STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
E 000	Initial Comments A recertification and complaint survey was conducted on 08/20/19 through 08/23/19. The facility was found to be in compliance with CFR 483.73, Emergency Preparedness. Event ID: 5CLV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 08/20/19 to 08/23/19. A total of 3 allegations were investigated with 1 allegation substantiated. Event ID: 5CLV11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		9/20/19

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

Electronically Signed | 09/19/2019

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations in 2 of 4 dining areas, staff interviews and review of facility records, the facility failed to maintain the dignity of residents when Resident #16 did not receive her lunch meal at the same time her table mates ate their meal and when staff referred to residents who required staff assistance with meals as "feeders". This occurred during 1 of 4 dining observations. The findings included: A continuous dining observation occurred on 08/20/19 from 12:33 PM until 1:05 PM in the activity room where residents who required staff assistance or cueing/encouragement ate their lunch. Additionally, a continuous dining observation of the lunch meal service on the North Unit occurred on 08/20/19 from 1:10 PM until 1:20 PM. The following concerns were noted:	F 550	1. Lunch tray for resident #16 was immediatley provided once staff was made aware that resident has not been served a lunch tray while other residents were eating. Staff were immediatley educated on how to properly address residents who require assitance with eating. 2. All residents have the potential to be affected. All residents were interviewed for dining preferences. Residents care plans were updated to reflect preferences. 3. Director of Nursing / Executive Director / Unit Managers educated all staff on the dining process and how to properly address residents that require assistance with eating. Education will be provided in orientation for all new hires. Department managers will audit dining servies during meal times 3x a week for 4 weeks, 1x a week for 2 months and then 1x monthly	

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F 550	Continued From page 2 A. Resident #16 was observed seated at a table with 4 other residents. The 4 table mates received and ate their lunch meal or received assistance with eating their lunch from 12:35 PM until 12:48 PM (13 minutes) while Resident #16 awaited her lunch. Resident #16 watched as her tablemates ate their lunch and she did not have a beverage or her meal during this time. At 12:48 PM Resident #16 received her lunch tray, Unit Manager #1 (UM #1) set up her tray and the Resident fed herself lunch. An interview with Unit Manager (UM) #1 occurred on 08/20/19 at 1:00 PM. The interview revealed the lunch tray for Resident #16 was sent to another area, but then redirected to the activity room. UM #1 further stated that staff should have either removed the Resident from the activity room or placed the Resident at a table where residents were not eating to allow residents seated at the same table to eat their meals together. Medical record review revealed Resident #16 was admitted to the facility on 5/14/19 with diagnoses to include Alzheimer's dementia. An admission Minimum Data Set assessment dated 5/21/19 assessed Resident #16 with severely impaired cognition and required supervision, oversight, or cueing of one staff person with meals. B. On 08/20/19 at 12:38 PM Nursing Assistant #2 (NA #2), while assisting a resident in the activity room with their lunch meal was observed twice to identify the residents who required assistance with their meals as "feeders" during a conversation she had with NA #3. An interview occurred on 8/21/19 at 10:06 AM	F 550	for 3 months. 4. The Director of Nursing will report the results of the audits to the quality assurance performance improvement committee and findings will be reivewed by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 550	Continued From page 3	F 550		

with NA #2. During the interview, NA #2 acknowledged that she referred to residents as "feeders" during the lunch meal on 8/20/19. NA #2 reported that she should have indicated that the residents were assisted with feeding by staff as opposed to using the terminology "feeders". NA #2 also stated that she recently received training provided by the facility regarding not calling residents "feeders" as this terminology could impact a resident's sense of dignity.

Attempts to interview NA #3 were unsuccessful.

C. On 08/20/19 from 1:10 PM to 1:20 PM Nurse #1 was observed on the North Unit to distribute lunch meal trays to residents who ate lunch in their rooms. During this observation Nurse #1 used the terminology "feeders" to identify residents who required assistance with their meals as she discussed with 2 other staff which residents would receive their lunch.

A telephone interview occurred with Nurse #1 on 8/23/19 at 11:47 AM. Nurse #1 stated that staff should address residents in a dignified manner, preferably by their name, particularly their last name. Nurse #1 further stated that she was recently trained not to use the terminology "feeder". Nurse #1 also stated she did not recall using the terminology "feeder", but if she did, it was an oversight.

An interview with the Administrator occurred on 8/23/19 at 11:50 AM. The Administrator stated during the interview that staff were trained to ensure residents who were seated at the same table, received their meals at the same time. She also stated if a resident's meal tray was not available the resident should be moved out of the

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F 550	Continued From page 4 dining area and not left to sit and watch other residents eat while waiting on a meal tray. The Administrator stated that staff were recently in-serviced not to refer to residents who required assistance with meals as "feeders."	F 550		
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). (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	F 580		9/20/19

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F 580	Continued From page 5 (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 record review and staff interviews, the facility failed to notify the physician and the nurse practitioner of a recommendation made by the registered dietician regarding adding a fortified cereal every morning at breakfast and an appetite stimulant for a resident experiencing weight loss (Resident #81). The findings included: Resident #81 was admitted to the facility on 6/29/19 with medical diagnoses inclusive of dementia in other diseases classified elsewhere with behavioral disturbance and dysphasia, oropharyngeal phase. Resident #81's minimum data set dated 7/29/19 identified him as moderately cognitively impaired. A review of Resident #81's diet orders dated	F 580	1. On 9/4/19 Physician notified of Registered Dietician recommendations for resident #81 (Ronald Green) and New Orders received on for appetite stimulant (Remeron) & fortified cereal Q a.m. with breakfast meal. 2. Current residents with weight loss have the potential to be affected. Audit completed on all Registered Dietician recommendations for the past 90 days, any issues identified were addressed. 3. Regional Director of Clinical Services re-educated Director of Clinical Services & Nurse Managers on new process for notification of Medical Director/Nurse Practitioner of Registered Dietician Recommendations on 9/5/19. Medical Director/Nurse Practitioner	

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F 580	Continued From page 6 7/3/19 revealed regular diet, pureed texture, honey thickened fluids consistency. An order for fortified cereal every morning at breakfast was pending confirmation. A review of the Registered Dietician (RD)'s progress note dated 8/9/19 regarding Resident #81, he was eating less than 25% per charted meals. She had increased frozen treats to all meals and recommended a fortified cereal every morning. She also noted Resident #81 may benefit from appetite stimulant per MD approval. An interview with the RD on 8/22/19 at 1:50 PM, she reported the process for the Dietary Manager and the Medical Director receiving her recommendations was that she placed a copy of the nutrition therapy recommendations in the Director of Nursing's (DON's) mailbox and the Dietary Manager's mailbox. The RD stated orders placed in the resident's electronic medical record were signed off by the facility's medical providers. The RD reported on 8/9/19, she placed recommendations for a fortified cereal every morning with breakfast and per MD approval, Resident #81 may benefit possibly from appetite stimulant in the Dietary Manager's mailbox and the DON's mailbox. An interview with the nurse practitioner (NP) on 8/22/19 at 1:29 PM, she reported she was not informed of Resident #81's weight loss. The NP reported nursing staff verbally inform her of residents with weight loss. The NP stated she expected nursing staff to inform her of significant weight loss and any nutritional recommendations by the RD for Resident #81. The NP also stated she had not been instructed on how to sign off dietary orders pending confirmation in the	F 580	educated on new process of notification in the facility on 9/19/2019. Registered Dietician will provide, Director of Clinical Services, Dietary Manager and Nurse Managers with recommendations upon completion .Nurse Managers will follow up on recommendations with Medical Director/Nurse Practitioner and ensure the orders are processed and/or confirmed in Point Click care. Audits will begin on 9/20/2019. The Director of Nursing and or Nurse Mangers to audit Registered Dietician recommendations 3x/week for 4 weeks, then 1 x weekly for 2 months, then once monthly for 3 months. 4. The Director of Nursing will report the results of the audits to the quality assurance performance improvement committee. Findings will be reviewed by the quality assurance improvement committee monthly and audits updated if changes are needed based on findings. The quality assurance improvement committee meets monthly and as needed.	

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F 580	Continued From page 7 electronic medical record. During an interview with the Medical Director on 8/22/19 at 5:15 PM, she stated was aware of Resident #81's weight loss, however she had not been informed of the RD's recommendation to add a fortified cereal every morning at breakfast and that he may benefit from appetite stimulant. The Medical Director indicated she received the RD's dietary recommendations from the DON on a weekly basis. The Medical Director stated she would have expected the DON to notify her of the RD's nutritional recommendations for a fortified cereal every morning and an appetite stimulant for Resident #81. On 8/22/19 at 3:20 PM an interview was conducted with the DON. She reported that she had received the RD's nutritional recommendations for Resident #81 to have a fortified cereal every morning and an appetite stimulant per MD approval. The DON stated the Dietary Manager had been informed of the recommendations by the RD on 8/9/19, but it was an oversight that she had not informed the Medical Director of the recommendation for a fortified cereal every morning at breakfast and an appetite stimulant for Resident #81. The DON reported nutritional recommendations from the RD were placed in her mailbox. The DON also stated she had the responsibility of notifying the Dietary Manager and the Medical Director of nutritional recommendations. The DON stated that the expectation was for the Medical Director to be notified of the RD's recommendations for all residents each week during the time when she shared updates.	F 580		
F 641	Accuracy of Assessments	F 641		9/20/19

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F 641 SS=E	Continued From page 8 CFR(s): 483.20(g)	F 641		

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews, the facility failed to accurately code minimum data set assessments related to Level II Preadmission Screen Resident Review (PASRR) for 1 of 2 (Resident #26), discharge for 1 of 3 (Resident #107), and Hospice for 4 of 5 (Resident #44, Resident #92, Resident #94 and Resident #97).

The findings included:

1. Resident #26 was admitted on 10/11/18 with medical diagnoses inclusive of peripheral vascular disease.

Resident #26's significant change minimum data set (MDS) dated 3/10/19 included a new diagnosis of a serious mental illness and that she had received antipsychotic medication. Section A1500 for the significant change MDS dated 3/10/19 indicated she was not screened and referred for Level II PASRR.

An interview was conducted on 8/22/19 at 5:32 PM with the MDS Coordinator who reported she had completed Section A1500 (PASRR), Section I6000 (Active Diagnosis) and Section N0410 (Medications) for Resident #26's significant change MDS dated 3/10/19. The MDS coordinator stated Resident #26 had experienced a significant change due to her decline in activities of daily living, altered mental status and

1. On 8/23/2019 residents # 44, 92, 94, 97□s MDS was updated to accurately reflect the residents□ MDS assessment for palliative/hospice by the Minimum Data Set Nurse.

2. On 9/19/2019 application was submitted for Level II PASRR for resident #26 by Social Worker. Upon confirmation of Level II PSARR Social Worker will inform, Minimum Data Set Nurse and a new assessment will be open and completed to reflect new PASRR Level.
On 8/21/2019 resident #107□s MDS was updated to accurately reflect the residents□ place of discharge by the Minimum Data Set Nurse.
On 9/19/19 Minimum Data Set Nurses and Regional Minimum Data Assessment Nurse performed quality improvement monitoring of all residents whose most recent MDS assessment was coded as receiving hospice services to ensure accurate coding of hospice/palliative. Any issues identified were addressed.

3. On 9/19/19 Minimum Data Set Nurse□s and Regional Minimum Data Assessment Nurse performed quality improvement monitoring for all current residents with significant change that would need to be referred for Level II

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F 641	Continued From page 9 refusal of care. The MDS Coordinator stated she was not aware of the need to code yes for a Level II screening for PASRR with a significant change in status for residents with a diagnosis of a severe mental illness. During an interview with the Social Worker on 8/22/19 at 5:35 PM, he reported that a screening and referral for Level II PASRR should be conducted with a new serious mental illness and when a resident with a serious mental illness experienced a significant change. The SW stated he was not employed at the facility at the time of Resident #26's significant change MDS dated 3/10/19. An interview with the Director of Nursing (DON) on 08/22/19 at 12:49 PM revealed the MDS should be accurate. 2. Resident #107 readmitted to the facility on 7/10/2019. His diagnoses included cerebral infarction, type 2 diabetes, and chronic kidney disease stage III. Resident #107's discharge Minimum Data Set (MDS) dated 7/10/2019 revealed Resident #107 was independent for decision making. Review of Section A2100 (Discharge Location) revealed Resident #107 was discharged to an acute care hospital from the facility. A nursing progress note dated 7/12/2019 read in part: "Resident #107 stated he was leaving the facility. The DON (Director of Nursing) and NP (Nurse Practitioner) tried to explain discharge procedures and Medicare policy to the resident and family if resident leave against doctor's advice. Resident stated, "he don't care". DON	F 641	PASRR status to ensure accurate coding on most recent comprehensive assessment. Any issues identified were addressed. On 9/19/19 Minimum Data Set Nurse□s and Regional Minimum Data Assessment Nurse performed quality improvement monitoring of the last 30 days of MDS Discharge assessments for accurately coding of place of discharge. Any issues identified were addressed. The Minimum Data Set Nurse was re-educated by the Regional Minimum Data Assessment Nurse on accurate coding of hospice/palliative (Section O), accurate coding of Level II PASSR (Section A1500), and discharge location (Section A2100) on an MDS Assessment, on 9/19/19. All travel MDS nurses will be educated to the process prior to working. Education will also be included as a part of orientation for new hires. The Director of Nursing and/or Regional Minimum Data Assessment Nurse to perform Quality Improvement Monitoring of MDS assessments for accurate coding of palliative/hospice three times a week for four weeks, then one time a week for two months, and then one time monthly for three months. Audits will begin on 9/20/2019. 4. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by QAPI	

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F 641	Continued From page 10 tried to get resident to sign AMA (Against Medical Advice) form, but resident refused to sign the AMA form and walked out of facility." An interview was completed with the Director of Nursing (DON) on 8/21/2019 at 3:10 PM. The DON reported she recalled Resident #107. The DON verbalized Resident #107 discharged AMA and not to an acute care hospital. An interview was completed with the MDS Coordinator on 8/21/2019 at 5:14 PM. The MDS Coordinator stated she used the facility discharge status report to verify discharge location. The MDS Coordinator reported she thought the resident discharged to an acute care hospital. A follow up interview was completed with the DON on 8/21/2019 at 5:18 PM. The DON expressed the discharge location should be accurately coded on the MDS. 3. Resident #44 readmitted to the facility on 4/3/2019. His diagnoses included chronic respiratory failure and end stage chronic obstructive pulmonary disease (COPD). Resident #44's clinical record revealed a start of care date of 3/28/2019 for Palliative Care services. Resident #44's quarterly Minimum Data Set (MDS) dated 7/3/2019 revealed he received hospice services. The MDS reflected he did not have a prognosis of life expectancy of less than 6 months. An interview with the MDS Coordinator on 8/22/2019 at 12:26 PM was completed. She	F 641	committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 641	Continued From page 11	F 641		

revealed Resident #44 did not receive hospice services. The MDS Coordinator reported she thought palliative care should be documented on the MDS.

An interview with the Director of Nursing (DON) was completed on 08/22/2019 at 12:49 PM. She verbalized the MDS should be coded accurately.

4. Resident #92 was admitted to the facility on 07/18/17 with diagnoses which included seizure disorder.

Review of Resident #92's clinical record revealed Resident #92 received palliative care visits on 05/15/19, 06/19/19 and 07/30/19.

Review of Resident #92's annual Minimum Data Set (MDS) dated 07/30/19 revealed Resident #92 received hospice services. The MDS indicated Resident #92 did not have a prognosis of life expectancy of less than 6 months.

Interview with the MDS Coordinator on 08/22/19 at 12:26 PM revealed Resident #92 did not receive hospice services. The MDS Coordinator reported she thought palliative care should be documented on the MDS.

Interview with the Director of Nursing (DON) on 08/22/19 at 12:49 PM revealed the MDS should be accurate.

#5. Resident #94 was re-admitted to the facility 7/11/19. Diagnoses included end stage renal disease, adult failure to thrive, vascular dementia, chronic pain and chronic obstructive pulmonary disease.

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F 641	Continued From page 12	F 641		

Medical record review revealed Resident #94 was referred for Palliative Care Services on 7/17/19.

Review of Resident #94's Minimum Data Set (MDS) assessment, a significant change dated 8/1/19, revealed Resident #94 did not have an end of life prognosis. However, section O, recorded he received Hospice Services.

In an interview with the MDS Coordinator on 8/22/19 at 5:29 PM, she stated that she completed the MDS assessment for Resident #94. The MDS Coordinator stated that Resident #94 received Palliative Care Services, but did not receive Hospice Services. She further stated that she coded the MDS based on prior guidance the MDS department received to code the MDS for Hospice Services when the service provider offered both Hospice and Palliative services. She stated the MDS was coded in error.

In an interview with the Director of Nursing (DON) on 8/22/19 at 4:22 PM, she stated Resident #94 did not receive Hospice Services, but received Palliative Care Services. The DON stated that the MDS assessments were coded based on a prior understanding from a Regional MDS Consultant to code no for end of life prognosis and yes for Hospice Services because the service provider offered both Hospice and Palliative Services.

#6. Resident #97 was admitted to the facility 1/4/18. Diagnoses included colon cancer, vascular dementia, congestive heart failure, chronic pain and chronic obstructive pulmonary disease.

Medical record review revealed Resident #97 was referred for Palliative Care Services on 1/18/18.

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F 641	Continued From page 13 Review of Resident #97's Minimum Data Set (MDS) assessments, an annual dated 2/2/19, quarterly 5/3/19 and quarterly 8/2/19, revealed Resident #97 did not have an end of life prognosis. However, section O, recorded he received hospice services. In an interview with the MDS Coordinator on 8/22/19 at 5:29 PM, she stated that the MDS Coordinator who completed the MDS assessments for Resident #97 no longer worked at the facility. MDS Coordinator stated the MDS was coded that way based on prior guidance the MDS department received to code the MDS for Hospice Services when the service provider offered both Hospice and Palliative services. The MDS Coordinator further stated that Resident #97 did not receive Hospice Services, but rather received Palliative Services. She stated the MDS was coded in error. In an interview with the Director of Nursing (DON) on 8/22/19 at 4:22 PM, she stated Resident #97 did not receive Hospice Services, but received Palliative Care Services. The DON stated that the MDS assessments were coded based on a prior understanding from a Regional MDS Consultant to code no for end of life prognosis and yes for Hospice Services because the service provider offered both Hospice and Palliative Services.	F 641		
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	F 925		9/20/19

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F 925	Continued From page 14 by: Based on observations (North Unit, Rooms 201 and 206, conference room, kitchen, and administrative offices), pest activity voiced by 3 of 9 Residents who attended Resident Council (Resident #80, #35 and #40), staff interviews and review of pest service records, the facility failed to follow pest control recommendations to maintain an effective pest control program. The findings included: 1a. Observations of pest activity occurred during the following: -8/20/19 at 9:20 AM, flying insects were observed in the conference room. -8/20/19 at 9:31 AM, flying insects were observed in the kitchen -8/20/19 at 11:00 AM, flying insects were observed during tour of 200 hall of the North Unit and in Room 201. -8/21/19 from 10:30 AM - 11:00 AM, flying insects were observed at the North Unit nursing station. -8/21/19 from 4:30 PM to 5:30 PM, flying insects were observed in the main dining room during Resident Council meeting. -8/22/19 from 9:00 AM - 9:30 AM, flying insects were observed at North Unit nursing station. -8/22/19 at 10:00 AM, flying insects were observed in the Director of Nursing (DON) office. -8/22/19 at 12:29 PM, flying insects were observed in the conference room. -8/22/19 at 12:58 PM, flying insects were observed in room 206 1b. A Resident Council Meeting was held on 8/21/19 from 4:30 PM until 5:30 PM in the main dining room. A total of 9 Residents attended. During the meeting, 3 Residents expressed the	F 925	1. The facility's pest control vendor came out on 9/5/2019, 9/13/2019,/19/2019 and treated the areas that were noted to have pest. Maintenance staff addressed the areas in the pest control vendor's reports. Door sweeps have been ordered, and will be installed on the noted doors per the pest control vendor's recommendations. 2. The facility's pest control vendor has scheduled to increase visits from monthly to weekly until the noted issues are resolved. 3. The Executive Director educated the Maintenance Staff on the importance of Maintaining an Effective Pest Control Program specific to following recommendations on the pest control vendor's report as well as all staff on ensuring they report the citing of pest in the Steritech book. The Executive Director will review the pest control vendor's reports with maintenance staff weekly x 1 month, and monthly x 2 months, or until the pest control issues have been resolved. 4. The Maintenance Staff will report on the results of any findings to the Quality Assurance Performance Improvement committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly	

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F 925	Continued From page 15 following concerns related to pest activity: -Resident #80 stated he saw gnats, spiders and water bugs recently in his room, he further stated that pest activity had gotten worse ever since his admission to the facility. -Resident #35 stated that fly activity was an ongoing problem that had gotten worse. Resident #35 further stated he had reported the problem to the Maintenance Director. -Resident #40 stated that roaches had been an ongoing problem and that he had reported this to the Maintenance Director. 1c. On 8/22/19 at 12:12 PM, a review of pest sightings logs and service maintenance records revealed the following pest sightings and pest service recommendations made by the pest service contractor: -Review of the Pest Sightings Log revealed roaches, gnats and flies were reported on 8/1/19 and 8/15/19 in the Social Workers office, resident rooms on the North Unit and the Business Office. -On 7/9/19, 6/11/19, and 5/2/19, the pest service contractor recorded that the facility had gaps under doors which provided entry points for rodents and other pests. Recommendations were to ensure the base doors was sealed with a door sweep in order to deter pest entry. -On 3/5/19 the pest service contractor recorded debris collected under the kitchen sink with recommendations to remove the debris to prevent unsanitary conditions and attraction by pests. During an interview on 8/22/19 at12:48 PM, the Administrator stated she did not review the pest service reports, but rather the Maintenance Director received the reports and was responsible to follow up on any recommendations made. The	F 925	at a minimum.	

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F 925	Continued From page 16	F 925		

Administrator further stated that the facility had an ongoing challenge with repeated gnat activity despite monthly service calls to treat for gnats and that she had contacted the pest service provider to follow up that week due to current gnat activity.

An interview with the Maintenance Assistant (MA) occurred on 8/22/19 at 12:54 PM. During the interview, he stated that a log for pest activity was kept at each nursing station for staff to record any pest activity observed or reported. He stated when the pest service contractor serviced the facility, the contractor would review the pest sightings log for record of any current pest activity. He also stated that if he received a complaint regarding pest activity, he called the service contractor as needed and also used products purchased from the contractor to address any pest concerns. He further stated that the products the facility purchased from the contractor were not effective for flies/gnats, but that if the facility had a challenge getting rid of flies/gnats, the affected area was cleaned/emptied, treated and allowed 2 hours for the treatment to work.

A telephone interview occurred on 08/22/19 at 1:28 PM with the Maintenance Director. He stated that he tried to look out for the pest service technician when he visited the facility, but he did not always talk to the technician during his visits. He stated that pest sightings log books were kept at each nursing station for the contractor to review with each service call. He also stated that the contractor provided him with a service report when he was able to connect while the contractor was in the facility, otherwise he did not receive a report. The Maintenance Director further stated

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F 925	Continued From page 17 that he had not been able to connect with the pest service technician in the last few months in order to find out exactly which doors he was referring to regarding the door sweeps, but as far as he knew all of the doors had door sweeps.	F 925		