STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. BUILDING _____ B. WING _____	C 08/02/2024

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MACGREGOR DOWNS HEALTH CENTER BY HARBORVIEW	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

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F 000	INITIAL COMMENTS The survey team conducted an onsite complaint investigation from 7/17/24 through 7/18/24. The survey team returned to the facility on 7/29/24 for an additional complaint investigation. Additional information was obtained off site from 7/30/24 through 8/1/24. The survey team returned on 8/2/24 to validate the credible allegation of immediate jeopardy removal. Therefore, the exit date was changed to 8/2/24. The following intakes were investigated: NC00219378, NC00219318, NC00219275, NC00218783, NC00218579, NC00218398, NC00217061, NC00214659, NC00213719 and NC00219695. 6 of the 23 complaint allegations resulted in deficiency. Intake NC00218398, NC00219275, NC00219318, and resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.90 at tag F925 at a scope and severity (K) Immediate Jeopardy began on 07/01/24 and was removed on 08/02/24.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(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. §483.25(e)(2)For a resident with urinary	F 690		8/19/24

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

Electronically Signed | 08/08/2024

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F 690	Continued From page 1 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (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. §483.25(e)(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, record review, and staff interviews the facility failed to maintain an indwelling urinary catheter drainage tubing from touching the floor for 1 of 1 resident reviewed for indwelling urinary catheter use (Resident #14). This deficient practice placed the resident at increased risk for infection of the urinary system. The findings included: Resident #14 was admitted to the facility on 6/17/24 with diagnoses that included obstructive	F 690	1. Immediate action(s) taken for the resident(s) found to have been affected include: • Resdent #14s catheter bag was ensured to not be touching the floor by the DON at approximately 2pm on 7/18/24. 2. Identification of other residents having the potential to be affected was accomplished by: • All residents with catheters have the potential to be affected by this deficient	

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F 690	Continued From page 2	F 690		

and reflux uropathy (a condition in which the flow of urine is blocked and can cause urine to back up and injure one or both kidneys).

Review of the care plan dated 6/17/24 indicated Resident #14 was at risk for alteration of elimination of bladder with a goal of no complications related to indwelling urinary catheter use. Interventions included to check catheter tubing for proper drainage and positioning.

A review of Resident #14's admission Minimum Data Set (MDS) assessment dated 6/24/24 revealed Resident #14 was cognitively intact. He required partial to moderate assistance for toileting. The MDS assessment indicated Resident #14 had an indwelling urinary catheter.

An observation was conducted of Resident #14 's urinary catheter drainage collection system on 7/18/24 at 9:30 am. Resident #14 was noted to be sitting in a wheelchair in his room. He was observed to have an indwelling urinary drainage catheter system in place. The urinary drainage bag was noted to have a privacy cover in place. The bag had been secured to the framework of Resident #14's wheelchair beside the seat. The urinary drainage tubing was noted to be partially lying on the floor of the resident's room underneath his wheelchair.

In an interview with Nurse #1 on 7/18/24 at 9:49 am she stated she had been assigned to Resident #14 on 7/18/24 and was not aware that Resident #14's urinary catheter drainage tubing was in contact with the floor. She stated the drainage bag should have been attached to a metal bar on the wheelchair frame so that it was

practice.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
• The Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator inserviced RNs, Medication Aides, CNAs and LPNs on the facilities Catheter Care policy and ensuring that Urinary Catheter bags and drainage tubing is secured high enough not to touch the floor starting 7/23/24.
• All new RNs, Medication Aides, CNAs, and LPNs will be in serviced on these items and policies during the orientation process by the DON, SDC or Assisted Director of Nursing.
• Any RNs, Medication Aides, CNAs, and LPNs who have not went through the training prior to the compliance date will have to do so prior to working again by the Staff Developer.
• Any Agency Staff will be educated prior to working by Staff Developer.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
• The Director of Nursing (DON), ADON, Unit Manager and/or Regional Nurse will assess all residents with urinary catheters 5 days per week for 8 weeks to ensure all catheter bags are not touching the floor.
• Any deficient practice found during the audits will be corrected immediately and education and/or corrective action

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F 690	Continued From page 3 situated lower than the bladder to ensure proper drainage, but no parts of the urinary catheter drainage system, to include the drainage tubing should have been in contact with the floor. She indicated there was a concern for infection for the resident if the drainage tubing touched the floor. She further indicated the Nursing Assistant (NA) should have known how to position the tubing to keep it off the floor. During an interview with NA #1 on 7/18/24 at 9:51 am it was revealed that NA's complete urinary catheter care and that the urinary catheter drainage tubing should not touch the floor. She stated that she had not assisted Resident #14 with his morning care on 7/18/24. She further indicated that care for a resident with an indwelling urinary catheter care included hanging the urinary catheter drainage bag on the metal frame of the wheelchair and clipping the tubing to a metal bar under the wheelchair so that the drainage tubing did not touch the floor. She stated that if the tubing touched the floor, it was unsanitary and created a risk for infection for the resident. During an interview with NA #2 on 7/18/24 at 9:58 am it was revealed that she was assigned to care for Resident #14 on 7/18/24 after she had been called in because the facility was short of staff. She stated she arrived at work late on 7/18/24. She stated she did not check on Resident #14 when she first arrived to work because he was already up in his wheelchair and breakfast trays were already on the hall, so she immediately assisted with serving breakfast trays. She stated when she checked on him after breakfast she did not look to see if the tubing touched the floor. She stated that if the urinary tubing touched the floor,	F 690	done by the DON as appropriate. • The Audit findings will be reported by the DON in a Monthly QAPI meeting for a minimum of 3 months Compliance Date – 8/19/24	

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F 690	Continued From page 4	F 690		

it created a risk of infection for the resident. The interview further revealed that NA #2 received training on indwelling urinary catheter care and maintenance at least once a year by the facility and the training included to keep the urinary catheter drainage tubing straight so it would drain properly and to keep it off the floor.

In an interview with the Director of Nursing (DON) on 7/18/24 at 1:19 pm she stated Resident #14's indwelling urinary catheter drainage tubing should not have been in contact with the floor. She stated that Resident #14's urinary catheter drainage tubing should have been secured underneath the wheelchair seat so that it did not touch the floor. She stated the tubing on the floor was an infection control concern. She further indicated that staff received training when hired and annually in a skills fair on how to maintain a urinary catheter that included tubing placement. She stated that the skills fair included firsthand practice with indwelling urinary catheter care and maintenance.

In a follow-up interview with the DON on 7/18/24 at 2:59 pm she stated that the facility had a policy on urinary catheter care and the facility further followed the urinary catheter manufacturer recommendations on catheter use and maintenance. The interview further revealed that the facility's infection preventionist/staff development coordinator was on vacation and unavailable for interview.

In an interview with the facility Administrator on 7/18/24 at 3:18 pm she stated the urinary drainage bag tubing for Resident #14 should not have been on the floor.

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F 925	Continued From page 5	F 925		
F 925 SS=K	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with pest control staff, resident and facility staff, the facility failed to maintain an effective pest control program to prevent an infestation of mice and to protect a vulnerable resident from mice. On 7/1/24 Resident #18 was in bed when she felt something touch her foot. She pressed her call bell for assistance and when Nurse Aide (NA) #7 responded the NA pulled the blankets off the bed and a mouse jumped out of the bed and onto the floor. On 7/7/24 Resident #18 was in bed when NA #7 pulled the covers down to provide care and a mouse jumped out of the bed and onto the floor. On 7/26/24 Resident #18 saw a mouse running across the floor of her room. Resident #18 was shocked when the mouse was in her bed, and she was afraid of being bitten by a mouse. Mice are known to carry multiple diseases that can be life threatening. Diseases can spread by rodent bites and contact with their feces, urine, and saliva. This deficient practice affected 1 of 3 residents and had a high likelihood of affecting other vulnerable residents in the facility. Immediate jeopardy began on 7/1/24 when the facility failed to maintain an effective pest control program. The immediate jeopardy was removed on 8/2/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of	F 925	1. Immediate action(s) taken for the resident(s) found to have been affected include: " Housekeeping supervisor cleaned and checked the room for mice on 7/26/24 at approximately 530pm to ensure no mice were in the room. " Glue traps provided by the exterminators were placed approximately every 10 feet within the attic space on 7/31/24 by the Maintenance Director and Maintenance Assistant. Additional traps were placed 8/1/24 in many outlying areas such as closets and break rooms etc. by the Maintenance Director. " On 7/31/24 NHA and DON also offered room change to Resident #18 and Resident #18□s roommate and both said they did not want to move. 2. Identification of other residents having the potential to be affected was accomplished by: " The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence	8/19/24

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compliance at a lower level and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective.

Findings included:

The Centers for Disease Control and Prevention's website indicates rodents such as mice are known to carry many diseases that can spread directly to people through: contact with rodent feces, urine, and saliva; rodent bites; and the handling of rodents. Rodent feces, urine, and saliva can spread by breathing in air or eating food that is contaminated with rodent waste. Rodents can spread bacterial and viral diseases that can be life threatening.

Review of facility Pest Control Treatment Logs from Pest Control Company #1 dated 6/25/24 indicated Pest Control Technician #1 inspected and treated all offices, restrooms, pantries, dining rooms, medical offices, and nurses' stations. The exterior bait boxes were cleaned and rebaited. No mice were found in the facility or the bait stations.

In an interview with the Maintenance Director on 7/18/24 at 10:07 am, he stated he had been in this position for approximately two years. He explained construction began in the field beside the facility on 1/11/24. He stated shortly after the construction began he started receiving reports of rodent activity in the facility but cannot recall who reported it and the exact dates. The facility had a contract with Pest Control Company #1 and they came weekly to service the facility. This weekly service was in place prior to the identification of

include:
" The facility□s policy and procedures for Pest Control Program was reviewed on 7/31/24 at approximately 1pm by the Director of Nursing, Administrator, Infection Preventionist, Environmental Services Supervisor, Maintenance Director and Corporate Maintenance Director. The Corporate Maintenance Director inserviced the participants on the Pest Control Program policy and the importance ensuring all residents are kept safe from household pests and rodents.
" All staff from all departments will be 100% educated on facility Pest Control Policy, education regarding mice, what to be concerned about, what we can do to prevent and eliminate rodents and will understand the diseases mice can carry. Education included reporting any sightings or droppings to their supervisor. Supervisors who receive reports of mice sightings or droppings will then call Maintenance Director who will advise on how to trap the mouse/mice and if that is unsuccessful Maintenance Director will come to the facility to ensure the process was successful. Inservice began on 7/31/24 at approximately 3pm by the Administrator, DON and/or Maintenance Director.
" Effective 8/2/24, no Staff shall work without having gone through the inservice training. This will include agency and new staff.
" The Director of Nursing and/or Maintenance Director were educated by the Administrator on the pest control policy, mice, reasons to be concerned,

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F 925	Continued From page 7 rodent activity. The pest control service included treating the interior and exterior of the facility. The facility had rodent bait stations placed every 20 feet around the facility. The facility had a total of 44 black exterior rodent bait stations around the entire facility. The rodent bait stations were serviced monthly on 5/28/24 and 6/25/24. A review of Resident #18's quarterly Minimum Data Set (MDS) dated 6/21/24 revealed she was cognitively intact. She required assistance from one staff member to turn and reposition her in the bed. She also required a mechanical lift with two staff members for transfers. She had limited physical mobility on her left side related to a stroke. In a phone interview with Nurse Aide (NA) #7 on 7/18/24 at 9:17 am, she stated she worked with Resident #18 on night shift that began at 11:00 pm on 6/30/24 and ended at 7:00 am on 7/1/24. She further stated she answered the call light for Resident #18 on 7/1/24 within 5 minutes of activation. Resident #18 reported she felt something on her foot and when NA# 7 pulled the blankets off the bed, a mouse jumped out of the bed onto the floor. She stated Resident #18 was surprised it was a mouse. Resident #18 did not have any bite marks noted on her. She reported the event to Nurse #3. Nurse #3 did not assess Resident #18. No crumbs were noted in the room and Resident #18's food/snacks were in plastic containers. NA #7 was unaware that mice could carry diseases. She indicated she had seen mice throughout the facility in the past two months. NA #7 explained maintenance was not available during her shift to report the pest activity. She reported to the nursing staff about pest activity. It was her understanding that the nursing staff	F 925	what to do to prevent rodents and the process for trapping on 8/1/24. " The Director of Nursing/Maintenance Director will be responsible for keeping up the list of staff training completion. " On 8/5/24 the Maintenance Director placed 100 high frequency rodent deterrent plug ins throughout the facility. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: " The traps will be checked Monday through Friday by the Maintenance Director and/or Maintenance Assistant weekly for 8 consecutive weeks then weekly for 2 months. The audit will assess if the traps are in place and set as planned. " The Maintenance Director and/or assistant will check 10 random rooms Monday through Friday every week for 4 weeks then 10 random rooms weekly for 8 weeks for mice and/or mice droppings. " Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the Administrator as appropriate. " The Audit findings will be reported by the Maintenance Director in a Monthly QAPI meeting for a minimum of 3 months. Corrective action completion date: 8/19/24	

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would contact maintenance about the pest activity during day shift (7:00 am until 3:00 pm). The facility educated the staff and the residents after reports of mice activity about keeping food/snacks in enclosed containers in the residents' rooms. NA #7 was unable to recall the exact date of this training.

During a phone interview with Nurse #3 on 7/18/24 at 9:17 am, she stated she was working on Resident #18's hall on night shift that began at 11:00 pm on 6/30/24 and ended at 7:00 am on 7/1/24. She remembered hearing about a mouse from NA #7 during her shift on 7/1/24. She indicated NA #7 did not state the mouse was in a resident's bed. She indicated she had not seen any mouse activity in the facility. Nurse #3 further stated she reported the mouse activity to Nurse #6 for day shift. She did not report it to maintenance because maintenance was not in the building during night shift. She explained she did a verbal report to the oncoming shift in the morning of what happened during her shift. She did not know if it was reported to maintenance or anyone in administration.

Attempts were made to interview Nurse #6 via phone with messages left on 7/31/24 with no return phone call received. Nurse #6 was the day shift supervisor scheduled to work on 7/1/24.

Attempts were made to interview NA #8 (Medication Aide) via phone with messages left on 7/31/24 with no return call received. NA #8 was scheduled to work on Hall 4 (the hall where Resident #18's resided) on 7/2/24 for day shift (6:45 am until 3:15 pm on 7/2/24).

The pest control treatment log from Pest Control

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Company #1 dated 7/2/24 revealed, Pest Control Technician #1 treated the interior and exterior of the facility. The dining rooms, pantries, and the main kitchen were all treated and inspected. The 44 exterior bait boxes around the exterior of the facility were cleaned and rebaited. No mice were identified on this visit.

In a phone interview with NA #7 on 7/18/24 at 9:17 am, she stated she worked with Resident #18 on night shift that began at 11:00 pm on 7/6/24 and ended at 7:00 am on 7/7/24. On 7/7/24 Resident #18 was in bed when NA #7 came to the room to provide incontinence care. NA #7 reported she pulled the covers down to provide care and a mouse jumped out of the bed and onto the floor. She stated Resident #18 was shocked because it was another mouse found in her bed. Resident #18 did not have any bite marks noted on her. She reported the event to Nurse #3. Nurse #3 did not assess Resident #18. No crumbs were noted in the room and Resident #18's food/snacks were in plastic containers.

During a phone interview with Nurse #3 on 7/18/24 at 9:17 am, she stated she was working on Resident #18's hall on night shift that began at 11:00 pm from 7/6/24 and ended at 7:00 am on 7/7/24. She remembered hearing about a mouse from NA #7 during her shift 7/7/24. She indicated NA #7 did not state the mouse was in a resident's bed. She further stated she reported the mouse activity to the oncoming nurse for day shift (Nurse #4). She did not know if it was reported to maintenance or anyone in administration.

In a phone interview with Nurse #4 on 7/31/24 at 10:39 am, she stated she was the day shift nurse (6:45 am until 7:15 pm) on 7/7/24 on Resident

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#18's hall. She further stated she was not given a report from Nurse #3 related to a mouse being found in Resident #18's bed. She indicated she had seen mice in Nurses' Station 1 running under the chairs on the floor but could not recall the dates the mice were seen.

Attempts were made to interview Nurse #6 via phone with messages left on 7/31/24 with no return phone call received. Nurse #6 was the day shift supervisor scheduled to work on 7/7/24.

The pest control treatment log from Pest Control Company #1 dated 7/9/24 revealed Pest Control Technician #1 treated and inspected all the rooms in Hall 4, all dining rooms, pantries, and the kitchen area. No mice were found during this inspection.

The previous DON was interviewed via phone on 7/18/24 at 9:43 am. Her last day of employment in the facility was 7/10/24. She stated she recalled being told about a mouse in Resident #18's room by the ADON but did not recall the exact date. She was unaware the mouse was found in the bed. She explained she informed the Maintenance Director and the Housekeeping Supervisor about the mouse activity. She indicated Resident #18's room was cleaned by housekeeping staff immediately. She was unaware of the second incident involving a mouse in Resident #18's bed.

In an interview with the Maintenance Director on 7/18/24 at 10:07 am he explained he had the pest control company come again and rebaited the exterior rodent bait stations on 7/2/24 and 7/9/24 after reports of mice. He explained he would receive texts via his cell phone from the staff

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about the mice and where the mice were located. He was unaware of a mouse being found in a resident's bed. He indicated the pest control company donated glue traps in addition to the exterior rodent bait stations and explained how to use these traps. He placed glue traps when he received a text message. The glue traps were small boxes with a sticky substance on the inside. The mice would go into the trap and get stuck on the glue in the box. He did not have a log of when and where he placed the glue traps. He checked the glue traps daily. He reported a "significant" amount of mice had been caught with the glue traps throughout the facility. He stated the mice could enter in deceivingly small places. He could not determine any specific entry point in the facility. He indicated he contacted another pest control company in June with a rodent specialist for more options to treat the rodent issue. This meeting was scheduled for later this day (7/18/24). The facility educated the staff and the residents after reports of mice activity about keeping food/snacks in enclosed containers in the residents' rooms.

During an interview with the Housekeeping Supervisor on 7/17/24 at 5:01pm, he stated he was called about mouse activity by the previous DON in Resident #18's room. He could not recall the exact date. He was unaware of the second incident. He reported Resident #18's room was cleaned immediately. No crumbs were noted and all Resident #18's snacks/food were in sealed plastic containers. He further stated Resident #18's room was deep cleaned last Thursday (7/11/24). (The process of deep cleaning a room involved moving every dresser and nightstand, cleaning along the walls of the room, cleaning every vent in the room, and everything in the

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bathroom.)

Resident #18 was interviewed on 7/17/24 at 4:26 pm and stated the facility had a problem with mice and has had the problem for the past 3 to 4 months. She indicated last week she felt something on her foot, and she pushed her call bell for assistance. Within 5 minutes the NA came into her room and pulled the blankets off her bed, a mouse jumped off the bed onto the floor. She explained this happened twice in the last week but could not recall exact dates. She stated there was no injury or harm from the mice. The NA reported this incident to the floor nurse. She also stated after this happened, she had seen several mice in her room and on the dresser beside the bed. She stated she reported this to the staff. She further stated she did not want mice in her room and was afraid of getting bitten.

During an observation of Resident #18's room on 7/17/24 at 4:45 pm, the facility had placed a glue trap on the floor (date unknown) beside the air conditioning (AC) unit on the wall. No cracks or holes were noted around the AC unit. The glue trap was a small white box approximately 7 inches in height by 3 and ½ inches in width. A sticky substance was located on the inside of the box. Small black pellets were observed around and on inside of the glue trap. Resident #18 gave permission to look in the dresser's top drawer and there was no evidence of mice activity observed. No food or crumbs were noted in Resident #18's room.

The service inspection report from Pest Control Company #2 dated 7/23/24 control on the first Thursday of each month and the interior of the facility on the third Friday of each month. Pest

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Control Technician #2 installed 50 rodent bait stations spaced 20 feet apart on the exterior of the facility (replacing the existing rodent bait stations), 3 boxes of glue boards, and installation of 60 metal rodent traps placed in the following locations:

- 2 metal rodent traps at each exit of nursing stations
- 2 metal rodent traps in each dining room
- 1 metal rodent trap in each pantry
- 5 metal rodent traps in the main kitchen

Attempts were made to interview Pest Control Technician #2 via phone with messages left on 7/31/24 with no return phone call received.

In an interview with Resident #18 on 7/30/24 at 3:19 pm, she stated she had seen one mouse in her room since 7/18/24. She further stated the mouse ran from under her bureau out into the hall on 7/26/24. Resident #18 revealed she reported the sighting to the Social Worker and to someone in Housekeeping.

On 7/30/24 at 4:15 pm an interview was conducted with Floor Technician #1. He stated Resident #18 reported to him that she had seen a mouse on 7/26/24. The Floor Technician further stated he checked the traps in her room, finding one with a mouse in it. He revealed he disposed of the trap and replaced it with a new one the same day. He reported this to the Maintenance Director and asked for another glue trap.

An interview was conducted on 7/30/24 at 4:25 pm with the Social Worker (SW). She stated Resident #18 reported on 7/26/24 she saw a mouse in her room the same day. The SW

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indicated she looked for the mouse and did not find it but later heard that Floor Technician #1 had found it in a trap in her room and disposed of it.

During a text conversation with the Maintenance Director on 7/30/24, he indicated texting was the quickest and easier way of communication. He stated the facility met with another Pest Control Company in July but did not provide the date of this meeting. He further indicated he had found a few possible entries for mice (did not indicate locations) and he had sealed them. He stated he was still currently looking for points of entry. He further stated he checked the glue traps in the room Resident #18 resided in yesterday (7/30/24) and no mouse was found. (The Maintenance Director identified the room by room number and did not use resident specific information in the text messages.)

A phone interview with a contracted Pest Control Account Manager for Pest Control Company #1 on 7/18/24 at 12:45 pm revealed they provided pest control services to the facility and treated the facility. He stated the facility had 44 exterior rodent bait stations with poison placed around the building to help prevent mice from entering the building. He indicated mice could enter the building through small holes. He confirmed the pest control company donated glue traps during the visits in July to the Maintenance Director for the interior of the facility.

During a phone interview with the Pest Control Technician #1 on 7/30/24 at 2:19 pm, he stated he treated the facility weekly interiorly and exteriorly. No mice were found on the interior of the facility. He did find a couple of dead mice on his visits in July outside around the bait boxes

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and he disposed of them. He indicated he was made aware of the mice problem by the Maintenance Director.

In an interview with the previous administrator, Administrator #1, on 7/17/24 at 3:56 pm she stated she was aware the facility had a problem with mice and connected it to the construction which began in January 2024. The facility sent out notification flyers to the family members. The flyer asked the family members to help decrease the clutter in the residents' rooms and ensure all food items were in plastic containers. She indicated the facility had contracted with a pest control company and they came to the facility weekly and as needed. She further indicated she was not aware of a mouse being found in a resident's bed.

In an interview with the current administrator, Administrator #2, on 7/30/24 at 5:24 pm, she revealed she had visited Resident #18 on 7/29/24 and the resident reported she had not seen any mice recently. The Administrator stated Resident #18 asked her to spray peppermint spray around her bed as she had seen mice in the past. Peppermint spray is one of the interventions they have added. She further stated she has added a new intervention each week; the first week was to change poisons, this week was to add the peppermint spray as a deterrent and next week she would add high frequency noise plug-ins.

During a follow up phone interview with Administrator #2 on 7/31/24 at 4:44 pm, she stated mice had been seen throughout the facility and in the attic. She indicated the flyers were placed in all resident rooms on Station 2 on 6/27/24. The facility held a family council meeting

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on 7/16/24 to inform the family members about the mice activity. The flyers were mailed to the family members on 7/25/24 as a reminder. She also stated that she thinks the interventions from Pest Control Company #2 have shown improvement with the rodent activity. The maintenance department was responsible for disposing of the mice. She further stated the facility had a manager on the weekends who checked the traps and housekeeping staff also checked the traps during the weekends.

In a phone interview with the Physician on 7/31/24 at 5:03 pm, she stated she was made aware of the mice in the facility today. She further stated her concern was mice carry germs and diseases. She stated she had never heard of a mouse biting a human, but it was possible. The resident would be exposed to the germs and diseases the mice carried. She explained she has worked in the facility for 5 years and has never seen any insects, roaches, or mice.

Administrator #2 was notified of immediate jeopardy on 7/31/24 at 10:58 am.

The facility provided the following credible allegation of immediate jeopardy removal:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

- On 7/1/24 Resident #18 was in bed when she felt something touch her foot. She pressed the call bell for assistance and NA #7 responded. NA #7 pulled the blankets off the bed and a mouse jumped out of the bed and onto the floor.
- On 7/7/24 Resident #18 was in bed when NA #7

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F 925	Continued From page 17 came to the room to provide routine incontinence care. NA #7 pulled the covers down to provide care and a mouse jumped out of the bed and onto the floor. - On 7/26/24 Resident #18 saw a mouse run out from under her bureau in the room and out of the door to her room. She reported to staff who checked an interior mouse trap and the mouse was there. - Resident #18 was unable to get out of bed without staff assistance to protect herself. - On 7/31/24 the DON notified Resident #18's responsible party about the Pest Control problem. She voiced understanding. - On 7/31/24 NHA and DON also offered room change to Resident #18 and Resident #18's roommate and both said they did not want to move. - The Administrator reviewed grievances for the last 30 days with no concerns regarding mice in resident rooms on 8/1/24 - The wound nurse will complete skin checks on 8/1/24 to ensure cognitively impaired residents with Brief Interview for Mental Status (BIMS) of 12 or less do not have any evidence of mouse bites. - Resident #18 was provided with education by the Administrator regarding room decluttering for prevention of pests on 8/1/24 and was educated regarding facility pest control program, education about mice of why to be concerned inclusive of bite wounds, consumption of food/water for breathing dust contaminated by rodent droppings and other waste products, what you can do to prevent rodents by keeping living spaces clean, clutter free eliminating potential nesting areas, sealing up access points and reporting to staff when rodent is seen.	F 925		

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F 925	Continued From page 18 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: - Facility provided education to Responsible Parties by sending out a mailer regarding decluttering of resident rooms on 7/25/24. Residents and Responsible Parties were sent another mailer with a letter on 8/1/24 regarding education about mice of why to be concerned inclusive of bite wounds, consumption of food/water for breathing dust contaminated by rodent droppings and other waste products, what you can do to prevent rodents by keeping living spaces clean, clutter free eliminating potential nesting areas, sealing up access points and reporting to staff when rodent a is seen. - Social Workers also went to every resident room on 8/1/24 and reviewed the mailer that went out responsible parties and education about mice of why to be concerned inclusive of bite wounds, consumption of food/water for breathing dust contaminated by rodent droppings and other waste products, what you can do to prevent rodents by keeping living spaces clean, clutter free eliminating potential nesting areas, sealing up access points and reporting to staff when rodent a is seen. For residents that were not interviewable, a copy was left in the room for education for visitors. There are 2 different exterminator companies (Pest Control Company #1 and Pest Control Company #2) working on their common practices of rounding the facility and inspecting for entry points for mice removal in the building along with re-baiting the outside traps. Pest Control Company #1 was at the facility on 7/2/24 and 7/9/24. Pest Control Company #1 and Pest Control Company #2 were	F 925		

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both at facility on 7/23/24.
- Glue traps provided by the exterminators were placed approximately every 10 feet within the attic space on 7/31/24 by the Maintenance Director and Maintenance Assistant. The traps will be checked Monday through Friday by the Maintenance Director and/or Maintenance Assistant and replaced if necessary and designated housekeeping and manager on duty will complete task on the weekend. Additional traps will be placed 8/1/24 in many outlying areas such as closets and break rooms etc. by the Maintenance Director. These will be mapped out and checked Monday through Friday by the Maintenance Director and/or Maintenance Assistant and designated housekeeping and manager on duty will complete tasks on the weekend. The staff who are responsible for this on the weekend were educated by the Administrator on this responsibility on 8/1/24.
- The facility's policy and procedures for "Pest Control Program" was reviewed on 7/31/24 at approximately 1pm by the Director of Nursing, Administrator, Infection Preventionist, Environmental Services Supervisor, Maintenance Director and Corporate Maintenance Director. The Corporate Maintenance Director inserviced the participants on the "Pest Control Program" policy and the importance ensuring all residents are kept safe from household pests and rodents.
- All staff from all departments will be 100% educated on facility Pest Control Policy, education regarding mice, what to be concerned about, what we can do to prevent and eliminate rodents and will understand the diseases mice can carry. Education included reporting any sightings or droppings to their supervisor. Supervisors who receive reports of mice sightings or droppings will then call Maintenance Director

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who will advise on how to trap the mouse/mice and if that is unsuccessful Maintenance Director will come to the facility to ensure the process was successful. Inservice began on 7/31/24 at approximately 3pm by the Administrator, DON and/or Maintenance Director. Effective 8/2/24, no Staff shall work without having gone through the inservice training. This will include agency and new staff. The Director of Nursing and/or Maintenance Director were educated by the Administrator on the pest control policy, mice, reasons to be concerned, what to do to prevent rodents and the process for trapping on 8/1/24. The Director of Nursing/Maintenance Director will be responsible for keeping up the list of staff training completion.
- The Medical Director was informed by the Director of Nursing services on 7/31/24 of the Immediate Jeopardy related to Pest Control. The Medical Director had no recommendations.

Alleged Date of Immediate Jeopardy Removal: 8/2/24

Onsite validation of the immediate jeopardy removal plan was conducted on 8/2/24. The following was verified: Resident #18's responsible party was informed of the pest control problem. A room change was offered to Resident #18 and Resident #18's roommate and the residents declined. Resident #18 was provided with education that included the pest control program, education about mice, and pest prevention. Grievances were reviewed by the Administrator with no additional concerns and skin checks were conducted with all residents with a BIMS of 12 or less. Education via mailers was confirmed for responsible parties. Residents were provided with mailers and residents who

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F 925	Continued From page 21 were interviewable had education completed by the Social Worker. Interventions by Pest Control Company #1 and Pest Control Company #2 were verified to be completed as indicated via interview and observations. The policy and procedure were reviewed for the Pest Control Program as indicated. Staff interviews with staff from various departments confirmed education was completed on the Pest Control Policy, education regarding mice, what to be concerned about, prevention and elimination techniques, and the dangers of mice to include the diseases that they can carry. The facility's immediate jeopardy removal date of 8/2/24 was verified.	F 925		