STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 5/5/25 through 5/8/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #05J211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/5/25 through 5/8/25. Event ID# 05J211. The following intakes were investigated: NC00228513, NC00228300, NC00227043, NC00226002, NC00225848, NC00224761, NC00224489, NC00221158, NC00221145, NC00220510, NC00219648, NC00218313, NC00217407, NC00216346 and NC00214711. 6 of the 37 complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		5/30/25

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

Electronically Signed | 05/29/2025

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff and Nurse Practitioner (NP) interviews and record review, the facility failed to ensure a resident's code status information was consistent throughout the medical record for 1 of 2 residents reviewed for advanced directives (Resident #43). The findings included: Resident #43 was admitted to the facility on 3/12/24. His diagnoses included malignant neoplasm of the right lung (lung cancer),	F 578	Corrective Action for those residents that have been affected. The physician's order for the Full Code Status for Resident # 43 was data entered by the Director of Nursing (DON) on 5/7/25. The Full Code status was entered on the Care Plan and on the resident banner on 5/7/25 by the DON. Corrective action will be accomplished for those residents to be affected by the same deficient practice.	

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F 578	Continued From page 2 secondary malignant neoplasm of the brain (when a cancer that started somewhere else in the body has spread to the brain), cerebral edema (brain swelling caused by an abnormal buildup of fluid in the brain's tissues), and seizure disorder. The electronic medical record (EMR) profile indicated Resident #43's code status as Do Not Resuscitate (DNR). Review of Resident #43's EMR revealed a signed Advance Directive form dated 3/8/24 which indicated no code (DNR) status. Review of Resident #43's physician orders dated 3/12/24 revealed he had an order for Do Not Resuscitate (DNR). Review of the quarterly Minimum Data Set (MDS) assessment dated 3/10/25 revealed Resident #43 was cognitively intact. Further review of Resident #43's EMR revealed a signed Medical Orders for Scope of Treatment (MOST) form dated 4/17/25 which indicated attempt resuscitation. An interview was conducted on 5/6/25 at 11:57 AM with the Social Worker (SW). She stated when she spoke to Resident #43 on 4/17/25 he stated he wanted to be a full code (receive cardiopulmonary resuscitation). She stated Resident #43 understood the difference between full code and DNR status. She further stated she spent approximately 1 ½ hours reviewing the MOST form and he changed his code status from DNR to full code. The SW stated she took the signed MOST form to the Admission Director, but	F 578	The Social Worker was educated by the DON on 5/8/25 to immediately notify the DON of any change of resident code status.On 5/8/25 the clinical Interdisciplinary team was educated by the Director of Nursing (DON) to make the DON aware of any change in Code Status so she can ensure the documentation for code status is consistent throughout the resident(s) medical record. On 05/14/25 the Social Work Director and Interdisciplinary Team IDT including the DON, the Minimum Data Set Coordinators, and the Unit Managers completed an audit of all residents' medical records to ensure each residents' Advanced Directives status DNR (Do not recesitate) or Full Code are consistently documented throughout the medical record to include the Physician's order, the Care Plan, the resident banner and the Most Form, as appropppriate. No other resident had inconsistent documentation of Advanced Directives / Code Status in their electronic medical record. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. During Clinical Morning Meeting the Social Worker will report to the Interdisciplinary Care Team any changes of code staus. The DON will validate the code status is consistent throughout the resident's medical record. This will be documeted on the weekly audit by the DON , her designee or Minimum Data Set Coordinator (MDSC). The IDT will review three resident charts weekly to validate Advanced Directives	

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F 578	Continued From page 3 did not verbally notify anyone about the change in his code status. An interview was conducted on 5/6/25 at 2:39 PM with the Admissions Director. She stated the facility completed an audit of advance directives in April 2025. The Admissions Director and SW divided the residents into 2 teams to review those residents who were missing MOST forms in their EMR. The Admissions Director stated any changes made to a resident's code status should have been communicated to the Director of Nursing (DON) immediately, who in turn changed the code status in the EMR system and notified the Unit Manager of the resident's hall. The MOST form for Resident #43 indicating a change in his code status may have been missed during the audit. An interview was conducted on 5/6/25 at 2:33 PM with the Director of Nursing (DON). She stated if a resident made a change to their code status, the person who was notified of the change in code status was supposed to notify the DON or the Unit Manager immediately. A nurse and a witness would discuss this change in code status with the resident and confirm the change. The Nurse Practitioner would be notified and an order for the new code status would be obtained. The DON further stated that on 5/6/25 once she was notified of the discrepancy in code status, she spoke to Resident #43 confirming full code status and notified the Nurse Practitioner. An interview was conducted on 5/7/25 at 10:29 AM with the Nurse Practitioner (NP). She stated that she typically was notified in a resident's change in code status by the staff member who spoke to the resident and/or family member, such	F 578	are consistently documented throughout the resident's medical record. This audit will include all new admissions. The audit will be done for 12 weeks. This will be documented on the audit tool that will contain the date reviewed, the resident's name, the code status order, the documentation of the code status on the banner, the care plan, and if applicable the MOST form. Any inconsistenies will be immediately addressed by the MDSC and DON will be notified. The facility plans to monitor its performance to ensure solutions are sustained The SDON or her designee will present the audit results in the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of three months, or as determined by the QAPI Committee. The QAPI Committee will review the results of these audits for identification of trends, action taken, will make recommendations as needed, and will to determine the need for further monitoring to assure compliance is sustained ongoing.	

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F 578	Continued From page 4 as the DON, Unit Manager, or SW. She further stated she did not update the EMR to the new code status, but gave a verbal order to change code status and would sign the MOST form. An interview was conducted on 5/6/25 at 2:45 PM with the Administrator. He stated it was his expectation for staff to follow the change in code status process for the facility. Any changes in code status should be communicated with nursing and the SW. The Unit Managers and DON conducted daily clinical meetings and changes should be communicated during that time.	F 578		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		5/30/25

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F 584	Continued From page 5 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide maintenance to the following areas in resident rooms: missing and scraped paint to the doorway and bathroom door (Room #066), paint scraped from the walls (Rooms #068 and #074), maintain a clean wall from a red splattered substance (Room #074), and the bathroom sink free from buildup (room #068) for 3 of 7 resident rooms reviewed for environment on 1 of 4 halls. The findings included: a. Observation of Resident Room #066 on 5/5/25 at 11:42 AM revealed scuff marks and missing paint on both sides of the doorway entering the bathroom. The surface of the bathroom door facing inside the bathroom revealed scraped paint approximately 3 inches in height across the	F 584	Corrective Action for those residents that have been affected. On 5/20/25 room #66 scuff marks were sanded, bonded, and painted. On 5/20/25 the scrapped paint areas were sanded, bonded and painted. On 5/22/25 room 74 the wall at the foot of the bed and the wall next to the closet, the rest room areas were all sanded, bonded, and painted. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/15/25 the maintenance director conducted an audit of all resident room and documented repairs to be made. He has prioritized the order of rooms to be addressed. These repairs on this initial audit have been completed by 5/20/25.	

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F 584	Continued From page 6 length of the bathroom door, exposing what appeared to be a wood-like color underneath. The bathroom sink interior basin was observed to have a light black colored film halfway up from the bottom surface of the sink. b. Observation of Resident Room #068 on 5/5/25 at 11:47 AM revealed a linear area approximately 25 inches in length and 10 inches in width of scraped paint on the right wall upon entering the room. There was an additional area of scraped paint halfway up the wall behind the headboard measuring approximately 15 inches in length and 6 inches in width. c. Observation of Resident Room #074 on 5/5/25 at 2:35 PM revealed the wall at the foot of bed A had a linear area of scraped paint approximately 40 inches in length and 5 inches in width. The wall next to the closet door had an area of approximately 10 inches in diameter of a white material where it appeared damage to the wall had been repaired but remained unpainted. The area around the upper part of the bathroom mirror had an area of exposed, crumbling dry wall measuring approximately 8 inches in width and 24 inches in length. There was a red splattered substance approximately 6 inches in length and 2 inches in width on the wall at the foot of bed A approximately 20 inches from the floor. An interview and observation were conducted with the Maintenance Director on 05/07/25 at 12:04 PM. Observations were conducted of rooms #066, #068, and #074. The observations conducted on 05/07/25 at 12:04 PM revealed the same issues discovered on 5/5/25. The Maintenance Director stated since he started in his current position in August 2024, the	F 584	Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 5/15/25 the Maintenance Director was educated by the Administrator of the importance of having room repairs addressed timely. The Maintenance Director or his designee will inspect the resident rooms 15 room audits weekly for 4 weeks, and then 10 room audits weekly for 4 weeks, and then 5 room audits weekly for 4 weeks. He will prioritize and address the rooms to be painted and/or repaired. This audit will be documented on the tool noting date, time, room, issues /resolution, initial and admin initials. The facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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F 584	Continued From page 7	F 584		

maintenance department had been in the process of redoing/painting resident rooms. He stated they had completed 7 rooms to date. He further stated some residents do not like them in their rooms so that slows the process down, as work cannot be done while the residents are in their room.

An interview and observation were conducted with the Housekeeping Manager on 5/7/25 at 12:15 PM. Observations were conducted of room #066 and #074. The observations conducted on 05/07/25 at 12:04 PM revealed the same issues discovered on 5/5/25. She stated staff did a general cleaning of resident rooms each morning and rechecked each room again in the afternoon. The facility had a cleaning schedule which included specific cleaning tasks that were done on specific days. The housekeeping manager attempted to remove the light black colored film in the sink in Resident Room #066 with water and a paper towel and could not. She stated the housekeeping staff would need to use a pumice stone to remove the film. Regarding the splatter on the wall in Resident Room #074, she stated it would be taken care of right away.

Work history reports dated November 2024 through May 2025 were reviewed. There were no entries found for repairs in Resident Rooms #066, #068, and #074.

In an interview with the Administrator on 5/8/25 at 2:03 PM he stated there was a process for cleaning and he expected that process to be followed. He further stated staff had been working to improve the facility and the goal was to complete more resident rooms. He stated the facility had to prioritize the work that was needed

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F 584	Continued From page 8 to be completed, as they had to attend to other major repair issues that have come up.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to implement their	F 607	Corrective Action for those residents that have been affected.ON 3/10/25 nursing	5/30/25

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F 607	Continued From page 9 abuse policy in the area of reporting and investigating. When there was an allegation of abuse the Administrator was not immediately notified (Resident #32 and Resident #331) and an investigation was not initiated at the time of the allegation (Resident #331) for 2 of 3 residents reviewed for abuse. Findings included: 1. Review of the facility policy entitled "Prohibition of Abuse Administration", dated 12/24/21 revealed anyone who has any knowledge of abuse should report immediately to their immediate supervisor. All violations will be reported to the State agency within two hours if there is an allegation of abuse. Resident #32 was admitted to the facility on 6/15/18. Resident #32's most recent Minimum Data Set (MDS) assessment dated 4/24/25 revealed he was cognitively intact with no behaviors. Review of a facility reported incident initial report completed by the Administrator dated 3/11/25 revealed on 3/10/25 at 1:30 AM Resident #32 stated Nurse Aide #5 struck him with a washcloth. The incident report revealed the Administrator was made aware of the incident on 3/11/25 at 7:15 AM. The Administrator notified the local Adult Protective Services on 3/11/25 at 8:30 AM, local law enforcement on 3/11/25 at 8:45 AM and the State agency on 3/11/25 at 8:17 AM. Review of the facility investigation revealed a statement written by Nurse Aide (NA) #6 who stated Resident #32 told her NA #5 struck him	F 607	staff on 2nd shift were aware of an initial allegation of abuse approximately 11:23 pm by resident. Both nurses aware did not notify the Administrator. On 3/11/25 At 7:15 am Nurse on 1st shift nurse notified Admin by phone call stating resident alleged abuse. Administrator submitted 24 hour report at 8:15 AM. Both staff that did not report this timely have been educated on reporting allegations of abuse immediately upon knowledge to the Administrator. On 5/6/25 Upon being informed by surveyor of an allegation of abuse on a discharged resident #331 the administrator submitted a 24 hour report and initiated the investigation. The Social Worker that received a call on 1/14/25 via police officer regarding the allegation of abuse has been educated to report any allegations of abuse immediately to the administrator, including discharged residents. Corrective action will be accomplished for those residents to be affected by the same deficient practice. On 5/7/25 an all staff in-service regarding abuse and reporting was initiated. On 5/29/25 of 104 facility staff 92 have completed this in-service. Any staff member that has not completed this by 6/4/25 will be removed from schedule until this is completed. New hired staff will complete abuse and reporting prior to orientation. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. Beginning on	

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F 607	Continued From page 10 after supper on 3/10/25. She reported this disclosure occurred on 3/10/25 at 11:45 PM. A telephone interview was conducted with NA #6 on 5/8/24 at 8:26 AM who stated she informed Nurse #3 on 3/10/25 at approximately 11:50 PM that Resident #32 had stated he was struck by NA #5. NA #6 stated she also wrote a statement. During a telephone interview with Nurse #3 on 5/8/24 at 8:30 AM stated she was never made aware that Resident #32 was struck by NA #5. A telephone interview was conducted with Nurse #4 on 5/7/25 at 3:11 PM. She stated she was advised on 3/10/25 at 11:59 PM by NA #6 that Resident #32 had stated he was struck by NA #5. Nurse #4 stated she heard NA #6 tell Nurse #3. She reported she was not Resident #32's nurse and she believed Nurse #3 reported the incident. An interview was conducted with Resident #32 on 5/6/25 who reported he never stated Nurse Aide #5 struck him. During a telephone interview with Nurse #2 on 5/7/25 at 3:17 PM she stated she reported the allegation of abuse at 7:15 AM on 3/11/25 to the Administrator. She stated she contacted the Administrator when she was made aware of the allegations. Nurse #2 stated she wanted to ensure the allegations were reported. An interview was conducted with the Administrator on 5/8/25 at 10:15 AM. He stated he contacted local Adult Protective Services, law enforcement and the State agency within 2 hours of his notification of the incident. He further stated the allegations should have been reported	F 607	5/14/25 15 staff members are interviewed weekly to determine if any allegations of abuse were reported. This will be done for 4 weeks and then 10 staff members will be interviewed weekly of 4 weeks, and then 5 staff members interviewed weekly. This will be documented by the Administrator or his Designee. The facility plans to monitor its performance to ensure solutions are sustained. The DON and Administrator will review the findings with the Interdisciplinary Team during QAPI for 90 days or until substantial compliance is achieved.	

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ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

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to him or another manager when NA #6 was told by Resident #32 he had been struck by NA #5.

2. Resident #331 was admitted to the facility on 10/31/24 and left against medical advice (AMA) on 11/12/24.

Review of the 5-day Medicare Minimum Data Set (MDS) assessment revealed that Resident #331 was cognitively intact with adequate hearing/vision, clear speech, and understood/understands.

A telephone interview was conducted with Resident #331 on 5/05/25 at 1:03 PM. He revealed that a female staff member (name unknown) came into his room on either 11/5/24 or 11/7/24 walked towards his bed near the window, groped his groin area over his clothing, and walked out while another female staff member (name unknown) stood at the doorway. Resident #331 stated that he did not notify anyone at the facility; however, he told Adult Protective Services (APS) when they visited his home after discharge (date unknown) because no one would believe him. He reported the alleged sexual abuse to the police department himself on 11/25/24.

The Police Investigator assigned to Resident #331's case was interviewed via telephone on 5/06/25 at 12:52 PM. She revealed that the report was made on 11/25/24, and the date of the incident occurred either on 11/5/24 or 11/7/24. Resident #331 seemed confused because he forgot who the accused staff member was exactly; however, he described the alleged perpetrator as a black female, 5 foot 7 inches in height, and walked with a limp. The Police Investigator stated that she tried to reach the

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Administrator by phone but was unsuccessful. When she visited the facility on 1/14/25, the Administrator was away at a conference, so she spoke to the Social Worker Director. The Police Investigator provided a description of the alleged perpetrator, but the Social Worker Director told her that no staff member was a match. The case was inactivated on 1/14/25 due to lack of sufficient evidence.

An interview was conducted with the Social Worker Director on 5/06/25 at 1:11 PM. She revealed that the Police Investigator and maybe an APS representative visited the facility on 1/14/25 and asked her if she recalled Resident #331 and how he had been discharged. She was also asked about any concerns with nonconsensual touching, but she could not recall Resident #331 ever saying that he was inappropriately touched. The Police Investigator provided a description of the alleged perpetrator, but the Social Worker Director told her that the facility did not have a staff member employed at the facility described by Resident #331. The Social Worker Director stated that she could not recall if the Police Investigator was looking for the Administrator but rather was at the facility to speak to her. She indicated that she did not report the Police Investigator's visit to anyone at the facility because there was not a specific person identified, and Resident #331 was often confused. The Social Worker Director recalled that Resident #331 often complained about his hospital experience, and she thought he referenced a hospital staff member. She stated that she was trained to report all abuse allegations to the Administrator.

During an interview with the Director of Nursing

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F 607	Continued From page 13 (DON) on 5/08/25 at 12:42 PM, she revealed that she was not aware of the sexual abuse allegation made by Resident #331 until it was reported by the state on 5/06/25. However, an investigation was initiated immediately thereafter. The DON stated all abuse allegations should be reported to either the DON and/or the Administrator. The Administrator was interviewed on 5/08/25 at 3:53 PM. He revealed that he should have been notified immediately of the newly reported sexual abuse allegation by Resident #331 on 1/14/25, so that he could follow the abuse policy and procedures and report to the appropriate authorities. The Administrator stated that he would be the one to determine how to move forward with any abuse allegation, not the Social Worker Director.	F 607		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of falls, gradual dose reduction (GDR), and diagnoses for 4 of 24 residents (Resident #7, Resident #9, Resident #44, and Resident #57) whose MDS assessments were reviewed. 1. Resident #7 was admitted to the facility on 3/1/23 with diagnoses that included falls, fracture of left radius, generalized muscle weakness, and abnormalities of gait and mobility.	F 641	Corrective Action for those residents that have been affected. On 5/7/25 the MDS staff completed a MDS corrections to accurately code the fall for resident #7 and on 5/21/25 contraindicated Gradual Dose Reduction (GDR)coding for residents # 57, 9, & 44. These assessments were transmitted on 5/21/25. Corrective action will be accomplished for those residents affected by the same	5/30/25

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F 641	Continued From page 14 Review of Resident #7's progress notes revealed she sustained a fall with no injury on 10/15/24. Resident #7's care plan dated 10/15/24 revealed a focus for falls. Resident #7's annual Minimum Data Set (MDS) assessment dated 11/26/24 revealed she was cognitively intact and was not coded for falls. During an interview on 5/7/25 at 2:45 PM with the MDS Coordinator, she stated when updating the MDS she reviewed the fall risk section of a resident's record. She further stated that Resident #7's MDS should have been updated and coded for falls. In an interview with the Director of Nursing (DON) on 5/7/25 at 3:13 PM she stated her expectation was that the MDS should be done timely and coded accurately. She further stated Resident #7's MDS assessment should have been coded correctly for falls. 2. Resident #9 was readmitted to the facility on 3/26/25 with a diagnosis including paranoid schizophrenia. A physician order dated 3/26/25 revealed Resident #9 received Quetiapine Fumarate (an antipsychotic medication used to treat they symptoms of schizophrenia) oral tablet 100 milligrams (mg) two times a day related to paranoid schizophrenia. Review of Resident #9's significant change MDS assessment dated 3/31/25 revealed the resident was coded as not receiving an antipsychotic.	F 641	deficient practice. On 5/19/25 the MDS Coordinators initiated an audit to ensure falls and contraindicated GDR were coded correctly on each resident's most recent MDS Assessment. Any modifications needed were completed and transmitted on or before May 18,2025. Measures put into place or systemic changes made to ensure that deficient practice will onto occur. 5/10/25 the DON educated the MDS Coordinators on the importance of correctly coding fall & GDRs per the Resident Assessment Instrument. The MDS Director will audit three MDS assessments weekly to validate accurate coding of falls and contraindicated GDRs. This will be done for 12 weeks and documented on an Audit tool which will include the date, resident name, assessment audited, validation of falls and GDR coding, any notes or corrections, and initials of auditor. The facility plans to monitor its performance to make sure the solutions are sustained. The MDS Director will present the audit results in the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of three months, or as determined by the QAPI Committee. The QAPI Committee will review the results of these audits for identification of trends, action taken, will make recommendations as needed, and will to determine the need for further monitoring to assure compliance is sustained ongoing.	

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An interview was conducted with the MDS Nurse on 5/07/25 at 2:20 PM. She revealed she coded Resident #9 as receiving an antipsychotic 7 out of the 7 days during the review period. However, she did not notice that she had chosen "no" to the section of antipsychotic related to the gradual dose reduction (GDR) questions. The MDS Nurse stated she had missed this detail because she was the only MDS nurse for the last 2.5 years while the facility was looking for a new hire, and all the MDS activity was solely her responsibility.

Psychiatric Nurse Practitioner (NP)#1 was interviewed on 5/08/25 at 10:11 AM. She revealed that Resident #9 received an antipsychotic to manage his symptoms and behaviors related to paranoid schizophrenia.

During an interview with the Director of Nursing (DON) on 5/08/25 at 12:39 PM, she revealed that the MDS Nurse should have reviewed Resident #9's medical record to ensure the resident received an antipsychotic and code the MDS assessment accordingly.

The Administrator was interviewed on 5/08/25 at 3:48 PM. He revealed that the MDS nurse should have coded Resident #9's MDS correctly related to receiving an antipsychotic. However, the interdisciplinary team (IDT) should have completed a final review of the assessment.

3. Resident #44 was readmitted to the facility on 7/19/24 with a diagnosis including stroke.

A physician order dated 12/31/24 revealed Resident #44 received Risperdal tablet 0.5 mg daily in the afternoon for bipolar disorder.

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Review of Resident #44's annual Minimun Data Set (MDS) assessment dated 4/10/25 revealed the resident was coded as receiving an antipsychotic without a GDR attempted and the physician did not document a GDR as clinically contraindicated.

A psychiatry follow up note dated 3/3/25 completed by Psychiatric Nurse Practitioner (NP) #1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal.

An interview was conducted with the MDS Nurse on 5/07/25 at 2:20 PM. She revealed that she coded Resident #44 as receiving an antipsychotic, but she did not notice that a GDR was documented as clinically contraindicated by Psychiatric NP #1 in her note dated 3/3/25. The MDS Nurse stated she was the only MDS nurse for the last 2.5 years while the facility was looking for a new hire, and all the MDS activity was solely her responsibility.

During an interview with the Director of Nursing (DON) on 5/08/25 at 12:39 PM, she revealed that the MDS nurse should have reviewed Resident #44's medical record to see if a GDR had been attempted before completing the MDS assessment. GDRs were also included in pharmacy recommendations, which the DON reviewed herself and all that information was uploaded to the resident's medical record.

The Administrator was interviewed on 5/08/25 at 3:48 PM. He revealed that the MDS nurse should have identified the documentation in Resident

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#44's medical record that included a GDR as clinically contraindicated. However, the interdisciplinary team (IDT) should have completed a final review.

4. Resident #57 was admitted to the facility on 9/15/23 with a diagnosis including schizoaffective disorder.

A physician order dated 4/17/25 revealed Resident #44 received Risperdal tablet 0.5 mg daily for schizophrenia.

Review of Resident #57's quarterly Minimum Data Set (MDS) assessment dated 2/25/25 revealed the resident was coded as receiving an antipsychotic without a GDR attempted and the physician did not document a GDR as clinically contraindicated.

A psychiatry follow up note dated 2/21/25 completed by Psychiatric NP #3 revealed that Resident #44 had a diagnosis of schizoaffective disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal.

An interview was conducted with the MDS Nurse on 5/07/25 at 2:20 PM. She revealed that she coded Resident #57 as receiving an antipsychotic, but she did not notice that a GDR was documented as clinically contraindicated by Psychiatric NP #3 in her note dated 2/21/25. The MDS Nurse stated she was the only MDS nurse for the last 2.5 years while the facility was looking for a new hire, and all the MDS activity was solely her responsibility.

During an interview with the Director of Nursing

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F 641	Continued From page 18 (DON) on 5/08/25 at 12:39 PM, she revealed that the MDS nurse should have reviewed Resident #57's medical record to see if a GDR had been attempted before completing the MDS assessment. GDRs were also included in pharmacy recommendations, which the DON reviewed herself and all that information was uploaded to the resident's medical record. The Administrator was interviewed on 5/08/25 at 3:48 PM. He revealed that the MDS nurse should have identified the documentation in Resident #57's medical record that included a GDR as clinically contraindicated. However, the interdisciplinary team (IDT) should have completed a final review.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644		5/30/25

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F 644	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II referral was resubmitted after a resident was given a new mental health diagnosis for 1 of 2 residents (Resident #44) reviewed for PASRR. The findings include: Review of Resident #44's medical record revealed the resident was originally admitted to the facility on 04/18/24 and a PASRR level I was completed. She qualified for PASRR level II that was halted on 11/8/24. The resident was diagnosed with depression upon admission and when readmitted on 12/31/24 was diagnosed with bipolar disorder. Review of physician orders for Resident #44 revealed that Psychiatric Nurse Practitioner (NP)#2 ordered Risperdal (an antipsychotic medication) 0.5 milligrams (mg) 1 tablet in the afternoon on 12/31/24 for bipolar disorder. A psychiatry follow up assessment dated 3/3/25 completed by Psychiatric NP #1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic medication. Review of Resident #44's most recent comprehensive Minimum Data Set (MDS) dated 4/10/25 revealed the resident was coded for a level II PASRR and received antipsychotic medication on a routine basis. Psychiatric NP #2 was interviewed via telephone	F 644	Corrective Action for those residents that have been affected. On 5/29/25 a new request for PASARR II was requested by the Social Worker due to the new diagnosis of bipolar. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/27/25 the DON, Social Worker and MDSC performed a medical record audit for residents who receive psychiatric services to review if a new mental health diagnosis was added to determine if a new Pasarr needed to be submitted. No other residents identified who required resubmission of PASARR. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 5/14/25 the DON educated the interdisciplinary team when new mental health diagnosis are added, the resident should be submitted for a PASARR II review. The Interdisciplinary team will review all new mental health diagnosis in clinical meetings held Monday - Friday. The Social Worker will submit a Pasarr request for any new mental health diagnosis. the MDS director will document this on the audit tool for 90 days. This audit will be conducted weekly. The facility plans to monitor its performance to make sure the solutions are sustained. The RN MDS Director or will present the audit results in the	

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F 644	Continued From page 20 on 5/08/25 at 11:02 AM. He revealed that since Resident #44 had a previous depression diagnosis and was fairly young, he stated that she was misdiagnosed as unipolar and then correctly diagnosed her as bipolar on 12/31/24. An interview was conducted with the Director of Nursing (DON) on 5/08/25 at 3:43 PM. She revealed that if she had been notified when Resident #44 was diagnosed with bipolar disorder on 12/31/2 4, she would have notified the Social Worker Director, who would have then initiated the PASRR II resubmission for a significant change. The Administrator was interviewed on 5/08/25 at 3:52 PM. He revealed that when a resident was given a new mental illness diagnosis or a significant change occurred, a new PASRR II submission would be required. However, The Administrator stated that he was not notified of Resident #44's newly diagnosed bipolar disorder on 12/31/24. If he had been, he would have ensured the resubmission was done in a timely manner.	F 644	monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of three months, or as determined by the QAPI Committee. The QAPI Committee will review the results of these audits for identification of trends, action taken, will make recommendations as needed, and will to determine the need for further monitoring to assure compliance is sustained ongoing.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		5/30/25

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F 657	Continued From page 21 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise care plans in the areas of antipsychotic use, and a new mental illness diagnosis for 1 of 24 residents (Resident #44) whose comprehensive care plans were reviewed. The findings included: Resident #44 was readmitted to the facility on 7/19/24 with diagnoses including stroke and depression. A physician order dated 12/31/24 revealed Resident #44 received Risperdal antipsychotic tablet 0.5 milligrams (mg) daily in the afternoon for bipolar disorder. A psychiatry follow up note dated 3/3/25 completed by Psychiatric Nurse Practitioner (NP)#1 revealed that Resident #44 had a	F 657	Action for those residents that have been affected. On 5/29/25 resident #44 care plan was revised by the MDS Director to reflect the new mental health diagnosis of Bipolar. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/23/25 a medical record audit was completed by the MDS Director to assure residents given a new mental diagnosis had their respective care plan revised reflecting the diagnosis as well as any treatment. This was completed on 5/30/25. No other resident with a new mental health diagnosis was noted. Measures put into place or systemic changes made to ensure that the deficient	

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F 657	Continued From page 22 diagnosis of bipolar disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal. Review of Resident #44's annual Minimum Data Set (MDS) assessment dated 4/10/25 revealed the resident was coded as receiving an antipsychotic without a gradual dose reduction (GDR) attempted and the physician did not document a GDR as clinically contraindicated. Review of Resident #44's care plan revealed no revision was made to address the use of Risperdal and the diagnosis of bipolar disorder that was identified on 12/31/24. The MDS Nurse was interviewed on 5/7/25 at 2:17 PM. She revealed that there should have been a care plan for the antipsychotic medication and the diagnosis associated with the physician order, which was bipolar disorder. The MDS Nurse stated that the care plan for both Risperdal and bipolar disorder were not added because she was never notified about the new diagnosis or the addition of an antipsychotic. During an interview with the Director of Nursing (DON) on 5/8/25 at 12:33 PM, she revealed that she would expect that the bipolar disorder and Risperdal were included in Resident #44's care plan when initiated. The care plans were given a final review by the MDS Nurse, so it would have been her responsibility. An interview was conducted with the Administrator 5/8/25 at 3:54 PM. He stated that Resident #44's care plan should have included bipolar disorder and Risperdal. Unfortunately,	F 657	practice will not occur. The Interdisciplinary team was educated by the DON that all new mental health diagnosis and treatment should be included in the resident's plan of care. A weekly audit of five residents per week will be preformed by the MDS Director to validate the resident's care plan is updated to reflect any mental health diagnosis and any treatment. This will be done in the clinical meeting, and documented on an audit tool for 90 days. The facility plans to monitor its performance to make sure the solutions are sustained. DON or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a pattern of compliance is obtained.	

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F 657	Continued From page 23 there was a breakdown of communication, and the appropriate departments were not aware of the new diagnosis.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and Nurse Practitioner (NP) interviews, the facility failed to provide supportive documentation of a newly diagnosed mental illness associated with a newly ordered antipsychotic for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #44 was readmitted to the facility on 7/19/24 with a diagnosis including stroke and depression. A psychiatry follow up assessment dated 12/31/24 completed by Psychiatric NP #2 revealed that Resident #44 was seen for a follow-up assessment due to depression per the facility's request. She was experiencing auditory hallucinations in the evening confirmed by staff and the resident. The note read in part: "Continue Risperdal for auditory hallucinations. Monitor as patient is taking Risperdal which can affect morbidity mortality." Documentation did not include the newly diagnosed bipolar disorder or supportive evaluation of how the bipolar disorder	F 658	Action for those residents that have been affected. On 5/7/25 resident #44 received supportive evaluations of the Dx of bipolar Disorder. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/22/25 the MDS director conducted an audit on residents with Mental Health Diagnosis to validate there is supporting documentation from the provider regarding the diagnosis. No additional concerns for supporting documentation was noted. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. on 5/14/25 the DON educated the IDT for the review of all new mental health dx in the clinical meeting. On 5/28/25 the DON educated the Psychiatric Service provider to provide supporting documentation when giving a resident a new mental health diagnosis. On or before 5/28/25, the Interdisciplinary	5/30/25

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F 658	Continued From page 24 (BPD) diagnosis was determined. A physician order dated 12/31/24 revealed Resident #44 received Risperdal tablet 0.5 milligrams (mg) daily in the afternoon for bipolar disorder entered by Psychiatric Nurse Practitioner (NP) #2. Psychiatric NP #2 was interviewed via telephone on 5/08/25 at 11:02 AM. He revealed that since Resident #44 had a previous depression diagnosis and was young, she was misdiagnosed as unipolar and then correctly diagnosed as bipolar on 12/31/24. Psychiatric NP #2 stated that some patients, such as Resident #44, get diagnosed with depression and then hallucinate or become manic or wander, etc. She was having auditory hallucinations when he assessed her on 12/31/24. Psychiatric NP #2 indicated that provisional diagnoses could take up to 6 months, and medications were prescribed before a diagnosis was confirmed. The bipolar disorder diagnosis was included in the psychiatry follow up assessment dated 3/3/25. He stated that he could have documented better about how he concluded Resident #44 had bipolar disorder in the 12/31/24 note when looking back in hindsight. He said the bipolar disorder diagnosis was provisional based on her response to the Risperdal, and he made a mistake in the note when he listed "Continue Risperdal" in the "Treatment Plan" section of the note. A psychiatry follow up assessment dated 2/21/25 completed by Psychiatric NP #3 revealed that there was not any documentation that included bipolar disorder. Under "current medications" Risperdal oral tablet 0.5mg once daily in the afternoon for bipolar disorder was listed. Resident	F 658	team will review all new mental health diagnosis to validate there is supportive documentation from the provider. The MDS director, Social Worker and or Nursing Administrative Team will complete a weekly audit of all new psychoactive medication orders to validate supportive diagnosis for the medication. This will be documented on an audit tool for 90 days. The facility plans to monitor its performance to make sure the solutions are sustained. DON or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a pattern of compliance is obtained.	

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F 658	Continued From page 25	F 658		

#44 told Psychiatric NP #3 that she felt sad. No hallucinations were noted in the assessment.

A telephone interview was conducted with Psychiatric NP #3 on 5/08/25 at 3:20 PM. She revealed that she saw Resident #44 on 2/21/25 for insomnia and depression. Resident #44 did not have any concerns with auditory hallucinations on 2/21/25. Psychiatric NP#3 stated she was unaware of the newly diagnosed bipolar disorder and did not research it. She might have reviewed the psychiatry follow up assessment from 12/31/24 because she often reviewed prior notes to understand why the antipsychotic was prescribed. The assessment automatically generated the medication list, but she was not sure where the bipolar disorder diagnosis came from. Psychiatric NP #3 indicated Psychiatric NP #2 should have discussed the new diagnosis with the Director of Nursing (DON).

A psychiatry follow up assessment dated 3/3/25 completed by Psychiatric NP #1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal.

A telephone interview was conducted with Psychiatric NP #1 on 5/08/25 at 10:04 AM. She revealed that she began seeing residents at the facility in March 2025. The bipolar disorder diagnosis was automatically generated in the assessment for Resident #44 on 3/3/25. Psychiatric NP #1 stated that she did not know the origination of the diagnosis but rather that it was associated with the order for Risperdal on 12/31/24.

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F 658	Continued From page 26	F 658		

Review of Resident #44's annual MDS assessment dated 4/10/25 revealed the resident was coded as receiving an antipsychotic without a gradual dose reduction (GDR) attempted and the physician did not document a GDR as clinically contraindicated.

During a telephone interview with the Pharmacist on 5/08/25 at 1:10 PM, she revealed that she reviewed Resident #44's medical record and saw that Risperdal was ordered on 12/31/24 and associated with bipolar disorder. During her monthly medication reviews and a new antipsychotic was initiated, she would review the origination of the diagnosis. The Pharmacist stated she was required to ensure that any medication had an appropriate diagnosis. For Resident #44, she only looked at the Risperdal order dated 12/31/24, which had an appropriate diagnosis for the medication, and she did not question the bipolar disorder diagnosis.

An interview was conducted with the Director of Nursing (DON) on 5/08/25 at 3:41 PM. She revealed that no provider had notified her of Resident #44's bipolar disorder diagnosis initiated on 12/31/24. Had they done so, she would have included this information in Resident #44's medical record and then notified all necessary personnel. The DON indicated that an assessment would support the order with a new diagnosis; however, an order with a new diagnosis would not support the assessment.

The Administrator was interviewed on 5/08/25 at 4:13 PM. He revealed that Psychiatry NP#2 should have notified the DON as soon as bipolar disorder was decided as a new diagnosis, so that the appropriate departments could respond as

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F 658	Continued From page 27 instructed.	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to apply a right-hand palm guard for 1 of 1 resident reviewed for a range of motion (Resident #15). The findings included: Resident #15 was admitted to the facility on 1/7/20 with diagnoses which included cerebral infarction, hemiplegia (complete paralysis) affecting the left nondominant side, contractures of multiple sites, and cognitive communication deficit.	F 688	On 5/7/25 resident #15 did not have her carrot Right palm splint documented on the Medication Administration Record (MAR). The order was initially under therapy and was not added to the Medication Administration Record (MAR) to be documented. On 5/8/25 the order for the Right Palm Splint was changed by the Unit Manager and added to the MAR for documentation of application. Corrective action will be accomplished for those residents to be affected by the same deficient practice. On 5/14/25 an	5/30/25

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F 688	Continued From page 28 A physician's order for Resident #15 dated 1/26/23 revealed a green carrot (a green carrot palm guard is a therapeutic device designed to support and protect the fingers from the palm. It is typically made of smooth cotton fabric and packed with washable wool fleece, which helps keep the hand cool and dry while reducing friction and irritation.) applied to the right hand on at night and off during the day. Resident #15's quarterly Minimum Data Set Assessment dated 2/22/25 revealed she was moderately cognitively impaired. Resident #15 had impairments on bilateral upper and lower extremities. Record review of the nursing progress notes for April and May 2025 revealed no documentation for Resident #15's refusal to have the carrot placed in her right hand. Resident #15's April 2025 Medication Administration Record (MAR) revealed no order for a green carrot to be placed in her right hand at night and removed the next morning. Resident #15's May 2025 MAR revealed no order for green carrot to be placed in her right hand at night and removed the next morning prior to 5/7/25. An interview and observation was made on 5/7/25 at 8:00 am revealed Resident #15 sitting up in her bed awake and her right hand resting on the right side of her bed without the carrot. When asked did the nursing staff place the carrot in her right-hand last night, she replied, "No". Resident #15's right hand was observed, and her fingernails were neatly trimmed. There was no	F 688	audit was conducted by WHOM to of all brace/splint orders to determine if the order was flowing to the MAR. All brace /splint orders were validated and were correctly flowing to the MAR. This audit was completed on 5/19/25 Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 5/14/25 the DON educated the therapist who input orders and the nursing administration team on reviewing the orders to validate therapy splint orders are added to the MAR for documentation. Beginning 5/14/25 an audit was conducted by the DON to review all splint and brace orders to determine if the orderswere correctly added to the MAR. There were no other discrepancies noted. Beginning 5/14/25 the nursing management team will audit all newly ordered splint/braces and verify they are inputted to include the MAR for nurse to document application. This will be done weekly for three months. It will be documented on an audit tool that reflects the date resident order verified in the MAR, notes, and nurse & supervisor initials. The facility plans to monitor its performance to ensure solutions are sustained The DON will review will present the Findings of the audit to the Quality Assurance Performance Improvement Monthly for three months or until a pattern of compliance is obtained. The QAPI team will review the outcome of this audit and make changes to ensure	

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F 688	Continued From page 29 redness or irritation noted to her palm. In an interview with Nursing Assistant (NA) #1 on 5/7/25 at 9:29 am, she indicated Resident #15 was supposed to have a carrot in her right hand at night to protect the skin from moisture, pressure and nail puncture injuries. When asked where the carrot was, NA #1 presented the carrot from the second drawer of Resident #15's night stand. During an interview with the Unit Manager (UM) #1 on 5/7/25 at 11:15 am, she stated Resident #15 was supposed to have the carrot placed in her right hand at night and removed the next morning. She further stated the carrot was to be placed in Resident #15's right hand at 7:00 pm. UM #1 indicated the night shift and/or the day shift nursing staff would remove the carrot from Resident #15's right hand the next morning. When asked where the nursing staff documented the carrot being placed and being removed for Resident #15, she stated it was on the Medication Administration Record (MAR). The UM #1 looked on Resident #15's MAR and stated the order was placed in the wrong area and immediately corrected the error. In an interview with the Occupational Therapy (OT) Director on 5/7/25 at 10:31 am, she explained Resident #15 was not currently being seen by the therapy department. The OT Director further explained the nursing staff would make referrals for Resident #15 for therapy services and Resident #15 would be picked up on caseload. The therapy department would evaluate and work with Resident #15. The OT Director stated Resident #15 was to have the carrot placed in her right hand and was in the	F 688	the plan is acheiving compliance.	

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F 688	Continued From page 30	F 688		

functional maintenance program. She further stated she had in serviced the nursing staff on how to place the carrot in Resident #15's right hand.

A second observation made on 5/8/25 at 6:16 am revealed Resident #15 lying in bed on her back and appeared to be sleeping. The resident's right hand was resting on her waist with her fingers closed against her palm.

In a telephone interview with NA #3 on 5/8/25 at 11:29 am, he stated he cared for Resident #15 on 5/7/25 during the 3:00 pm to 11:00 pm shift. When asked did he place the carrot in Resident #15's right hand, he replied "day shift placed the carrot, and my shift removed the carrot". When asked did he remove the carrot from Resident #15's right hand during his shift on 5/7/25, he replied, "No". After the order was recited to NA #3, he then indicated he had placed the carrot in Resident #15's right hand during his shift on 5/7/25.

During an interview with NA #2 on 5/8/25 at 6:18 am, she stated she was assigned to care for Resident #15 during the night shift (from 11:00 pm on 5/7/25 until 7:00 am on 5/8/25). When asked did Resident #15 have a carrot in her right hand at the beginning of her shift, she replied, "No". NA #2 further stated Resident #15 should have had the carrot in her right hand but did not know why the carrot was not in her right hand. NA #2 indicated the 3:00 pm to 11:00 pm shift placed the carrot in Resident #15's right hand and the 11:00 pm to 7:00 am shift removed the carrot from Resident #15's right hand.

In an interview with Resident #15 on 5/8/25 at

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F 688	Continued From page 31 6:20 am, she was asked if the carrot was placed in her right hand at 7:00 pm on 5/7/25, she replied, "No". When asked if she refused to have the staff place the carrot in her right hand, she replied, "No". Nurse #1 was interviewed on 5/8/25 at 6:30 am and stated did not see a carrot in Resident #15's right hand during her assessment. She further stated that she was an agency nurse and was not familiar with Resident #15. During an interview with the Director of Nursing (DON) on 5/7/25 at 11:15 am, she stated she was aware of Resident #15's right hand carrot palm guard and Resident #15 would refuse at times. The DON indicated the order should have been placed on the MAR for the nursing staff to document placement and refusals. The DON further indicated the nursing staff should have attempted to place the carrot in her right hand and if Resident #15 refused, the nursing staff should have documented the refusals.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		5/30/25

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F 812	Continued From page 32 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to implement a system to air dry all cleaned dishes. The facility also failed to follow the manufacturer's instructions for a minimum temperature of 120 degrees Fahrenheit (F) and the sanitization up to the required level of at least 50 parts per million (ppm) for three of three observations. These practices had the potential to affect food served to residents. The findings included: An observation and interview with the Certified Dietary Manager (CDM) were conducted on 5/05/25 at 10:43 AM in the kitchen. The CDM stated that all dishes near the dish room were ready for service. The following cleaned dishes were observed wet and nesting: Plate warmers (92) and domes (8) were observed face down stacked on top of each other, small ceramic bowls (79) were stacked on top of each other on a mobile cart, and coffee cups (68) and juice cups (72) were placed face down on meal trays and then stacked on top of each other (at least 3 levels). The CDM stated that the health department and previous state surveyors told her that clean/wet dishes needed to be stacked so that the water could drain downward, but nothing was mentioned about the air-dry process. It was observed that the meal trays and remaining	F 812	Corrective Action for those residents that have been affected. 5/7/25 the Dishwasher external temperature booster was cleaned and drained to reach a min temp of 120 F. On 5/8/25 the service rep arrived at the facility and adjusted the chemical flow into the dish washer to provide the correct amount of sanitizer. When the water temperature is below 120 or PPM below 50 facility used plastic ware until the issue is resolved. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/7/25 an in-service was conducted on the Dietary Staff to not stack items on top of each other in order to dry appropriately, to check the temperature and chemical inflow for the correct minimum temperatures of 120 F and the PPM of at least 50 prior to use after each meal. If the readings are not appropriate the staff is to alert Maintenance or the vendor to correct the issue. Staff to use plastic ware until the issue is resolved. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Food Service	

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F 812	Continued From page 33 domes were air dried on 2 separate racks. At 10:49 AM, it was observed that the outside gauge to the dish machine was not oscillating. The CDM stated normally they use a temperature pad to measure the wash/rinse cycles for the dish machine temperature log. An interview was conducted with Dietary Aide (DA) #1 on 5/05/25 at 10:51 AM. He stated that he was instructed by the CDM to stack all dishes after being cleaned because there was not any room for the air-dry process. An observation and interviews with DA #1 and the CDM were conducted on 5/05/25 at 10:52 AM. The temperature pad placed on a dish rack and passed through the dish machine measured 115.7 degrees F for the wash/rinse cycles. The CDM stated the minimum required temperature of the dish machine was 120 degrees F. Also, the CDM used a testing strip to measure the dish machine sanitization level, and it remained without color and did not reach the 50 ppm minimum requirement. The dish machine temperature log for 5/7/25 was recorded as 100 ppm and 115 degrees F. DA #1 stated the minimum temperature was supposed to be 120 degrees F. The CDM stated DA #1 did not notify her that the dish machine did not meet the required temperature that morning. DA #1 stated he told the Maintenance Assistant about the inadequate temperature measurement but continued to wash the dishes from breakfast anyway. The CDM instructed DA #1 to rewash all dishes from breakfast once the dish machine temperature was brought up to the minimum requirement of 120 degrees F. An observation of the tray line area was	F 812	Director was in-serviced by the Administrator on the proper procedure for air-drying all dishes. Additionally, the Food Service Director received an in-service on following the manufacturers guidelines for the dishwasher, including maintaining a minimum wash temperature of 120F and ensuring the sanitation level reaches at least 50 PPM. An audit tool was crated to document the Temp, PPM, & non wet nesting, and initials of staff and supervisor. The Dietary Manager or her designee will complete this audit tool. On 5/6/25 the dietary staff prior to use will observe the temp, ppm and non stacking of items for drying. This will be done 20 times weekly for 4 weeks and 10 times weekly for 4 weeks and 5 times weekly for 4 weeks. The administrator will review the findings weekly. The facility plans to monitor its performance to make sure the solutions are sustained. The Administrator will report the findings for three months or until substantial compliance is met.	

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conducted on 5/05/25 at 11:00 AM. Forty-nine dinner plates in the warmer ready for service were wet and nesting, and ten cereal bowls were stacked on top of each other on a rack wet and nesting.

Dietary Aide #2 was interviewed on 5/05/25 at 11:03 AM. She revealed that she was taught by the CDM to store clean dishes stacked on top of one another and not air-dried.

An interview was conducted with the Maintenance Assistant on 5/05/25 at 11:04 AM. He stated he was not made aware that the dish machine did not meet temperature or sanitization requirements this morning. The Maintenance Assistance indicated that he checked the dish machine weekly, but he was not aware of today's concerns.

An observation and interview with the CDM were conducted on 5/07/25 at 9:40 AM. The dish machine measured 50 ppm for sanitization. However, the temperature gauge was not working at the time. The CDM stated that the temperature pad device was no longer working, but the dish machine gauge measured 120 degrees F earlier that morning, which was marked on the dish machine temperature log. It was observed that the dish machine gauge reached 118 degrees F. The CDM contacted the Maintenance Assistant, and he arrived shortly after.

An observation of the kitchen was conducted on 5/07/25 at 9:41 AM. The plate warmers (42) and domes (17) were stacked wet on top of each other after being sent through the dish machine. The coffee cups (25), juice cups (29), and small plastic bowls (59) were also wet face down on

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meal trays and then stacked on top of each other (3 levels total).

During a follow-up interview with the CDM on 5/07/25 at 11:26 AM, she revealed that she tried to purchase a new temperature pad from local sources, but it was not available. So, the Maintenance Assistant used a heat gun, and the temperature measured 119 degrees F. The CDM indicated that the Administrator purchased a new temperature pad, and it was scheduled to arrive on 5/8/25.

An observation of the kitchen was conducted on 5/07/25 at 11:27 AM. The domes, plate warmers, and dinner plates were air dried prior to service. However, the coffee cups (25), juice cups (29), and small plastic bowls (59) were still wet and stacked on top of each other with a meal tray in between.

An interview was conducted with the Administrator on 5/07/25 at 11:28 AM. He stated that the kitchen staff needed to use plasticware because the dish machine was unable to reach the minimum required temperature during use.

During a follow-up interview with the CDM on 5/07/25 at 11:30 AM, she stated that the dish machine reached 121 degrees F on 5/6/25, and she was not sure why there was an issue today.

During a follow-up interview with the Maintenance Assistant on 5/07/25 at 11:35 AM, he stated that the dish machine had reached 121 degrees F consistently with the heat gun after he inspected it.

During a follow up interview with the Administrator

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F 812	Continued From page 36 on 5/08/25 at 3:59 PM, he revealed that the cleaned dishes should have been air dried and not stacked prior to service. Although there was limited space in the kitchen, it could have been used to manage the air-drying process. The Administrator indicated there was an issue with the dish machine reaching the required minimum temperature of 120 degrees F because the heating unit underneath had kicked off to prevent an electrical fire due to a buildup of water. Once the water buildup was addressed, the heating unit was turned back on. The flow of chemicals needed to be adjusted anytime the measurement did not reach at least 50 ppm.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to close the doors to dumpsters that contained waste. This was for 2 of 3 dumpsters observed and the deficient practice had the potential to attract pests and rodents. The findings included: An observation of the dumpster area and interview with the Certified Dietary Manager (CDM) were conducted on 5/05/25 at 11:20 AM. Both doors to the middle dumpster area and the right door to the far-left dumpster were left open. The CDM stated the dumpsters were shared by all departments and they all were educated to keep all doors to the dumpsters closed.	F 814	Corrective Action for those residents that have been affected. On 5/5/25 the dumpster door was opened. Door closed upon observing. Education provided to staff member that left it open. At no other time were the dumpster doors left open. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/5/25 the House Keeping Supervisor and the Dietary Manager were both in-serviced by the Administrator of the importance of having the dumpster door closed. the House Keeping Supervisor and Dietary Supervisor initiated an Inservice to their staff pertaining to closing dumpster doors	5/30/25

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F 814	Continued From page 37 During an interview with the Administrator on 5/08/25 at 3:59 PM, he revealed that he checked the dumpsters routinely to ensure the area was clean and all doors were closed. Therefore, the doors to the dumpsters were rarely left open. The Administrator indicated that he was not on the property the morning of 5/6/25, and a housekeeper was discarding trash and left the doors open by mistake. They should have closed all the doors after the trash was placed in the dumpsters.	F 814	after discarding trash. This will be done 20 times weekly for 4 weeks and then 10 times weekly for 4 weeks and then 5 times weekly for 4 weeks. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. An audit tool was created on 5/5/25 to track the dumpster doors. This tool will include Date, Time, open/closed, note section for action & signature page for staff checking as well as supervisor review. The Dietary Manager will observe the dumpster door 20 times weekly for 4 weeks and then 10 times weekly for 4 weeks and then 5 times weekly for 4 weeks. The facility plans to monitor its performance to make sure the solutions are sustained. The Dietary Manager and Housekeeping Manager will present these finding to the QAPI for three months or until substantial compliance is attained.	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and a pest control service technician interviews, the facility failed to maintain an effective pest program that was free of roaches for 3 of 4 observations for pest control.	F 925	Corrective Action for those residents that have been affected. On 5/5/25 it was noted a rodent observed in Dietary Managers office. Area was treated by Maintenance, it was also noted that a rodent was observed in room 32a and	5/30/25

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F 925	Continued From page 38 The findings included: Review of the pest control invoices provided by the Administrator from February - April 2025 revealed the following information related to cockroach activity and pest control identification of problem areas: 2/21/25: Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - spilled food material found on the floor. This has been like that for months and remained untouched. Structural concerns: kitchen area interior - floor tiles or baseboards loose/missing. Near Entry Interior - hole/gap noted exit door next to front desk. 3/25/25: Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - Spilled food material found on the floor of the kitchen. This has remained untouched for months. Structural concerns: kitchen area interior - Hole/gap noted by the cooler in the kitchen. Also, floor tiles or baseboards missing/loose in the kitchen. 3/28/25: Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - spilled food material found on the floor. This has been like that for months and remained untouched. Structural concerns: kitchen area interior - hole/gap noted by ice machine in scrapping area; "Many areas in need of work and fixing;" floor tiles or baseboards loose/missing. Near Entry Interior - exit door does not close/seal properly 1/4-inch gap or greater exists	F 925	that area was treated by Maintenance. Prior to survey Rose Manor has contracted with a new entomology company as the current company was not addressing issues brought to the vendors attention. The new company completed their initial assessment on 5/2/25 with the contract being signed on 5/7/2. with the first treatment and new equipment set up on 5/10/25. This will be a bi monthly service. All structural concerns were addressed by the Maintenance Director. Corrective action will be accomplished for those residents affected by the same deficient practice. On 5/9/25 the Maintence Director filled in any open cracked areas in the dietary department and treated the entire facility as well, as well as a precautionary procedure. on 5/14/25 Dietary Staff were in serviced on cleaning any spilled food up timely as well as reporting any insect activity to the Maintenance Director. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Maintenance Director was in-serviced by the Administrator to ensure timely follow-up on all recommendations made by the pest control company. The Maintenance Director or his designee will inspect the facility 3 times weekly for any signs of rodents or high volume areas needing sealed and will treat/fix accordingly. The entomology company will be alerted as well of any new findings. This will be documented on the audit tool and will be	

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F 925	Continued From page 39 4/24/25 Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - spilled food material found on the floor. This has been like that for months and remained untouched. Structural concerns: kitchen area interior - hole/gap noted by ice machine in scrapping area; "Many areas in need of work and fixing." Rear door introduction point -needs door sweeps Review of the facility's Pest Activity Log from March - May 2025 revealed the following sightings: 3/31/25: multiple cockroaches found in room 35A 4/29/25: large-sized cockroaches found by activity room and near room 70 4/30/25: medium-sized cockroach found near nursing station 2 5/1/25: large-sized cockroach found in conference room An observation and interview with the Certified Dietary Manager (CDM) were conducted on 5/05/25 at 10:37 AM. A live, brown roach was seen in the CDM's office adjacent to the kitchen. The CDM explained the pest control company sprayed recently for cockroaches, and the Maintenance Assistant also sprayed for cockroaches. She indicated she had seen more German cockroaches with the warmer weather. The CDM then stepped on the cockroach and killed it. During an observation outside of room 74 on 5/05/25 at 11:56 AM, a live, brown roach was noted climbing the wall in the hallway. An observation and interviews with Wound Nurse	F 925	done for 90 days. The facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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#1 and Wound Nurse #2 on 5/07/25 at 2:44 PM. During wound care in room 32, a live, brown roach came out from under the bed and moved towards the window. As soon as it sensed motion in the room, the roach went back under the bed towards the wall next to the door and could not be observed. Wound Nurse #1 stated that she had never seen roaches previously in the facility.

An interview was conducted with the Maintenance Director on 5/08/25 at 8:40 AM. He revealed he began with the facility in August 2024. The Maintenance Director indicated when the pest control service technician visited the facility bimonthly, he accompanied him during the tours. He stated there was a pest control sighting log at each nursing station, to keep track of sightings of pests, where the pests were observed, and the pest control service technician used the logs as a reference of where to tend to in the building in addition to the routine monthly service. The common areas and the kitchen were treated at each visit. As far as the pest control recommendations included in the invoice to prevent further infestation, the Maintenance Director stated he would repair whatever was needed immediately if it was a small project and did not interrupt meal service. Bigger projects were reserved for a scheduled time. The Maintenance Director stated he had completed "a lot of work" in the kitchen, including floor tiles and baseboards. However, he stated he could not provide any receipts or work orders for the work completed in the kitchen. The hole/gap by the ice machine in the scrapping area was sealed a month ago. The gap at the exit door (courtyard) next to the front desk was filled. On 4/24/25, the "Many areas in need of work and fixing" in kitchen could not be explained by the Maintenance

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Director. The pest control service technician never discussed the spilled food in the kitchen with him, and perhaps the CDM would know more. The Maintenance Director revealed the details included in the 4/24/25 pest control invoice related to "hole/gap noted by ice machine in scrapping area and 'Many areas in need of work and fixing'" were incorrect. He revealed he did not accompany the pest control service technician during his visit on 4/24/25 and may have been busy with something else. The Maintenance Director stated the cockroach activity had improved since he was hired in August 2024; however, he could not give an expert opinion on why cockroaches were still being observed. However, a new pest control company was contacted to hopefully further improve the situation.

During an observation of the kitchen and interview with the Maintenance Director on 5/08/25 at 9:01 AM, he showed where in the kitchen he had made repairs including the hole filled next to ice machine in scrapping area and holes sealed behind the sink in cook's area as well as tiles re-caulked, and baseboards replaced. However, the baseboard replaced was not completely sealed to the wall and had a 12-inch separation gap present. He also showed that he had replaced tiles and filled in holes behind the 3-compartment sink at the baseboard area; however multiple gaps were observed between tiles connected to the wall and the flooring where the sealant was missed.

During a follow up interview and observation with the CDM on 5/08/25 at 9:07 AM. The CDM stated the pest control service technician never spoke to her about areas that needed attention in

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the kitchen. She further stated they did not normally spray well during their visits in the kitchen, and she had to guide them to additional areas before they left the area. The CDM indicated the Maintenance Director never discussed with her the spilled food descriptions included on the February - April 2025 pest control invoices. The dry goods area was observed, and seasoning, jelly, and food crumbs were on the floor in multiple areas. The CDM stated that kitchen staff swept and mopped the entire kitchen 3-4 times daily and all those spilled areas were new on 5/8/25.

Dietary Aide #1 was interviewed on 5/08/25 at 9:11 AM. He revealed he saw cockroaches in the kitchen multiple times in the past with the most recent sighting today (5/8/25) when the silverware/condiment holders were replaced on the tray line. He stated that the CDM was present in the kitchen at that time and saw the roaches near the tray line.

An interview was conducted with Cook #1 on 5/08/25 at 9:12 AM. She revealed she last saw cockroaches in the morning (5/8/25) on the steamer when it was turned on and the area where the silverware/condiment holders were replaced on the tray line. Cook #1 stated the CDM was also present when she saw the roaches near the tray line.

During an interview with the pest control service technician on 5/08/25 at 9:41 AM, he revealed he serviced the facility for pest control monthly unless the facility called for other services in between. The pest control service technician stated none of the facility staff accompanied him during his monthly tours, and the issues he

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identified for the past few months had not changed. He stated he also took pictures of the repeat problem areas that were not addressed. The pest control service technician indicated he had spoken to the Administrator as well the Maintenance Assistant about these issues, and they told him that they would notify the kitchen staff to clean and work on the other areas such as the baseboards (brick or ceramic) in multiple areas. The spilled food was located under the coffee machine and power to the outlet near the coffee machine was needed so that the insect light could work properly. He stated he had changed the bulbs to the insect light but did not resolve the power source problem, so he notified the Maintenance Assistant. There were pest control logs at each nursing station, and he reviewed them every time he visited the facility. He explained the pest control logs did have pest activity recorded, and he addressed each area identified.

An interview was conducted on 5/08/25 at 9:18 AM with Housekeeping Staff #2. She stated she had seen cockroaches in the hallways occasionally. She further stated she killed them and did not tell anyone when she saw them.

During a follow up interview with the CDM on 5/08/25 at 9:29 AM, she confirmed that she did see 2-3 "German cockroaches" near the tray line when the silverware/condiment containers were replaced on 5/08/25. She stated the Maintenance Assistant walked in shortly after and was notified about the sightings in the kitchen that morning.

An interview was conducted on 5/08/25 at 9:34 AM with Nurse Aide #4. She stated she saw cockroaches in the hallways occasionally, and

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she called maintenance immediately.

An interview was conducted on 5/08/25 at 9:44 AM with Nurse #2. She stated she saw cockroaches in the hallways on occasion. She further stated she entered each sighting in the pest control logbook.

The Maintenance Assistant was interviewed on 5/08/25 at 10:44 AM. When the pest control service technician visited the facility, the Maintenance Assistant revealed he tried to be present so he could be shown what needed to be addressed. The Maintenance Assistance stated he took pictures of the identified areas and would repair whatever was needed. When sightings of any pest were recorded in the pest control log, he would contact the pest control company to come out that day. The spilled food issue was discussed when the pest control service technician during the last visit on 4/24/25; however, every time there was a meal prepared, there was spilled food, but the kitchen staff cleaned after each meal. The Maintenance Assistant indicated he had recommended another pest control company to the Maintenance Director because he had experience with the current pest control company from a previous position and did not favor the chemicals used during service visits. Since he started 8 months ago, the Maintenance Assistant stated that the pest activity had improved. Wherever there were cracks in the walls located all over the facility, they would be filled because that was a common area where pests entered and exited. The more the facility was sprayed, the more pest activity because they would find new hiding spots. The Maintenance Assistant indicated he was not aware of the cockroach sightings in the kitchen this morning

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	345081	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(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 925	Continued From page 45 (5/8/25). An interview was conducted with the Administrator on 5/08/25 at 4:06 PM. He revealed he had given specific instructions for the pest control service technician to visit with maintenance upon entry and then speak with the Administrator when leaving the facility. The Administrator stated the pest control service technician would just leave the invoices on his desk and leave without talking with the Administrator during many of his visits. The Maintenance Director also treated the rooms in between service visits. The Administrator stated he did not contact a new pest control company within the last 12 months because there was more pest activity in the building due to the changing of seasons. The expectation was that no pests were present in the building and if present, they would be exterminated immediately.	F 925		