

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/12/2017
NAME OF PROVIDER OR SUPPLIER AVANTE AT REIDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 543 MAPLE AVENUE REIDSVILLE, NC 27320		
(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 157 SS=D	<p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(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-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(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);</p> <p>(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</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(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.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment</p>	F 157		8/15/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1 as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and physician interviews, the facility failed to notify the Physician when the tube feeding tube was dislodged from the port (Resident #4) and tube feeding was not provided as ordered by the physician (Resident #7) for 2 of 3 sampled residents who were observed for tube feeding.</p> <p>Findings Included:</p> <p>1. Resident # 4 was admitted to the facility on 12/13/16 with documented diagnoses of dysphagia (difficulty swallowing), and multiple sclerosis.</p> <p>Review of the Physician order dated 1/28/17 revealed, Enteral Feeding Order every shift Water 60 cubic centimeter (cc) tube feeding flushes every 2 hours continuous.</p> <p>Review of the Physician order dated 5/26/17 revealed, Enteral Feeding Order every shift Isosource 1.5 at 45 milliliters (ml) every hour (hr) continuous.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 6/15/17 revealed the resident's cognition was severely impaired. The</p>	F 157	<p>Corrective action has been accomplished for the alleged deficient practice in regard to resident #4 and #7. The resident #4 tube feeding tube was found dislodged from the port and resident #7 tube feeding was not administered as MD ordered. MD/NP/RP was notified of the medication errors noted on 7/11/2017.</p> <p>Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing completed an audit on 7/17/2017, of the current facility residents to identify resident with tube feeding orders and validate tube feeding is administered as per MD orders.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur including: The Director of Nursing provided in-service education beginning on 7/17/2017, for the licensed nurses regarding the process for notifying the MD/NP/RP of a medication error. The Director of Nursing and/or Unit Managers will observe 4 tube feeding residents weekly for 4 weeks then 6 tube feeding</p>		

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F 157	<p>Continued From page 2</p> <p>resident required extensive one person assist for activities of daily living (ADL's). The resident was coded as having a percutaneous endoscopic gastrostomy (PEG) tube feed.</p> <p>Review of Resident #4's care plan dated 6/16/17 revealed a focus area "Tube feeding related to dysphagia, swallowing issue and multiple sclerosis". The goal stated Resident # 4 will maintain adequate nutrition and hydration status as evidenced by stable weight. The interventions included provide tube feeding and water flushes per Physician (MD) orders, and monitor and report to MD as needed (PRN) for tube dysfunction or malfunction, tube dislodged and infection at the tube site.</p> <p>Review of weights from March 2017 to July 2017 reveal Resident# 4 with weight loss. Weight on 3/20/17 was 122 pounds (lb.). Weight on 7/5/17 was 110 lb.</p> <p>An observation of Resident # 4 on 7/11/17 at 8:42 AM revealed, Resident# 4 was lying in bed with eyes closed and making jerky hand movements. Tube feeding formula bag indicated Isosource 1.5 Cal. Tube feeding pump indicated rate at 45 ml/hr and flush 60 ml every 2 hours. Formula bag indicated 800 ml formula left in the bag. Resident's right side above the abdomen showed wetness.</p> <p>Resident # 4 tube feeding site was observed along with Nurse #1 on 7/11/17 at 9:05 AM. Observations revealed the feeding tube had been out of the port and the formula was leaking. Observation also revealed a small wash cloth placed underneath the binder, the wash cloth was wet with formula, and a small amount of formula</p>	F 157	<p>residents monthly for 3 months to ensure that tube feeding volume is administered per MD orders. The dietitian will meet with the Director of Nursing and/or Unit Managers weekly after completion of assessment to discuss progress and/or recommendations. The Director of Nursing, Unit Mangers, and/or charge nurse will notify MD/NP/RP regarding change and/or recommendations.</p> <p>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan base on outcomes and/or trends identified.</p>		

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F 157	<p>Continued From page 3</p> <p>was curdled on the wash cloth. Wash cloth, binder and resident's diaper was wet and soiled due to leakage of the formula. Resident #4 tube feeding site was observed. Site was clean and dry. No issues noted at the tube insertion site. During an interview with Nurse #1 at this time the nurse indicated she had hung a new formula bag and flush bag at 5:00 AM on 7/11/17. Nurse #1 explained she was unsure when the tube was dislodged from the port and who had placed a wash cloth under the binder. The nurse stated Nurse Aides (NA) check on the resident during morning care and report any tube feeding leak issues to nursing.</p> <p>During an interview with NA #11 on 7/11/17 at 9:10 AM, the NA indicated that she usually checked the resident during morning rounds, but was unable to do so this morning as she was assisting other residents with breakfast. She indicated the resident was checked every two (2) hours. She indicated she was unsure if anyone had checked on the resident this AM.</p> <p>During an interview with Nurse #6 on 7/11/17 at 10:20 AM, the nurse indicated the resident tends to grab onto her tube. The nurse explained the resident's shirt was pulled down and the covers were pulled up to prevent Resident # 4 from pulling the tube. She stated the NA's were supposed to check every two (2) hours and inform the nurse if they noticed the tube dislodged from the port.</p> <p>During an interview with Director of Nursing (DON) on 7/12/17 at 8:25 AM, she indicated it was her expectation that the resident was checked by a NA every two (2) hours and that the resident was turned and reposition during that</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>time. She further stated NA's should report any issues to the nurse in charge or nurse supervisor so that appropriate action can be taken. DON stated that the nurses should check the resident during medication administration and also on as needed basis. DON also stated nurse should inform MD and the resident's responsible party of any issues and should properly document the event.</p> <p>During an interview with Nurse # 6 on 7/12/17 at 1:07 PM, she stated she did not report to the Physician any issues related to leaks of tube feeding.</p> <p>During an interview with the Physician (MD) on 7/12/17 at 11:07 AM, the MD indicated he was not notified on 7/11/17 about the tube dislodged from the port for Resident #4. He stated it was his expectation that the staff inform him about any tube feeding issue.</p> <p>2. Resident # 7 was admitted to the facility on 3/27/13 with documented diagnoses of dysphagia (difficulty swallowing), neoplasm of digestive system, and Parkinson disease.</p> <p>Review of the Physician's order dated 8/12/16, revealed Flush peg tube with 50 milliliters (ml) water every hour (hr) while tube feeding was running.</p> <p>Review of the Physician order dated 5/26/17, revealed, Enteral Feeding Order: every shift Isosource 1.5 at 75 milliliters (ml) every hour for 16 hours (75 ml/hr x 16 h), turn on at 4:00 PM and turn off at 8:00 AM.</p> <p>Review of the Quarterly Minimum Data Set</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>(MDS) assessment, dated 6/14/17 revealed resident was coded as cognitively severely impaired, having no speech and adequate hearing. Resident was coded as needing extensive one person assist for activities of daily living (ADL's) and as having a tube feed with no significant weight loss or weight gain.</p> <p>During an observation of the resident on 7/11/17 at 4:20 PM, Resident #7 was alert and awake, lying in the bed with head of bed elevated. Resident #7 was observed to be well groomed and smiling at the staff. Resident #7 was not receiving any tube feeding and no tube feeding formula was hung to on the stand.</p> <p>During an observation of the resident on 7/11/17 at 4:50 PM, Resident #7 was not receiving any tube feeding and no tube feeding formula was hung to on the stand.</p> <p>During an interview with Nurse #8 on 7/11/17 at 4:55 PM, the nurse indicated that the nurse responsible for the floor had left early at 3:00 PM. Nurse #8 also stated that she usually did not work on a medication cart and was running late. She explained she was trying to get herself organized by making a list of residents needing insulin and blood checks. Nurse #8 stated she had not had the opportunity to read the orders of the resident and hence was not able to start the tube feeding.</p> <p>During an observation of the resident on 7/11/17 at 5:25 PM, Resident #7 was not receiving any tube feeding and no tube feeding formula was hung to on the stand.</p> <p>During an observation of the resident on 7/12/17 at 7:40 AM, Resident #7 was receiving tube</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>feeding. The formula bag was hanging on the stand and read "Isosource 1.5 CAL", date and time read "7/11/17 at 1800 (6:00 PM)". The bag indicated 250 ml formula remaining in the bag. Flush bag was also hung and "7/11/17 at 1800 (6:00 PM) "was noted on the bag. Observation of the pump indicated a rate of 70 ml per hour and flush rate of 60 ml every 3 hours.</p> <p>During an interview with Nurse #6 on 7/12/17 at 7:50 AM, the nurse stated the Medical Administration Record (MAR) indicated the rate of tube feeding was 75 milliliters per hour (ml/hr) with flushes 50 ml/ hr. She stated she was unsure why the formula was hung late and why the rate of feeding was not accurate. She indicated that no report regarding this issue was provided to her at the beginning of the shift. Nurse #6 further stated that she will follow MD orders and stop the feeding at 8:00 AM.</p> <p>During an observation of the resident on 7/12/17 at 8:10 AM revealed, Resident #7's tube feeding was disconnected and both formula and flush bags were removed from the stand.</p> <p>An interview was conducted with Director of Nursing (DON) on 7/12/17 at 8:17 AM. She indicated it was her expectation the nurses referred to the MAR and make sure the formula and the rate of administration matched the orders. She also stated the date and time on the formula bag should be noted only after the tube feeding has started. She added the physician and resident's responsible party should be notified and a medication error entered.</p> <p>During an interview with the Physician (MD) on 7/12/17 at 11:07 AM, the MD indicated he was not</p>	F 157			

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F 157	Continued From page 7 notified on 7/11/17 the tube feeding was not provided as ordered for Resident #7. He stated out of 10 medication doses missed for residents, only 2 were notified to him. He further stated he had informed the facility and nursing about lack of notification, however he was not notified of all missed medication doses. MD indicated that it was his expectation that MD or Nurse Practitioner were informed by facility when they did not have medications or when orders were not followed, so that appropriate action can be taken.	F 157			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide privacy cover for the urinary catheter drainage bag for 2 of 3 sampled resident with a catheter (Resident #5 and Resident #6). The findings included: 1. Resident #5 was admitted on 6/1/17. The diagnoses included urinary dysfunction of bladder. The 30 day Minimum Data Set assessment, dated 6/1/17, indicated Resident #5 's cognition was moderately impaired and required total assistance with activities of daily living	F 241	Corrective action has been accomplished for the alleged deficient practice in regard to resident #5 and #6. The resident #5 and #6 urinary catheter drainage bag was found without cover and on the floor. Urinary catheter drainage bag for resident #5 was discontinued per MD orders on 7/12/17. Urinary catheter bag for resident #6 was changed to a privacy bag and was hung below the bladder level. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing completed an audit on 7/17/2017, of the current facility residents to identify	8/15/17	

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F 241	<p>Continued From page 8</p> <p>During an observation on 7/11/17 at 5:40 AM, Resident #5 was lying in bed with an uncovered urinary catheter drainage bag on the floor that could be seen from the hall. The bed was at the lowest position on the floor and the drainage bag with tubing was lying beside the resident on the floor at the same level as the urinary bladder.</p> <p>During a follow-up observation on 7/11/17 at 6:00 AM and 6:54 AM, the urinary catheter drainage bag and tubing remained uncovered on the floor at the same level as the urinary bladder.</p> <p>During an interview on 7/11/17 at 6:56 AM, Nurse #2 confirmed Resident 5 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor without privacy cover. Nurse #2 stated the urinary drainage bag should be covered.</p> <p>During an interview on 7/11/17 at 7:02 AM, the Nurse Aide (NA#4) confirmed Resident #5 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor next to the resident without the privacy cover.</p> <p>During an interview on 7/12/17 at 9:24 AM, the Assistant Director of Nursing (ADON) stated the expectation was for the staff to provide a privacy bag over the drainage bag.</p> <p>During an interview on 7/12/17 at 9:45 AM, the Administrator stated the expectation was for staff to provide a privacy cover over the drainage bag.</p> <p>2. Resident #6 was admitted to the facility on 3/26/17. The diagnoses included hydronephrosis</p>	F 241	<p>resident with urinary catheter drainage bags and validate urinary catheter drainage bags are covered and positioned appropriately below the bladder.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur including: The Director of Nursing provided in-service education beginning on 7/17/2017, for the licensed nurses, certified nurse aides, housekeeping, and department heads regarding the appropriate position and covering of urinary catheter drainage bag. The Director of Nursing and/or Unit Managers will observe 5 residents with Urinary catheter drainage bag weekly for 4 weeks then 10 residents monthly for 3 months to validated urinary catheter drainage bag are covered and positioned appropriately. The Director of Nursing, Unit Mangers, and/or charge nurse will notify MD/NP/RP regarding change.</p> <p>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan base on outcomes and/or trends identified.</p>		

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F 241	<p>Continued From page 9</p> <p>with ureteral stricture and bacteremia. The quarterly Minimum Data Set assessment, dated 7/3/17, indicated Resident #6 had severe cognitive impairments and required total assistance with activities of daily living.</p> <p>During an observation on 7/11/17 at 5:41 AM, Resident #6 was lying in bed with an uncovered urinary catheter drainage bag on the floor that could be seen from the hall. The bed was at the lowest position on the floor and the drainage bag with tubing was lying beside the resident on the floor at the same level as the urinary bladder.</p> <p>During a follow-up observation on 7/11/17 at 6:01 AM and 6:55 AM, the urinary catheter drainage bag and tubing remained uncovered on the floor at the same level as the urinary bladder.</p> <p>During an interview on 7/11/17 at 6:56 AM, Nurse #3 confirmed Resident 6 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor without privacy cover. Nurse #3 stated the urinary drainage bag should be covered.</p> <p>During an interview on 7/11/17 at 7:02 AM, the NA #4 confirmed Resident 6 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor next to the resident without privacy cover.</p> <p>During an interview on 7/12/17 at 9:24 AM, the Assistant Director of Nursing (ADON) stated the expectation was for the staff to provide a privacy bag over the drainage bag.</p> <p>During an interview on 7/12/17 at 9:45 AM, the</p>	F 241			

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F 241	Continued From page 10	F 241			
F 253 SS=E	<p>Administrator stated the expectation was for staff to provide a privacy cover over the drainage bag.</p> <p>483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, review of housekeeping records and cleaning checklist, the facility failed to clean and remove soiled trash from the floor outside of resident room for 2 of 4 halls (A1, A5, A11, A 16, A24, A26, B5, B10, B17, B21, B22, B23 and B29).</p> <p>The findings included:</p> <p>1. During an observation on 7/11/17 from 5:30AM to 6:30 AM, the following rooms on 7/11/17 from 5:30AM through 6:30 AM, there was a strong urine and fecal odor present upon entry of the facility. There were bags of soiled briefs, gloves and linen stored on the floor in the halls outside of resident rooms (A1, A5, A11, A 16, A24, A26, B5, B10, B17, B21, B22, B23, and B29). In addition, the following rooms were not clean.</p> <p>a. Room A-1, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Underneath the bed and air condition there was large amounts of dust, gloves and food.</p> <p>b. Room A-5, there was a bag of soiled briefs,</p>	F 253	<p>Corrective action has been accomplished for the alleged deficient practice regarding housekeeping services. The facility cleaned and removed soiled trash from the hallway of resident rooms A1, A5, A11, A16, A24, A26, B5, B10, B17, B21, B22, B23 and B29 on 7/28/17. Rooms A1, A5, A11, A16, A24, A26, B5, B10, B17, B21, B22, B23 and B29 were deep cleaned by the housekeeping department. Deep cleaning the rooms included cleaning and sanitizing the bathrooms, removing gloves and trash on the floor, bags of soiled briefs, dusting as needed below the air conditioning unit, discarding of paper cups, and mopping to remove dried liquids on the floor.</p> <p>Current facility residents have the potential to be affected by the alleged deficient practice. The housekeeping manager completed an audit on 7/31/17 of the facility rooms to ensure that no other rooms had bags of soiled linen, gloves on the floor, paper cups on the floor, dried liquids on the floor, dust, and brown matter in the bathrooms.</p>	8/15/17	

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F 253	<p>Continued From page 11</p> <p>gloves and linen stored on the floor in the halls outside of the resident room. Underneath both beds there were used gloves, brown matter on the floor and large volume of dust.</p> <p>c. Room A-11, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Underneath the bed and air condition there was paper cups, torn paper and dried yellow stains and food. The bathroom had dried brown matter on the floor.</p> <p>d. Room A-16, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Near the bedroom door and bathroom there was dried yellow stains and sticky liquids on the floor. There were used gloves and brief under the head of the bed.</p> <p>e. Room A-24, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident ' s room. Underneath both beds there was large amounts of dust, food, used gloves, torn paper towels in the bathroom and dried yellow and brown matter around the toilet.</p> <p>f. Room A-26, there was bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room Underneath the bed were leftover food, paper cups, dust and a used brief on the floor in the bathroom.</p> <p>g. Room B-5, there was bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. The floor had a large amount of sticky liquids on the floor and used gloves in front of closet.</p> <p>h. Room B-10, there was bag of soiled briefs,</p>	F 253	<p>Measures put into place to ensure that the alleged deficient practice does not recur include: The Housekeeping Manager inserviced all housekeeping staff on 7/31/17 regarding policy and procedure of cleaning resident rooms, bathrooms, and facility hallways. Also, the Director of Nursing inserviced staff on policy and procedure regarding leaving bags of soiled linen in the hallways. The housekeeping manager will monitor ten rooms per week for four weeks and then weekly for three months to ensure compliance. The Director of Nursing will monitor all four halls three times a week for four weeks and then monthly thereafter to ensure compliance.</p> <p>The Housekeeping Manager and Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.</p>		

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F 253	<p>Continued From page 12</p> <p>gloves and linen stored on the floor in the halls outside of the resident room. Underneath the bed and air condition had a large amount of dust and leftover food.</p> <p>i. Room B-17, there was bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. The floor near the door and closet area had a large amount of sticky liquids and the bathroom had dried brown matter around the toilet.</p> <p>j. Room B-21, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Underneath the bed there was food, dried yellow liquids, trash at the sides and foot of bed.</p> <p>k. Room B-22, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Underneath the bed had a large amount of dust, leftover food and gloves. There was some dried sticky liquids and brown matter between both beds. The bathroom had strong urine odor.</p> <p>During a follow-up observation on 7/11/17 at 3:20 PM, Room B22 remained in the same condition.</p> <p>l. Room B-23, there was a bag of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Underneath the bed there was food, snack crumbs, empty soda bottle and paper cups. The floor had dried liquids, soda, and brown matter on floor near air condition unit and under personal chair. The floor near the door and night stand had left over food crumbs and paper on the floor.</p>	F 253			

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F 253	<p>Continued From page 13</p> <p>During a follow-up observation on 7/11/17 at 3:20 PM, Room B23 the room condition remained unclean, and there was the same empty bottle, dirty cup, and dried foods, and liquid on the side of the bed by the window and at the head of the bed.</p> <p>m. Room B-29, there was a bags of soiled briefs, gloves and linen stored on the floor in the halls outside of the resident room. Underneath the air condition and both beds was a large amounts of dust, dried liquids, used gloves and torn paper towels.</p> <p>During an interview on 7/11/17 at 1:29 PM, the Housekeeping Manager (HKM) indicated that he was made aware of concerns by residents and families regarding the cleanliness of the rooms in a timely manner. The HKM reported that he had been short of staff, and only had two housekeepers, and staff were getting to residents rooms as best as they could within the work hours of (7AM-3PM). The HKM stated there was 1 floor tech and 1 laundry staff that worked (3 AM- 11 PM). The HKM stated he was responsible for doing the quality check inspection after each room was clean and when the staff was short he would fill in. The HKM did not state who was responsible for cleaning after the evening shift.</p> <p>2. During a follow-up observation on 7/11/17 at 4:00 PM, the following room were rechecked (A-5, A-11, A24, A26, B5, B17 B21, B22 and B23) the soiled bag was removed the halls. The cleanliness of the identified room remained unclean and in the same condition.</p> <p>During an interview on 7/12/17 at 9:30 AM, the</p>	F 253			

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F 253	Continued From page 14 Administrator indicated the expectation was for that housekeeping follow the daily cleaning and deep cleaning schedule to ensure resident rooms and facility was clean. The administrator indicated the housekeeping manager and assistant was expected to check behind the housekeeping staff before the end of each shift to ensure resident rooms and common areas were clean. The administrator indicated he was unaware of the housekeeping concerns. During an interview on 7/12/17 at 10:00 AM, the Director of Nursing indicated that staff should not be placing soiled trash bags on the floors in the halls outside of resident rooms. The expectation was for staff to immediately take soiled bags to the soiled linen room and place them in the barrels after each incontinent care. In addition, staff could put a clean soil linen barrel on the hall for everyone to use to ensure there were no infection control issues. Review of the housekeeping form revealed what the housekeeping responsibilities were when cleaning resident rooms.	F 253			
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the	F 315		8/15/17	

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F 315	<p>Continued From page 15 facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to keep the urinary catheter drainage bag below the bladder and the drainage bag was lying on the floor for 2 of 3 sampled resident with a catheter (Resident #5 and Resident #6).</p> <p>The findings included:</p> <p>1. Resident #5 was admitted on 6/1/17. The diagnoses included urinary dysfunction of</p>	F 315	<p>Corrective action has been accomplished for the alleged deficient practice in regard to resident #5 and #6. The resident #5 and #6 urinary catheter drainage bag was found without cover and on the floor. Urinary catheter drainage bag for resident #5 was discontinued per MD orders. Urinary catheter bag for resident #6 was changed to a privacy bag and was positioned below the bladder level.</p> <p>Current facility residents have the</p>		

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F 315	<p>Continued From page 16</p> <p>bladder. The 30 day Minimum Data Set assessment, dated 6/1/17, indicated Resident #5 ' s cognition was moderately impaired and required total assistance with activities of daily living.</p> <p>Review of the care plan, dated on 6/16/17, identified the problem as incontinence of bowel and bladder and requirement for assistance with toileting. The goal included the resident would remain free from urinary catheter related trauma and signs and symptoms of infections. The interventions included monitor and document for pain/discomfort due to catheter, monitor and document intake and output, report signs/symptoms of urinary tract infections and abnormal laboratory data.</p> <p>During an observation on 7/11/17 at 5:40 AM, Resident #5 was lying in bed with the urinary catheter a drainage bag on the floor that could be seen from the hall. The bed was at the lowest position on the floor and the drainage bag with tubing was lying beside the resident on the floor at the same level as the urinary bladder.</p> <p>During a follow-up observation on 7/11/17 at 6:00 AM and 6:54 AM, the urinary catheter drainage bag and tubing remained uncovered on the floor at the same level as the urinary bladder.</p> <p>During an interview on 7/11/17 at 6:56 AM, Nurse #3 confirmed Resident 5 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor on the same level as urinary bladder. Nurse #3 stated the urinary drainage bag</p>	F 315	<p>potential to be affected by the alleged deficient practice. The Director of Nursing completed an audit on 7/17/2017, of the current facility residents to identify resident with urinary catheter drainage bags and validate urinary catheter drainage bags are covered and hanging appropriately.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur including: The Director of Nursing provided in-service education beginning on 7/17/2017, for the licensed nurses, certified nurse aides, housekeeping, and department heads regarding the process for Urinary catheter drainage bag. The Director of Nursing and/or Unit Managers will observe 5 residents with Urinary catheter drainage bag weekly for 4 weeks then 10 residents monthly for 3 months to validated Urinary catheter drainage bag are covered and hanging appropriately. The Director of Nursing, Unit Managers, and/or charge nurse will notify MD/NP/RP regarding change.</p> <p>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan base on outcomes and/or trends identified.</p>		

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F 315	<p>Continued From page 17 should be below the urinary bladder.</p> <p>During an interview on 7/11/17 at 7:02 AM, the Nurse Aide (NA#4) confirmed Resident #5 's bed was positioned on the floor and the urinary drainage bag was lying on the floor next to the resident on the same level as urinary bladder.</p> <p>During an interview on 7/12/17 at 9:24 AM, the Director of Nursing (DON) stated the expectation was for the staff to ensure the catheter was below the bladder. DON stated the resident's bed should have been at proper position.</p> <p>During an interview on 7/12/17 at 9:45 AM, the Administrator stated the expectation was for staff to ensure the urinary drainage bag was below the urinary bladder.</p> <p>2. Resident #6 was admitted to the facility on 3/26/17. The diagnoses included hydronephrosis with ureteral stricture and bacteremia. The quarterly Minimum Data Set assessment, dated 7/3/17, indicated Resident #6 had severe cognitive impairments and required total assistance with activities of daily living.</p> <p>During an observation on 7/11/17 at 5:41 AM, Resident #6 was lying in bed with the urinary catheter drainage bag on the floor that could be seen from the hall. The bed was at the lowest position on the floor and the drainage bag and tubing was lying beside the resident on the floor at the same level as the urinary bladder.</p> <p>During a follow-up observation on 7/11/17 at 6:01 AM and 6:55 AM, the urinary catheter drainage</p>	F 315			

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F 315	Continued From page 18 bag and tubing remained uncovered on the floor at the same level as the urinary bladder. During an interview on 7/11/17 at 6:56 AM, Nurse #3 confirmed Resident 6 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor at the same level as the urinary bladder. Nurse #3 stated the urinary drainage bag should be below the urinary bladder. During an interview on 7/11/17 at 7:02 AM, NA #4 confirmed Resident 6 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor next to the resident without privacy cover at the same level as the urinary bladder. During an interview on 7/12/17 at 9:24 AM, the Director of Nursing (DON) stated the expectation was for the staff to ensure the catheter was below the bladder. DON stated the resident's bed should have been at proper position. During an interview on 7/12/17 at 9:45 AM, the Administrator stated the expectation was for staff to ensure the urinary drainage bag was below the urinary bladder.	F 315			
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (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- (4) A resident who has been able to eat enough	F 322		8/15/17	

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F 322	<p>Continued From page 19</p> <p>alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review the facility failed provide to tube feeding as ordered by the physician (Resident #7) and failed to prevent the percutaneous endoscopic gastrostomy (PEG) tube from leaking (Resident #4) for 2 of 3 sampled residents who were observed for tube feeding.</p> <p>Finding Included:</p> <p>1. Resident #7 was admitted to the facility on 3/27/13 with documented diagnosis of dysphagia, gastrostomy status, neoplasm of breast, neoplasm of digestive system and Parkinson's disease.</p> <p>Review of the physician's order dated 8/12/16, revealed Flush peg tube with 50 milliliters (ml) water every hour while tube feeding was running.</p> <p>Review of the physician order dated 5/26/17, revealed, Enteral Feeding Order: every shift IsoSource 1.5 at 75 milliliters (ml) every hour for 16 hours (75 ml/hr x 16 h). Turn on at 4:00 PM and turn off at 8:00 AM.</p>	F 322	<p>Corrective action has been accomplished for the alleged deficient practice in regard to resident #4 and #7. The resident #4 tube feeding tube was found dislodged from the port and resident #7 tube feeding was not administered as MD ordered. MD/NP/RP was notified of the medication errors noted on 7/11/2017.</p> <p>Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing completed an audit on 7/17/2017, of the current facility residents to identify resident with tube feeding orders and validate tube feeding is administered at MD orders.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur including: The Director of Nursing provided in-service education beginning on 7/17/2017, for the licensed nurses regarding the process for notifying the MD/NP/RP of a medication error. The</p>		

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F 322	<p>Continued From page 20</p> <p>Review of the Quarterly Minimum Data Set assessment, dated 6/14/17 revealed resident was coded as cognitively impaired, having no speech and adequate hearing. Resident was coded as not having any psychosis or behavioral issues. Resident was coded as needing extensive one person assist for activities of daily living (ADL's). Resident was coded as having a tube feed with no significant weight loss or weight gain.</p> <p>Review of Resident #7's care plan dated 6/19/17 revealed a focus area "Tube feeding related to dysphagia". The goal stated Resident #7 will maintain adequate nutrition and hydration status as evidence by stable weight. The interventions included, provide tube feeding and water flushes, see the physician (MD) orders for current feeding orders. Monitor and report to MD as needed (PRN).</p> <p>During an observation of the resident on 7/11/17 at 4:20 PM, Resident #7 was alert and awake, lying in the bed with head of bed elevated. Resident #7 was observed to be well groomed and smiling at the staff. Resident #7 was not receiving any tube feeding and no tube feeding formula was hung to the stand.</p> <p>During an observation of the resident on 7/11/17 at 4:50 PM, Resident #7 was not receiving any tube feeding and no tube feeding formula was hung to the stand.</p> <p>During an interview with Nurse #8 on 7/11/17 at 4:55 PM, nurse indicated that the nurse responsible for the floor had left early at 3:00 PM. Nurse #8 also stated that she usually did not work on medical cart and was running late as she was</p>	F 322	<p>Director of Nursing and/or Unit Managers will observe 4 tube feeding residents weekly for 4 weeks and 6 tube feeding residents monthly for 3 months to validated tube feeding is administered according to MD orders. The dietitian will meet with the Director of Nursing and/or Unit Managers weekly after completion of assessment to discuss progress and/or recommendations. The Director of Nursing, Unit Mangers, and/or charge nurse will notify MD/NP/RP regarding change and/or recommendations.</p> <p>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan base on outcomes and/or trends identified.</p>		

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F 322	<p>Continued From page 21</p> <p>trying to get herself organized by making a list of residents needing insulin and blood checks. She indicated she was running late. Nurse #8 stated that she had not had the opportunity to read the orders of the resident and hence was not able to start the tube feeding.</p> <p>During an observation of the resident on 7/11/17 at 5:25 PM, Resident #7 was not receiving any tube feeding and no tube feeding formula was hung to the stand.</p> <p>During an observation of the resident on 7/12/17 at 7:40 AM, Resident #7 was receiving tube feeding. Resident was awake and was watching TV. Formula bag was hanging on the stand and read "Isosource 1.5 CAL", date and time read "7/11/17 at 1800". The bag indicated 250 ml formula remaining in the bag. Flush bag was also hung and "7/11/17 at 1800" was noted on the bag. Observation of the pump indicated a rate of 70 ml per hour and flush rate of 60 ml every 3 hours.</p> <p>During an interview with Nurse #6 on 7/12/17 at 7:50 AM, Nurse stated that the Medication Administration Record (MAR) indicated the rate of tube feeding at 75 ml / hr with flushes 50 ml/ hr. She stated she was unsure why the formula was hung late and why the rate of feeding was not accurate. She indicated that no report regarding this issue was provided to her at the beginning of the shift. Nurse #6 further stated that she will follow MD orders and stop the feeding at 8:00 AM.</p> <p>During an observation of the resident on 7/12/17 at 8:10 AM, Resident #7's tube feeding was disconnected and both formula and flush bags</p>	F 322			

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F 322	<p>Continued From page 22 was removed from the stand.</p> <p>During an interview with Director of Nursing (DON) on 7/12/17 at 8:17 AM. She indicated that it was her expectation that the nurses refers to the Medication Administration Record (MAR) and make sure the formula and the rate of administration matches the orders. She also stated that date and time on the formula bag should be noted only after the tube feeding has started. She stated that MD and resident's responsible party should be notified and medication error entered.</p> <p>2. Resident # 4 was admitted to the facility on 12/13/16 with documented diagnosis of dysphagia and with gastrostomy status, multiple sclerosis and dementia.</p> <p>Review of the physician order dated 1/28/17 revealed, Enteral Feeding Order every shift Water 60 cubic centimeter (cc) tube feeding flushes every 2 hours continuous.</p> <p>Review of the Physician order dated 5/26/17 revealed, Enteral Feeding Order every shift Isosource 1.5 at 45 milliliters (ml) every hour continuous.</p> <p>Review of the Dietitian (RD) note dated 5/26/17 read in part - Resident #4 receives 100% of nutrition via tube. History of pneumonia, sepsis and chronic dysphagia requiring PEG placement on 12/5/16. Tube feeding - Isosource 1.5 and observed to be running at 45 ml/hr continuous with water flushes of 60 ml every 2 hours, providing approximately 1485 kcal, 63 g protein and 752 ml free water, flushes providing 660 ml fluid for total of at least 1412 ml fluid daily via</p>	F 322			

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F 322	<p>Continued From page 23</p> <p>tube. Estimated nutritional needs are 1377 kcal, 79 gm protein and 1585 ml fluid. Prostat sugar free ordered bid and provides an additional 30 g protein and 200 kcal daily for total of 93 g protein daily via tube. No intolerance of feedings reported. Weight in May 116.4 lbs and current BMI is 22.7. History of weight loss, however, admission weight on 12/13/16 was 120 lbs. Will continue to monitor weight, tolerance of feedings and wound healing. No changes recommended at present time.</p> <p>Review of weights from March 2017 to July 2017 revealed Resident #4 with significant weight loss. Weight on 3/20/17 was 122 pounds (lb.). Weight on 7/5/17 was 110 lb.</p> <p>Review of the Quarterly Minimum Data Set assessment, dated 6/15/17 revealed resident was coded as cognitively impaired, having no speech and adequate hearing. Resident was coded as not having any psychosis or behavioral issues. Resident was coded as needing extensive one person assist for activities of daily living (ADL's). Resident was coded as having a PEG tube feed with weight loss of 5% or greater in last month or 10% in 6 months and resident not on prescribed weight loss.</p> <p>Review of Resident #4's care plan dated 6/16/17 revealed a focus area "Tube feeding related to dysphagia, swallowing issue and multiple sclerosis". The goal stated Resident # 4 will maintain adequate nutrition and hydration status as evidence by stable weight.</p> <p>The interventions included provide tube feeding and water flushes per physician (MD) orders for current feeding orders. Monitor and report to MD as needed (PRN) for tube dysfunction or</p>	F 322			

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F 322	<p>Continued From page 24</p> <p>malfunction, tube dislodged and infection at the tube site.</p> <p>Review of the Dietitian (RD) note dated 6/16/17 read in part -- Resident #4 receives 100% of nutrition via tube. June weight 113.4 lb and reflects a loss of 2.8 lb in past month, loss of 11% in past six months. No intolerance of feedings reported. History of weight loss, however, resident has history of aspiration with increase in tube feeding rate. Will continue to monitor weight, tolerance of feedings and wound healing. No changes recommended at present time.</p> <p>During an observation of Resident #4 on 7/11/17 at 8:42 AM revealed, Resident #4 lying in bed with eyes closed and making jerky hand movements. Tube feeding formula bag indicated Isosource 1.5 Cal. The formula bag indicated no date and 5:00 AM was noted on the bag. Water flush bag was dated and timed as "7/11/17 at 5:00 AM. Tube feeding pump indicated rate at 45 milliliters per hour (ml/hr) and flush 60 milliliters (ml) every 2 hours. Formula bag indicated 800 ml formula left in the bag. The resident's right side above the abdomen showed wetness.</p> <p>During an interview with Nurse #6 on 7/11/17 on 8:57 AM. Nurse indicated that she usually checks on the tube feeding and on the resident during her shift and during medication administration. She indicated that Nurse Aides (NA) check the resident every 2 hours for repositioning and to see if resident needed other assistance.</p> <p>Resident #4's tube feeding site was observed along with nurse #1 on 7/11/17 at 9:05 AM. Observations revealed the feeding tube was out</p>	F 322			

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F 322	<p>Continued From page 25</p> <p>of the port and the formula was leaking. Observation also revealed a small wash cloth placed underneath the binder, the wash cloth was wet with formula, and a small amount of formula was curdled on the wash cloth. Wash cloth, binder and resident's diaper was wet and soiled due to leakage of the formula. Resident #4's tube feeding site was observed. Site was clean and dry. No issues noted at the tube insertion site.</p> <p>During an interview with Nurse #1 on 7/11/17 at 9:05 AM, Nurse #1 indicated that she had hung a new formula bag and flush bag at 5:00 AM on 7/11/17. She also stated that she had marked the flush bag with time and date, however did not mark the formula with the date, just the time. Nurse also indicated that she was unsure when the tube was dislodged from the port and who had placed a wash cloth under the binder. Nurse indicated that Nurse Aide (NA) checks on the resident during morning care and reports any tube feeding leak issues to nursing.</p> <p>During an interview with Nurse Aide #11 (NA) on 7/11/17 at 9:10 AM, NA indicated that she usually checks the resident during morning rounds, but was unable to do so this morning as she was assisting other residents with breakfast. She indicated that the resident was checked every two (2) hours.</p> <p>During an interview with Nurse # 6 on 7/11/17 at 10:20 AM. , Nurse indicated that the resident tends to grab on her tube. Nurse indicated that the resident's shirt was pulled down and the covers were pulled up to prevent Resident # 4 from pulling the tube. She stated that the Nurse Aides were supposed to check every two (2) hours and inform the nursing if they notice tube</p>	F 322			

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F 322	Continued From page 26 dislodged from the port. During an interview with Director of Nursing (DON) on 7/12/17 at 8:25 AM, she indicated that it was her expectation that the resident was checked by a nurse aide (NA) every two (2) hours and that the resident was turned and reposition during that time. She further stated that Nurse Aides should report any issues to the nurse in charge or nurse supervisor so that appropriate action can be taken. DON stated that the nurses should checked the resident during medication administration and also on as needed basis. DON also stated that nurses should inform MD and the resident's responsible party of any issues and should properly document the event. During an interview with Dietitian (RD) on 7/12/17 at 10:43 AM, RD indicated that the resident's weight loss was a concern, however wounds were showing improvement, on protein supplementation. She stated that due to Resident #4 prior aspirations issues, the Nurse Practitioner did not want to change the rate of the formula. She indicated that she was not aware that the tube feeding tube was dislodged from the port or that the resident tends to pull her tube.	F 322			
F 469 SS=D	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews, the facility failed to maintain a pest free environment for 2 of 2 sampled residents ' (Resident #2 and Resident	F 469	Corrective action has been accomplished for the alleged deficient practice regarding effective pest control program. The dead bugs that were found in rooms of	8/15/17	

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F 469	<p>Continued From page 27 #3) rooms and 2 of 3 halls.</p> <p>The findings included:</p> <p>1.A. Resident #2 was admitted to the facility on 2/21/15. The diagnoses included chronic kidney disease, diabetes and dementia. The quarterly Minimum Data Set (MDS), dated 7/12/17, indicated that Resident #2 's cognition was moderately impaired and the resident required assistance with activities of daily living.</p> <p>During an observation on 7/11/17 at 5:30 AM, Resident #2's room there were dead bugs underneath the bed and air conditioner.</p> <p>During a follow-up observation on 7/11/17 at 3:22 PM, Resident #2's room was rechecked and the dead bugs remain underneath the bed and air condition.</p> <p>B. Resident #3 admitted to the facility on 4/13/15. The diagnoses included atrial fibrillation and cerebrovascular disease. The Minimum Data Set (MDS), dated 3/24/17, indicated Resident 3 ' s cognition was intact and the resident required total assistance with activities of daily living.</p> <p>During an observation on 7/11/17 at 5:30 AM, Resident #3's room there were dead bugs under bed and night stand.</p> <p>During an interview on 7/11/17 at 6:11 AM, NA #2 indicated that he had seen spiders and bugs in several rooms. NA#2 reported he had told the charge nurse a few days ago and the rooms that he had seen the spiders and bugs. NA #2 further stated nursing would report the concern to maintenance.</p>	F 469	<p>Resident # 2 and Resident # 3 were removed from the room. The facility <input type="checkbox"/>s contracted pest control company came in and treated those rooms for pests on July 13.</p> <p>Current facility residents have the potential to be affected by the alleged deficient practice. The Maintenance Director completed an audit on 7/31/17 of the all the facility rooms to ensure that no other rooms in the facility had any evidence bugs or pests. The facility <input type="checkbox"/>s contracted pest control company came in and treated the facility on July 13.</p> <p>Measures put into place to ensure that the alleged deficient practice does not recur include: The Maintenance Director inserviced staff on 7/31/17 regarding policy and procedure of reporting any pest control issues. The Maintenance Director will monitor ten rooms per week for four weeks and then weekly for three months to ensure compliance. The facility <input type="checkbox"/>s contracted pest control company will be treating the facility by weekly and additionally as required.</p> <p>The Maintenance Director will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.</p>		

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F 469	Continued From page 28 During an interview on 7/11/17 at 6:15 AM, NA#1 reported there had been a lot of spiders in the building in resident rooms, halls and in bathrooms. NA#1 reported the spiders was reported to nursing. During an interview on 7/11/17 at 8:23 AM, Resident #3 stated that he had seen a few roaches and ants in his closet and on the floor. Resident #3 reported he would just kill them. They would be dead a few days before housekeeping would clean the room. During an interview on 7/11/17 at 9:00 AM, Housekeeper (HK) #1 reported that he had seen some flies and other bugs, mostly dead in resident rooms and hallway. He reported he would just sweep them up. He indicated that he did not report this observation to maintenance. During an interview on 7/11/17 at 9:19 AM, HK#3 reported the expectation was to clean up any bugs, roaches and report to the maintenance director. HK#3 indicated there had been a few dead bug in resident rooms and offices. They were cleaned up with the daily routine schedule. HK#3 stated she had not reported the observations to maintenance. During an interview on 7/11/17 at 9:20 AM, HK#2 indicated when dead bugs were observed he would just clean them up as part of his daily cleaning. He stated that he had not reported the observation to maintenance, they would mainly be seen in the halls or staff offices. During an interview on 7/11/17 at 2:20 PM, the Maintenance Director, stated the pest control	F 469			

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F 469	<p>Continued From page 29</p> <p>company visited monthly for routine bugs, spiders, ants and sprayed inside and outside. He stated that he was unaware of any recent concerns reported regarding bugs, ants or roaches. He did receive a recent report on Monday for a spider in a staff office. He was unaware of any other pest in resident rooms. The Maintenance Director indicated he was unaware of any concerns reported by residents or family about roaches coming out of resident ' s closets.</p> <p>During a follow-up observation on 7/11/17 at 3:20 PM, Resident #3 room on the side of the bed by the window and underneath the bed there was dead bugs. NA #7 opened two drawers and a few roaches crawled out of the top drawer.</p> <p>During an interview on 7/11/17 at 3:30 PM, NA#7 indicated when he saw any form of bugs, roaches, spiders he would let the maintenance director and head housekeeper know .</p> <p>During an interview on 7/12/17 at 9:30 AM, the Administrator indicated the expectation was for staff to report all observations of any pest within the building to maintenance. Maintenance should contact the pest control company for an emergency visit in addition to the monthly visits when needed. He reported he was unaware of any concerns with pest in the facility.</p> <p>During an interview on 7/12/17 at 10:00 AM, the Director of Nursing indicated she was unaware of any recent reports of roaches or bugs in resident rooms or closet. However, she did receive an email regarding a spider being found in a resident bed. The expectation was for all staff to report any pest issues to the maintenance director.</p>	F 469			

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