Continued From page 16 facility. Resident #5 did not have transportation for the appointment with the cardiologist on 05/19/2023. The transportation company did not show up. Further review revealed that transportation did not show up for a scheduled dental appointment on 04/17/2023 for Resident #5. On 09/14/2023 during the end of day debriefing, the Administrator, Director of Nursing, and Assistant Director of Nursing were informed of the findings. No further information was provided.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		10/23/23

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F 692	Continued From page 17 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to prevent a significant weight loss for one resident (Resident #6) of a survey sample of eight (8) residents. The findings included: For Resident #6, the facility staff failed to prevent a significant weight loss of 20.0093% within 90 days. In addition, the facility staff failed to recognize, evaluate, and address Resident #6's nutritional needs in a timely manner. Resident #6 was admitted to the facility in June 2022. Resident # 6's diagnoses included but were not limited to: failure to thrive, and dementia. On 09/12/2023, a review was conducted of Resident #6's clinical record. Review revealed Resident #6 was edentulous, had difficulty swallowing, and was prescribed a mechanically altered diet. According to the Monthly Weight Report, Resident #6 had a 20.0093% decrease in weight between July 2022 and October 2022. There were no monthly weights documented in July 2022 and August 2022. The weights from June 2022 to January 2023 were: 01/06/2023 - 96.1 lbs. 01/03/2023 - 95.2 lbs. - Wheelchair 11/21/2022 - 95.2 lbs.	F 692	F692 Nutrition/Hydration Status Maintenance 1. Resident #6 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. An audit was conducted on all resident□s records to ensure no other residents experienced a significant weight loss or nutritional needs were not recognized, evaluated, and addressed in a timely manner. No other residents were identified. 3. The Director of Nursing or designee will educate current licensed nurses and dietitian to ensure residents who have a significant weight loss or inadequate nutrition are recognized, evaluated, and addressed with interventions in a timely manner. 4. Unit Managers or designee will complete audits weekly x 4 and monthly x 2 to ensure residents who have significant weight loss and nutritional needs are recognized, evaluated, and addressed with interventions in a timely manner. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023	

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F 692	Continued From page 18	F 692		

10/11/2022 - 100.0 lbs.

10/6/2022 - 96.7 lbs.

07/07/2022 - 118.2 lbs.

06/28/2022 - 116.0 lbs. - Mechanical Lift

05/11/2022 - 117.0 lbs.

03/10/2022 - 110.8 lbs.

Further review of weights taken monthly to twice monthly from January 2021 of 125.5 lbs. to November 2021 of 124 lbs. showed weights that were stable with slight fluctuations in weight.

The first weight calculated for 2022 was in March 2022 and was documented as 110 lbs., which was an 11.243% difference from the November 2021 weight of 124 lbs.

The Registered Dietitian's notes stated that Resident #6 was seen on 07/18/2022 and the plan was to continue the mechanically altered diet due to dysphagia, and continue with staff assisting with feeding. "Gradual weight gain" was noted.

The next Dietitian note dated 10/12/2022 documented "Nutrition Weight Change Note-significant weight loss noted and resident has dementia and weight loss is expected. Decreased oral intake noted. Ensure supplements increased to three times daily. Weight loss may be unavoidable."

On 09/13/2023 at 1:10 p.m., an interview was

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F 692	Continued From page 19	F 692		

conducted with Licensed Practical Nurse (LPN) C who stated the Certified Nursing Assistants (CNA) were expected to report food intake to the nurses. LPN C stated the nurses review the care plans of all residents, follow the plan of care, follow the physician's orders regarding diets, weights, and nutritional supplements. LPN C stated the physician should be notified to assess the residents.

On 09/14/2023 at 2:45 p.m., an interview was conducted with the Director of Nursing (DON) who stated Resident #6 had dementia and failure to thrive. The DON stated the expectation was for the staff to assess and monitor for significant weight loss. The DON stated she did not see any weights for August 2022 and September 2022. When asked if the nursing staff would be expected to monitor this resident closely for weight loss due to the medical diagnoses, history, decreased food intake, and prognosis, the DON stated "Yes." The DON agreed that a resident with a weight of 117 would look different at 96 pounds. There would be an obvious indication of a change in weight.

Resident #6's care plan was reviewed. It read, "Nutrition Risk R/t (related to) advanced dementia, advanced age, mechanically altered diet provided for ease of chewing/swallowing.

Goal: The resident will maintain adequate nutritional status aeb (as evidenced by) no significant weight change by next review.
Date Initiated: 01/06/2022 -Created on: 06/12/2018
Revision on: 10/25/2022

Interventions:

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F 692	Continued From page 20 · Monitor/document/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Date Initiated: 07/18/2022 · Monthly Weights Date Initiated: 01/06/2022 · Provide adaptive equipment for feeding; divided plate Date Initiated: 01/06/2022 · Provide and serve supplements as ordered Date Initiated: 01/06/2022 · Provide staff supervision/assistance with feeding at meal times." The care plan did not address the actual significant weight loss identified in October 2022. On 09/14/2023 at 3:00 p.m., the Administrator, Director of Nursing and Assistant Director of Nursing were notified of the findings. No further information was received.	F 692		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		10/23/23

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F 755	Continued From page 21 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation, and clinical record review, the facility staff failed to provide routine medications to one resident (Resident #6) in a survey sample of eight (8) residents. The findings included: For Resident #6, the facility staff failed to ensure the medication, Lorazepam, was available for administration as ordered by the physician. Review of the clinical record was conducted 09/12/2023 through 09/14/2023. Resident #6 was admitted to the facility in June 2022. Diagnoses included but were not limited to: anxiety disorder, schizophrenia, dementia,	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records 1. Resident #6 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. An audit by the DON or designee was conducted on all current resident records to ensure physician ordered medications are available and administered. No other residents were identified. 3. The Director of Nursing or designee will educate current licensed nurses on ensuring physician ordered medications are available and administered. Medications that are determined to be unavailable, the OMNI Cell STAT Box will be checked to see if the medication is	

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F 755	Continued From page 22 psychotic disturbance, mood disturbance, and anxiety. Review of the progress notes revealed the following documentation about medications being unavailable: "Effective Date: 12/25/2022 11:25 Type: Orders - Administration Note Note Text : LORazepam Tablet 0.5 MG (milligrams) Give 1 tablet by mouth two times a day for anxiety may give when arrive per MD RP (medical doctor, Responsible Party) is aware." "Effective Date: 12/24/2022 20:56 Type: Orders - Administration Note Note Text : LORazepam Tablet 0.5 MG-Give 1 tablet by mouth two times a day for anxiety Pending to due pharmacy." "Effective Date: 12/24/2022 09:13 Type: Orders - Administration Note Note Text : requires a new rx (prescription)" "Effective Date: 12/23/2022 20:08 Type: Orders - Administration Note Note Text : LORazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety" "Effective Date: 12/23/2022 10:40 Type: Orders - Administration Note Note Text : LORazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety on order" Review of the OMNI Cell STAT Box contents revealed the medication Lorazepam 0.5 mg tablet, quantity of 6 tablets, were on hand. The	F 755	available. If the medication is not available, the medical provider will be notified to receive new orders to include but not limited to an alternative medication or an order to hold the medication until it arrives from the pharmacy. 4. Unit Managers or designee will complete audits weekly x 4 and monthly x 2 to ensure physician ordered medications are available and administered. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023	

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F 755	Continued From page 23	F 755		

nurses could have retrieved the medication from the OMNI Cell STAT box.

Review of physician's orders revealed valid orders for the medications not available for administration.

Review of the care plan revealed the following problem:
"The resident has history of anxiety and psychosis. Date Initiated: 01/06/2022 Revision on: 01/06/2022

Goal: The resident will have decreased signs and symptoms of anxiety and psychosis through the review date.
Date Initiated: 01/06/2022 Target Date: 02/27/2023

Intervention: Administer medications as ordered."

On 09/13/2023 at 11:48 a.m., an interview was conducted with Licensed Practical Nurse (LPN) D who stated "the staff should notify the pharmacy when medications are not available for administration, check the OMNI Cell STAT box, notify the Medical Doctor (MD) and make sure the pharmacy sends the medication STAT."

On 09/13/2023 at 2:42 p.m., an interview was conducted with the Director of Nursing (DON) who stated the expectation was for the pharmacy to make sure medications were available for administration as per the physician's orders. The DON also stated the facility staff should check the OMNI Cell STAT box for medications to see if the missing medication is available in that supply. The DON stated the pharmacy should deliver the

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F 755	Continued From page 24 missing medication on the next run if it was not in the OMNI Cell STAT box. Review of the OMNI Cell STAT box content list revealed the medication, Potassium Chloride capsule 10 milliequivalents and quantity of 5 were available to the staff. There was no documentation the staff informed the physician that the Potassium Chloride Powder was not available as ordered and that Potassium Chloride capsules were available. On 09/14/2023 during the end of day debriefing, the Administrator, Administrator in Training, Director of Nursing and Assistant Director of Nursing were informed of the findings. The Administrator and Director of Nursing stated the pharmacy should ensure medications were available for administration as ordered by the physician. No further information was provided.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure one resident (Resident # 4) of eight (8) residents in the survey sample was free of significant medication errors. For Resident # 4, the facility staff failed to ensure the medication, Medrol, was available for	F 760	F760 Residents are Free of Significant Med Errors 1. Resident #6 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. An audit by the DON or designee was conducted on all current resident records to ensure	10/23/23

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F 760	Continued From page 25 administration as per physician's orders. The findings included: Resident #4 was admitted to the facility in March 2023 and discharged in April 2023. Resident # 4's diagnoses included but not limited to diabetes, methicillin susceptible staphyloccoccus aureus with sepsis (MSSA), and diabetic foot ulcer. Review of the physician's orders revealed an order for the medication: Medrol Oral Tablet Therapy Pack 4 MG (milligrams) (Methylprednisolone) Give 4 mg by mouth give four times a day. The times of scheduled administration of the medication, Medrol, 4 milligrams by mouth four times a day, were documented on the medication administration record (MAR) as to be administered at 9:00 a.m., 12:00 noon., 6:00 p.m., and 9:00 p.m. Review of Resident #4's MAR revealed the nursing staff failed to administer the medication as ordered by the physician on several dates and times to include: April 13, 2023 - 9:00 a.m., 12:00 noon., 6:00 p.m., and 9:00 p.m. April 14, 2023 - 9:00 a.m., 12:00 noon., 6:00 p.m., and 9:00 p.m. April 15, 2023 - 9:00 a.m., 12:00 noon., 6:00 p.m., and 9:00 p.m. April 17, 2023 - 9:00 a.m., 6:00 p.m., and 9:00 p.m. On 09/12/2023 during the initial tour, Licensed Practical Nurse (LPN) B was observed passing medications. LPN B was interviewed. LPN B	F 760	physician ordered medications are available and administered. No other residents were identified. 3. The Director of Nursing or designee will educate current licensed nurses on ensuring physician ordered medications are available and administered to prevent a potential significant medication error. Medications that are determined to be unavailable, the OMNI Cell STAT Box will be checked to see if the medication is available to be administered. If the medication is not available, the medical provider will be notified to receive new orders to include but not limited to an alternative medication or an order to hold the medication until it arrives from the pharmacy. 4. Unit Managers or designee will complete audits weekly x 4 and monthly x 2 to ensure physician ordered medications are available and administered to prevent a potential significant medication error. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee who will review and revise the action plan as needed. The plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023	

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F 760	Continued From page 26	F 760		

stated if the medications were not available, she would notify the pharmacy, check the STAT box, notify the pharmacy, notify the doctor, and notify the family.

On 09/13/2023 at 12:10 p.m., an interview was conducted with the Assistant Director of Nursing (ADON) who stated it was important to administer medications as ordered by the physician. The ADON stated the expectation was that the pharmacy would ensure medications were available for administration and provide them on the next run after notification was received that the medication was not available. She stated the staff should notify the doctor and family if the medications are not available for administration. The ADON stated the medicine was a steroid and it was important to administer the medication, Medrol, as ordered.

On 09/13/2023 at 4:15 p.m., the Administrator and Director of Nursing (Admin D) were informed of the findings.

An interview was conducted with the Director of Nursing (DON) on 09/14/2023 at 2:25 p.m. regarding the medication not being administered. The DON stated she reviewed the clinical record and noted the Medrol was not available from 04/13/2023 - 04/15/2023 but was administered on 04/16/2023. She stated the facility staff did not administer the medication because it had not been available from the pharmacy. The DON stated the nurses were waiting for the pharmacy to deliver the medication and did notify the physician. The DON stated the expectation was the medication would have been available on the next delivery as documented by the nursing staff. The DON stated it was not the expectation for

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F 760	Continued From page 27 prescribed medications to be unavailable for administration for several days. Valid physician's orders were evident for the medications and treatments not documented as administered. Review of the facility's policy entitled, "Medication Administration," revealed that all medications are to be given according to the prescriber's order. On 09/13/2023 at 3:30 PM, an interview was conducted with the Administrator who stated the expectation was that medications would be available for administration. The Administrator also stated staff were expected to check the OMNI Cell STAT box and notify the pharmacy so the medication could be delivered on the next run. The Administrator also stated staff should administer medications and treatments per physician's orders and to document them as having been administered immediately following administration. On 09/13/2023 at 4:00 p.m., the Administrator and DON were informed of the failure of the staff to ensure significant medications were administered. They were informed that more than 10 consecutive doses were not available for administration. On 9/14/2023 during the end of day debriefing, the Administrator, Director of Nursing and Assistant Director of Nursing were informed of the findings. No further information was provided.	F 760		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		10/23/23

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F 921	Continued From page 28 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for the facility in general. The findings included: For the facility, the facility staff failed to maintain a comfortable temperature throughout the entire building, failed to operate portable air conditioners safely in accordance to the manufacturer's instructions, and failed to maintain working ice machines on 2 of the 3 units. On 09/12/2023 during the initial tour of the facility, it was noted that each hall had 2 portable air conditioning units. The West unit felt much cooler than the East and Central units. Temperatures varied from 68 degrees on the West unit to 78.8 on the East and Central units. On 09/12/2023 at approximately 3:30 p.m., an interview was conducted with Employee E who stated the chiller runs the air on East and Central units; however, the West unit has its own air system. Employee E stated that the chiller has not worked properly since before he started working there. Surveyors B & C noted the units on the hallways were vented to the drop ceiling. When asked if the units were safe to operate without venting through a window, Employee E stated they were safe to operate like that. When	F 921	F921 Safe/Functional/Sanitary/Comfortable Environ 1. The chiller system is tentatively scheduled to be replaced in 2024. The current cooling system will be utilized and maintained until replacement. Ice machines located in the East and Central were serviced and all ice machines are functional. 2. All residents in the facility have the potential to be affected by this deficient practice. Portable units in the facility were checked by the Director of Maintenance to ensure they were vented, and condensation was drained as needed to ensure they operated efficiently. The thermostat switches on the east unit were switched on to ensure the chiller was operating properly to cool the unit off. Ice machines on East and Central units are serviced and all units are functional. 3. The Administrator or designee will educate the Maintenance Director on ensuring the portable units are vented and drained as needed to ensure efficient operation. Education also included ensuring the thermostat switches on the east unit were switched on to ensure the chiller was operating properly to cool off the unit. Repairing of ice machine, informing Administrator, arranging for external services for equipment that	

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F 921	Continued From page 29 asked if they were safe to operate without venting to a window or the ceiling, he stated they were safe to operate that way as well. When asked why some units were vented and some were not, he stated because the facility ran out of tubing. When asked why some residents' rooms have portable units and some do not, he stated it is the Administrator and Director of Maintenance that make the decision of which rooms have portable units and he "installs them where they tell me to." On 09/13/23 at approximately 11:45 a.m., an interview was conducted with Employee D who was asked why some residents' rooms have portable units and some do not, he stated that some parts of the building are warmer than others and some residents' families have supplied their own units. A phone call was placed to the manufacturer's help line and was found that the air conditioning units were Model #SLPAC105W Portable Air Conditioner Compact Home A/C Cooling Unit with Built-in Dehumidifier. 10,000 BTU. When asked if these units were commercial or for home use, the associate stated they were ideally designed for home use. When asked if they could be used without venting through the window, he stated the units were designed to be vented to the outside because the way the portable air conditioners work the push cool air into a room and vent hot air out through the compressor to the outside through a window. He stated not properly venting a portable air conditioning unit can result in the system not working, as moisture builds up, it will eventually overheat and shut off. He also stated that a 10,000 BTU air conditioner was only meant to cool a 20 ft x 20 ft area.	F 921	cannot be repaired internally. 4. The Administrator or designee will complete audits weekly x 4then monthly x 2 to ensure the temperature is comfortable for the residents and within the regulatory guidelines and ice machines are functional. Any discrepancies will be immediately corrected, and ice machines are functional. The findings will be reported to the QA Committee who will review and revise the action plan as needed. This plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023	

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F 921	Continued From page 30	F 921		

On 09/13/2023 at 12:55 p.m., an interview was conducted with LPN B who stated "the air conditioning has been a problem in this facility for years and it never gets fixed. These portable units do not cool enough to make a big difference. We have complained and residents and families complain but nothing gets done."

Throughout the survey, staff, residents, and family members voiced complaints about the air conditioning not being effective. A review of resident council meeting minutes revealed the lack of air conditioning has been brought up in every meeting since May.

Observations were made on 09/12/2023 at 2:00 p.m., and the ice machines that serves the East, Central, and West units were empty. An interview was conducted with Employee E who stated the ice machine on East and Central was "down for cleaning." The ice machine on the West unit was having to produce ice for the entire building and that is why they were both empty.

On 09/13/2023, an interview was conducted with the Administrator who stated the maintenance department had purchased ice for distribution until the ice machines could be on long enough to catch up and fill the bin.

On 09/14/2023, the ice machine on the East and Central units was still empty. The ice machine on the West unit had ice barely covering the bottom of the bin. Residents' rooms had water pitchers full of water; however, most of them were without ice.

On 09/14/2023 during the end of day meeting, the Administrator was made aware of the concerns.

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F 921	Continued From page 31 No further information was provided.	F 921		
F 925 SS=E	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, interview, and facility documentation, the facility staff failed to maintain an effective pest control program so the facility is free of pests. The findings included: For the facility in general, the facility staff failed to maintain an environment free of flies, gnats, fruit flies, ants, and roaches. From 09/12/2023 through 09/14/2023 flies and gnats were noted throughout the facility by Surveyors B and C in the conference room, the hallways, and residents' rooms. On 09/14/2023 at approximately 1:00 p.m., a large live cockroach was noted under a chair in the hall just outside the kitchen area. A review of the grievances revealed the following: 08/24/2023 - Room 64 A - Resident states there are ants in her bed. 09/01/2023 - Room 26 B - Resident requested pest control services. 09/01/2023 - Room 44 - Resident requested pest control services.	F 925	F925 Maintains Effective Pest Control Program 1. Room #□s 64, 59, 26, 14, and 44 were all serviced by the pest control provider on 10/17/2023. A replacement bulb for the fly light by room #82 has been ordered. It will be installed upon arrival. The bee/wasps nest located under the bench in the east courtyard has been removed. 2. All areas of the facility have the potential to be affected by this deficient practice. 3. The Administrator or designee will educate the Maintenance Director on ensuring any area identified as having pest control is serviced by the pest control provider in a timely manner. The facility staff will be educated by the SDC or designee on the process for documentation in the pest control book for pest sightings. 4. The Administrator or designee will complete weekly inspections x 4 weeks to review pest control book and ensure areas noted to have pest will be serviced by the pest control provider in a timely manner. The findings will be reported to	10/23/23

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F 925	Continued From page 32 09/05/2023 - Room 14 B - Resident requests pest control services. 09/11/2023 - Room 59 B - Social Worker noticed ants while interviewing residents. A review of the resident council minutes revealed the following: "June 26, 2023 - Resident #8: Excessive trash in the courtyard drawing bees, and wasps. Both insects are building nests in benches." A review of the Service Inspection Report revealed: "Inspected and treated rooms 28 and 58 for spiders. Treated rooms 18 and 79 for roach complaints. Treated rooms 37 and 59 for ants. Also, treated and inspected rooms 3, 5, 7, 9, 21, 39, 52, 62, 76, and 87 for flies. Recommend to clean trash cans, drains, and floor areas to help on the fly issues. Check pest sightings book at front desk. Also fly light near room 82 is out." **Please note that only 1 room (#59) out of the 5 above mentioned rooms were treated by pest control. On 09/13/2023 an interview was conducted with Employee E who stated the process of obtaining pest control services for a specific room is that if a staff or resident reports seeing bugs or flies, they inform maintenance so they can enter it into the pest sightings log. When the exterminator comes he will look at the book and know which rooms and/or areas need to be treated and for which pests. On 09/14/2023 during the end of day meeting, the Administrator was made aware of the findings.	F 925	the QA Committee who will review and revise the action plan as needed. This plan of action will continue until the QA Committee determines that substantial compliance has been achieved. 5. Date of Compliance: 10/23/2023	

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F 925	Continued From page 33 No further information was provided.	F 925		