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SWANNANOA VALLEY HEALTH AND REHABILITATION	**1984 US HIGHWAY 70 SWANNANOA, NC 28778**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/15/24 through 09/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # SZWG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/15/24 through 09/18/24. Event ID# SZWG11. The following intakes were investigated: NC00209723, NC00212043, NC00212201, NC00212905, NC00215650, NC00215863, NC00215927, NC00216741, NC00218038, NC00218733, NC00218773, NC00219102, NC00220203, NC00221767, NC00221783, NC00221997 and NC00222019. 12 of the 28 complaint allegations resulted in deficiency. The survey team completed the recertification survey and complaint investigation on 09/18/24. The posting of the 2567 was delayed due a hurricane in the region which greatly impacted internet and communication efforts. The posting was completed on 10/07/24. Event ID: SZWG11.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		10/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/15/2024

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

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F 584	Continued From page 1 §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, 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 resident and staff interviews, the facility failed to maintain the commodes free from dirty build-ups around the base for 2 of 2 toilets (rooms 309 and 316) and failed to replace broken blinds with sharp edges	F 584	The facility failed to maintain the commodes free from dirty build-ups around the base for 2 of 2 toilets (rooms 309 and 316) and failed to replace broken blinds with sharp edges in 2 of 2 resident	

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F 584	Continued From page 2 in 2 of 2 resident rooms (rooms 211 and 205) reviewed for orderly interior in 2 of 2 halls. The findings included: 1 a. An observation was conducted on 09/15/24 at 1:19 PM of the bathroom in Room #309 that shared with residents in Room #307. The caulking around the base of the commode had fallen off and filled with dark colored build-up approximately 1 centimeter in width around the base of the toilet. Further assessment of the commode revealed it was intact and functional without any broken parts or loosened base. The broken caulking around the base of the commode had trapped a layer of dirty build-up that might consist of urine, mopping water. During an interview conducted on 09/15/24 at 1:20 PM, Resident #36 stated the darkened substances around the base of the commode that had been accumulated for at least 6 months and it disgusted her. b. An observation was conducted on 09/15/24 at 2:48 PM of the bathroom in Room #316 that share with residents in Room #317. The caulking around the base of the commode had fallen off and filled with dark colored build-up approximately 1 to1.5 centimeter in width around the base of the toilet. Further assessment of the commode revealed it was intact and functional without any broken parts or loosened base. The broken caulking around the base of the commode had trapped a layer of dirty build-up that might consist of urine, mopping water, or other unknown substances. During an interview conducted on 09/15/24 at	F 584	rooms (rooms 211 and 205) reviewed for orderly interior in 2 of 2 halls. Toilets in rooms 309 and 316 were cleaned and recaulked when notified of the issue. Blinds in room 211 and 205 were replaced with blinds that were in good repair when notified of the issue. Current facility residents have the potential to be affected by this deficient practice. The maintenance director and housekeeping staff completed environmental rounds to identify other toilet bases needing cleaned and recaulked and other blinds needing replaced. The facility cleaned all toilet bases and recaulked all resident room toilets throughout the facility. & sets of blinds were replaced during audit due to blinds not functioning appropriately. The surveillance rounds were completed on 9/25/24,and a schedule initiated for ongoing cleaning and repairs to ensure a safe, clean, comfortable homelike environment for residents. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The administrator educated current housekeeping director and maintenance director, and current facility housekeeping staff on expectations of cleanliness, repairs, and the maintenance request clipboard located on the maintenance door. The current facility and agency nursing staff received education on reporting needed repairs in the Maintenance Binder located at each nurse□s station. Education was	

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F 584	Continued From page 3 2:49 PM, Resident #88 stated he had seen the black color build-ups around the base of the commode since he moved into his room in late April. Subsequent observations to Resident #36's and Resident #88's bathroom on 09/16/24 at 2:29 PM and 2:33 PM respectively revealed the base of the commode for both bathrooms remained dirty with broken caulking. During a joint observation conducted with Unit Manager #2 on 09/17/24 at 11:48 AM, she acknowledged that the caulking around the base of both commodes needed to be re-caulked as soon as possible. She explained she rarely went into residents' bathroom, and she expected the housekeepers to report repair needs to the maintenance department in a timely manner. An interview was conducted with Housekeeper #1 on 09/17/24 at 11:57 AM. She stated she noticed the base of both commodes accumulating buildups and recalled she had notified the Maintenance Manager about 2 weeks ago. However, she did not see anything had been done to fix the issues so far. During an interview with the Housekeeping Manager on 09/17/24 at 12:05 PM, he indicated he had just started his role about 2 weeks ago. He acknowledged that the darkened buildup around the base of both commodes needed to be removed and installed with a new caulking. He explained he walked through all residents' room at least twice weekly to ensure cleanliness, but he did not notice the base of both commodes were accumulated with buildups. He expected the housekeeper to notify him and the maintenance	F 584	completed by 10/16/24. New facility maintenance and housekeeping staff and current nursing and agency staff unable to complete education by 10/16/24 will be educated prior to working their next scheduled shift. The Administrator will monitor 5 resident rooms and all common areas twice weekly for 4 weeks and then weekly for 8 weeks to ensure toilets and blinds are clean and in good repair. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 10/16/24	

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department to keep the commodes clean all the time.

An interview was conducted on 09/17/24 at 12:12 PM with the Maintenance Manager. He stated he walked through all residents' room including bathroom at least once weekly. He did not notice the broken caulking with dirty build-ups and indicated that it was his oversight. He normally depended on staff reporting of repair needs by dropping the work orders in the mailbox outside of the maintenance office, or by verbal notification. He did not recall receiving any report from nursing or housekeeping staff regarding the broken caulking with dirty buildups for the commodes for both bathrooms so far. He acknowledged that both commodes needed to be cleaned and re-caulked as soon as possible.

During an interview conducted on 09/17/24 at 1:18 PM, the Administrator expected all the staff to communicate with each other to report environmental concerns in a timely manner to ensure residents' homes remained clean and in good repair all the time.

An interview was conducted with the Director of Nursing on 09/18/24 at 3:55 PM. She expected the facility to keep residents' home clean and in good repair all the time.
2. a. An observation was made in room 211 on 9/15/24 at 2:31 PM. The window blinds inside the room were missing three pieces of slat in the middle and had five broken slats at the bottom with sharp edges. During the observation, an interview with Resident #64 who resided in the room stated that the blinds in his room had been like this for two months.

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A follow-up observation in room 211 on 9/17/24 at 9:15 AM revealed three pieces of slat missing in the middle which measured approximately 6 inches long and 12 inches wide, and five broken slats with sharp edges at the bottom of the window blinds.

An interview with Housekeeper #2 on 9/18/24 at 7:33 AM revealed she had noticed the broken blinds in room 211 for a couple of months, but the Maintenance Manager already knew about them. Housekeeper #2 stated that there was a clipboard on the Maintenance Manager's door for repair requests, but she did not know whether he checked it or not so her supervisor gave them a note pad wherein they could write any repair requests and hand them directly to the Maintenance Manager.

An interview with Nurse #4 on 9/18/24 at 11:05 AM revealed she had noticed the broken blinds in room 211 which were due to Resident #64 pulling them down. Nurse #4 stated that it had been reported that they needed repair and that they had been broken for a while, but she couldn't remember exactly how long.

b. An observation was made in room 205 on 9/16/24 at 8:29 AM. The window blinds inside the room had 14 slats that were missing on the left side and made a hole which measured approximately 12 inches in length and 12 inches in width. All of the broken pieces had sharp edges.

A follow-up observation and interview with Resident #20 on 9/17/24 at 8:56 AM revealed the blinds in his room had been broken ever since he moved to the room about a month ago. Resident

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F 584	Continued From page 6 #20 stated that he was not sure how the blinds got broken like that when all they needed to do was to raise it up. He said he was not sure why they had to put a hole in the blinds. He further stated that he was sure they knew that the blinds needed to be replaced or repaired for as long as it had been that way. An interview with the Maintenance Manager on 9/18/24 at 10:29 AM revealed that he had a clipboard on the outside of his door where staff could notify him of any maintenance repair requests. The Maintenance Manager stated that he was in the process of changing the blinds that needed repair. He said that he saw the broken blinds in room 205 when he was walking outside the day before, and the blinds in room 211 got broken all the time because the resident often messed it. He shared that he had just changed the blinds in room 211 two weeks ago, but the problem was that they got rid of the pull cord from the blinds due to it being a choking or hanging hazard so you would need to pull on the blinds when lowering them. An interview with the Administrator on 9/18/24 at 4:47 PM revealed they had been replacing the blinds in room 211 because the resident often messed with them, but she was not aware of the broken blinds in room 205.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		10/16/24

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F 600	Continued From page 7 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview with resident and staff, the facility failed to protect a resident's right to be free from physical abuse when a cognitively intact resident (Resident #23) hit a resident with severely impaired cognition (Resident #19) who wandered into his room asking for cigarette. This affected 1 of 4 sampled residents review for abuse. The finding included: Resident #19 was admitted to the facility on 05/07/24 with diagnoses including dementia and traumatic brain injury. The admission Minimum Data Set (MDS) assessment dated 05/14/24 coded Resident #19 with severely impaired cognition. He was under Hospice care and utilized wheelchair as the primary mobility device. He weighted 132 pounds and was 5 foot 6 inches tall. He wandered and demonstrated verbal behavioral symptoms directed toward others 1-3 days during the 7-day assessment period. Resident #23 was admitted to the facility on 10/26/22 with diagnoses including depression and	F 600	The facility failed to protect a resident's right to be free from physical abuse when a cognitively intact resident (Resident #23) hit a resident with severely impaired cognition (Resident #19) who wandered into his room asking for cigarettes. This affected 1 of 4 sampled residents review for abuse. Resident #19 was placed on 1:1 supervision to ensure his safety due to wandering into other resident□s rooms. All current facility residents are at risk of being affected by the deficient practice. Resident abuse questionnaires completed by 10/16/24, on residents with a BIMs of greater than 12 by the social services director (SSD) and body audits were completed by 10/16/24, by the director of nursing (DON) and unit managers (UM), on residents with a BIMs of 12 or less. No further concerns were noted. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Current facility and agency staff were educated on the facilities abuse and neglect policy and	

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F 600

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psychoactive substance dependence.

The quarterly MDS assessment dated 05/02/24 coded Resident #23 with an intact cognition. He was 6 foot 6 inches tall and weighed 222 pounds. He had an acquired absence of left leg above knee and was using wheelchair as the mobility device.

A review of nurse's progress notes dated 06/06/24 revealed Resident #19 entered Resident' #23's room with his wheelchair and had a verbal and physical altercation in that evening. Upon assessment, Resident #19 suffered skin tear to the left brow, bruise and swelling about the size of a marble below the left eye. On 06/07/24, the Director of Nursing (DON) and Social Service Director (SSD) assessed Resident #19 and noted he was free of distress or mental anguish. Resident #19 denied pain and could not recalled the altercation that occurred with Resident #23 the previous night.

The physician's progress notes dated 06/06/24 revealed Resident #19 went into Resident #23's room and was being slapped and hit by Resident #23. At the time of assessment, Resident #19 appeared calm. He had limited insight into the incident due to his level of dementia and was unable to provide details.

The nurse's progress notes dated 06/06/24 revealed Resident #23 was under one-on-one staff supervision after having a physical altercation with Resident #19.

The physician's progress notes dated 06/06/24 indicated Resident #23 had slapped and punched Resident #19 who went into his room. At the time

F 600

redirecting residents with dementia by the Administrator and DON on 10/16/24. Newly hired facility and agency staff hired after 10/16/24 and staff not educated by 10/16/24 will be educated prior to working their next shift.

The SSD or Administrator will complete 5 resident abuse questionnaires on residents with a BIMs greater than 12 and the DON or UM will complete 5 body audits on residents with a BIMs of 12 or less, weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month to ensure residents are free from abuse. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.

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of assessment, Resident #23 appeared calm and stated when Resident #19 came into his room, he told him to leave even though he was his neighbor. However, Resident #19 would not leave and threw a cup of coffee at him. Resident #23 stated he felt like he had to defend himself by slapping Resident #19. When Resident #19 tried to hit him back, he punched him. Resident #23 denied having issues with his mood or anxiety after the incident during the assessment. He reported he had been eating and sleeping well, and it was confirmed by the staff.

The initial report submitted to the Health Care Personnel Registry (HCPR) by the facility on 06/06/24 indicated it was a resident-to-resident abuse between Resident #19 and Resident #23 which occurred on 06/06/24 in the evening. The report indicated Resident #19 entered Resident #23's room asking for cigarette. When Resident #23 told him to leave, Resident #19 threw a cup of coffee at Resident #23. Then, Resident #23 slapped Resident #19's. Both residents were placed on one-on-one after the incident. The Hospice nurse, in-house Nurse Practitioner (NP), local police, and Adult Protective Services (APS) were notified. Resident #19 suffered skin tears of approximately 0.5 centimeters (cm) to left brow, a marble size of bruise to left eye with slight swelling. Resident #23 was noted with bruises to his right anterior hand without any mental anguish. Resident #19 could not remember the incident when an administrative staff asked him about 30 minutes after the incident.

The investigation report submitted by the facility on 06/12/24 indicated the allegation of abuse was unsubstantiated. Resident #23 stated Resident #19 did enter his room and could not be

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redirected. When he told him to leave, Resident #19 threw a cup of coffee at him. Then, Resident #23 struck Resident #19 defensively once to remove him from his room.

An attempt to interview Resident #19 on 09/16/24 at 3:00 PM was unsuccessful. Resident #19 could not recall anything related to the episode of physical altercation with Resident #23 on 06/06/24. Observation of Resident #19 revealed he was calm, pleasant, and free of mental anguish.

During an interview conducted on 09/16/24 at 3:05 PM, Resident #23 could not recall the physical altercation with Resident #19 that occurred on 06/06/24. Observation of Resident #23's room revealed a "Stop" sign was in place by the entrance. He sat in the wheelchair and appeared to be calm, friendly, and free of any mental anguish.

An interview was conducted with Unit Manager (UM) #1 on 09/17/24 at 4:23 PM. She stated Resident #19 used to stay at the North side of West wing. After the physical altercation on 06/06/24, he was moved to the South side of West wing. A few days later, he was moved again to the East wing due to changing from rehab to long-term care. Resident #19 always thought his home was at West wing and wandered to West wing frequently. She stated that she was not in the facility when both incidents occurred.

During an interview conducted on 09/18/24 at 12:19 PM, UM #2 stated Resident #19 used to be Resident #23's neighbor and sharing the same bathroom. After the incident on 06/06/24, Resident #19 was moved to the south side of

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(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 600	Continued From page 11 West wing, separated by the nurse station. Resident #19 was place under one-on-one and Resident #23 under 15 minutes checks for several days. A banner with a "Stop" sign was placed at the entrance of Resident #23's room. An attempt to conduct a phone interview on 09/18/24 at 4:39 PM with Nurse #1 who was the hall nurse for Resident #23 on 06/06/23 was unsuccessful. She did not return the call. During a subsequent interview conducted on 09/18/24 at 5:53 PM, Resident #23 could not recall any administrative staff had ever educated him to call for help and refrained from using physical force toward any residents when he was provoked. Resident #23 stated he had the right to defense himself when he was provoked or physically attacked by an intruder in his home. An interview was conducted with the DON on 09/18/24 at 6:48 PM. She stated after the first incident on 06/06/24, Resident #23 was care planned for his physically aggressive behavior with the goal to control his behavior and seek staff for assistance when he became agitated. She personally educated Resident #23 to refrain from using physical force toward other residents and asked for assistance from the staff. She stated Resident #23 verbalized understanding after receiving the education. She stated the interventions put in place after the first incident were fully implemented and added they were sufficient to prevent any subsequent physical altercation from happen again.	F 600		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/16/24

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F 689	Continued From page 12 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with resident and staff, the facility failed to provide care in a safe manner when a resident fell from her bed during personal care. Resident #29 fell off her bed and hit her nose on an oxygen concentrator positioned next to the bed and subsequently fell to the floor. The resident was sent to the hospital evaluated and returned to the facility the same day with no injuries from the fall. This was for 1 of 5 residents reviewed for the prevention of accidents (Resident #29). Findings included Resident #29 was admitted to the facility on 6/9/23 with diagnosis that included dementia, respiratory failure, diabetes mellitus Resident #29's care plan prior to the fall read, Resident #29 was at risk for falls related to deconditioning, gait and balance problems (8/30/23). Interventions included risks and injury will be minimized through next review date and use sit to stand lift with transfers if the resident is having fatigue, shortness of breath, or other difficulty transferring. Resident #29's quarterly Minimum data set (MDS) dated 9/13/23 coded her as cognitively	F 689	The facility failed to provide care in a safe manner when a resident fell from her bed during personal care. Resident #29 fell off her bed and hit her nose on an oxygen concentrator positioned next to the bed and subsequently fell to the floor. The resident was sent to the hospital evaluated and returned to the facility the same day with no injuries from the fall. This was for 1 of 5 residents reviewed for the prevention of accidents (Resident #29). One on one staff education was completed at the time of fall. Current facility residents that require personal care while in bed are at risk for being affected by this deficient practice. The interdisciplinary team (IDT) reviewed residents who are currently identified as a one person assist for bed mobility and placed a screen for residents that have recently had a decline in function to evaluate appropriateness. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Current facility and agency certified nursing assistants will be educated by the director of nursing	

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F 689	Continued From page 13 intact. Resident #29 required 1-person maximum assistance with rolling left or right, dependent with 2-person assistance with bathing and with toileting. A review of the incident report dated 11/3/23 at 6:30 PM completed by Nurse #5 read in part: Nurse #5 was called to the resident's room by Nurse Aide (NA) #2. Resident #29 was lying on the floor on her right side with blood on the floor from her nose. The resident was complaining of head pain and right shoulder pain when assessed. Nurse #5 called Emergency Medical Services (EMS) immediately and notified the Director of Nursing (DON), Medical Director (MD), and family. The hospital discharge summary dated 11/3/23 was reviewed. The discharge summary read the resident was seen in the emergency room after a fall. A Computed Tomography (CT) scan of her head showed no intercranial hemorrhage, and x-ray of her right hip and hand showed no evidence of broken bones. Resident #29 was discharged back to the facility with no orders for pain medication. The discharge summary did not include a description of a nose injury or treatments to the nose or other areas of the head or face. A MD progress note dated 11/8/23 was reviewed and read in part: Resident #29 had a fall and was sent to the ER where a CT head scan and an x-ray of her hip and hand were normal. The resident had complained of pain in her head and right arm. The resident received Tylenol and Tramadol for arm pain. Resident #29 was interviewed on 9/15/24 at 10:42 AM. She stated on 11/3/23 she was getting	F 689	(DON) or unit mangers (UM) on the appropriate way to provide personal care to a dependent resident while in the bed and how to look on the Kardex in the electronic health record (EHR) to find out how many staff is needed to safely provide care. Newly hired facility and agency certified nursing assistants hired after 10/16/24 and staff not educated by 10/16/24 will be educated prior to working their next shift. The DON or UM will observe 5 residents receiving personal care while in bed weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month, to ensure staff are providing care appropriately and safely. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion date: 10/16/24	

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F 689	Continued From page 14 a bed bath from a NA who she couldn't remember. Resident #29 stated she was lying on her right side with the NA standing behind her. The resident stated her legs fell off the bed and she then fell out of the bed and hit her nose on the oxygen concentrator beside her bed before hitting the floor. She stated her left arm was hurting from the fall too. The nurse sent her to the hospital after the fall to check her out and the hospital did not find anything broken or wrong with her. Resident #29 said the hospital did not give her any pain medications and she did not need to take any because her pain wasn't bad. The resident stated she normally had 2 people assist her with bed baths, and there was one NA helping her when she fell from her bed. She also stated she had not fallen from her bed before that incident. Resident #29's assigned Nurse #5 was interviewed on 9/17/24 at 11:30 AM. She stated Resident #29 was receiving a bed bath from NA #2 during the shift change that evening. NA #2 provided the bed bath without assistance from another staff member. Resident #29 required 2-person assistance for all care areas and NA #2 knew Resident #29 required 2-person assistance with bed baths because it had been discussed during the huddle meeting at the beginning of her shift, earlier that day. NA #2 called down the hallway for help, and Nurse #5 quickly went to the resident's room. Nurse #5 stated Resident #29 was seen lying on the floor on her right side, and her nose was bleeding from her nostrils. Resident #29 told Nurse #5 her head was hurting and Nurse #5 provided first aide to the resident's nose, called EMS and then notified the MD, Director of nursing (DON), and family of the incident. NA #2 told Nurse #5 she was giving	F 689		

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F 689	Continued From page 15 Resident #29 a bed bath without assistance and the resident was laying on her side and she was behind the resident washing her. Resident #29 rolled out of bed and onto the floor. NA #2 was unavailable for interview. NA #2's written statement dated 11/3/23 read in part: NA #2 was providing a bed bath to Resident #29. Resident #29 was assisting NA #2 with rolling over on her right side. During the bed bath, Resident #29 threw her leg up and over causing her to roll over and out of the bed. NA #2 wrote she tried to stop Resident #29 from rolling out of bed, but Resident #29 continued to move herself. The DON was interviewed on 9/17/24 at 3:05 PM. She stated Resident #29 had previously been a 1-person assist but had a decline before the fall and needed 2-person assistance when providing care and bed baths. The DON said NA #2 did not remember Resident #29 needed 2-person assist when providing a bed bath. Resident #29 was lying on her side when NA #2 was washing her and the resident's legs rolled off the side of the bed, causing the resident to fall to the floor. The DON stated NA #2 was provided education to have 2 -person assistance when providing care with Resident #29. NA #3 was interviewed on 9/18/24 at 2:12 PM, she stated she had been assigned to Resident #29 prior the fall on 11/3/23. NA #3 said Resident #29 had required 2-person assistance for all care including bed baths, and all NA's who provided care for Resident #29 had been informed of her care needs during team huddles at the beginning of each shift.	F 689		

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F 689	Continued From page 16 The Administrator was interviewed on 9/18/24 at 4:29 PM. The Administrator stated Resident #29 should have had 2 people providing her a bed bath on 11/3/24, and NA #2 should have found assistance from another NA or Nurse before providing a bed bath.	F 689		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to maintain an effective pest control program as evidenced by the presence of flies on 2 of 4 hallways (West hallways) that affected resident rooms 222 and 231, and the dining room. The findings included: A review of the Pest Control Company service specifications and recommendations dated 12/23/22 indicated under Insect Control: Interior - Restrooms, break areas, vending areas, kitchen, dining area, and offices will be inspected and treated as needed monthly. Exterior - Perimeter treatment will be done quarterly at ground level, up to 6 feet out and 2 feet up from structure to control crawling insects. The services accepted (by the facility) included regular pest control, exterior insect control and addition for kitchen cleanout. Fly control was not included in the services. A review of the facility's pest control sheet from	F 925	The facility failed to maintain an effective pest control program as evidenced by the presence of flies on 2 of 4 hallways (West hallways) that affected resident rooms 222 and 231, and the dining room. The maintenance director and administrator made rounds of the building to observe fly activity and notate areas needing attention. Current facility residents are at risk of being affected by the deficient practice. The maintenance director and administrator made rounds of the building to observe fly activity and notate areas needing attention. Terminix was called to come in and do an inspection and identify entry points and evaluate for additional treatment for flies. Additional fly lights were installed, and room rounds were completed to identify any food that was not in a sealed container and areas needing cleaned. This was completed by 10/16/2024.	10/16/24

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F 925	Continued From page 17 May 2024 to September 2024 indicated the pest control issues reported were ants, roach-like bugs, stink bugs, and roaches. No issues regarding flies were reported. A review of the Pest Control service work order invoice dated 7/15/24 indicated a quarterly exterior treatment was done for crawling insects, and rooms 305 and 310 were inspected and no pest activity was found. Rooms 305 and 310 were treated for crawling insects. A review of the Pest Control service work order invoice dated 8/8/24 indicated the nourishment room, and the East and West nursing stations were treated for roaches. A review of the Pest Control service work order invoice dated 9/13/24 indicated spot treatment was done on crack crevices for roaches. a. An observation of residents in room 222 was made on 9/15/24 at 12:33 PM. There were three flies that were flying around, and two flies hovered over the first bed in which a resident was sleeping in. A second observation in room 222 was made on 9/16/24 at 8:37 AM. Two flies hovered by the footboard of the first bed. There were no residents in the room at this observation. b. An observation of the 200 hallway (West) was made on 9/15/24 at 1:00 PM. A fly was observed flying around near the hallway door. A fly light was observed positioned on the wall about ¼ of the way to the nurses' station. c. An observation of room 231 was made on 9/16/24 at 3:05 PM. There was a fly noted on the	F 925	The measures that have been put into place to ensure the deficient practice does not recur are as follows: On 10/16/2024 the Vice President of Operations reviewed the pest control policy with the Administrator to ensure compliance. This includes but not limited to the procedures for fly prevention to include the use of fly lights, and window screens. The facility's pest control included an air curtain in kitchen area, fly lights throughout the facility, reporting system through maintenance work orders, contracted pest control company servicing facility monthly and as needed for any problems that arise between services. The facility's policies also included management room rounds to include signs of pest or food items laying around, as well as Maintenance Assistant daily rounds of grounds to remove any trash throughout the parking lot around facility as well as the dumpster area. On 10/16/2024, current facility and agency staff were educated on the pest control policy, process of reporting sightings of pests, if a fly is seen to attempt to kill the fly and observing and reporting if residents have food or other items that could attract flies by the administrator or director of nursing. Newly hired facility and agency staff hired after 10/16/24 and staff not educated by 10/16/24 will be educated prior to working their next shift. Room rounds including common areas will be completed on 5 resident rooms and common areas 3 times per week for 4	

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F 925 Continued From page 18
resident's bed.

d. An observation of the dining room was made on 9/17/24 at 11:40 AM while the surveyor was heading to the kitchen. A fly was hovering and landed on the surveyor's face. There were no residents in the dining room at this time.

An interview with Resident #6 who resided in room 227 was conducted on 9/17/24 at 9:41 AM. Resident #6 stated that he had observed at least three flies in his room, and he attributed the presence of flies to urine not being completely cleaned off of his floor when spills occurred.

An interview with Housekeeper #2 on 9/18/24 at 7:33 AM revealed she had seen flies all over the facility for about a week, but she did not know where they were coming from. Housekeeper #2 stated she had noticed flies in room 222, and had observed flies in the East hallway the past week. She stated she knew a pest control company came to the facility to do treatments, but she was not sure what they did for flies.

An interview with Nurse Aide (NA) #1 on 9/18/24 at 11:22 AM revealed she had observed flies all over the facility, but the West hall was worse compared to the East hall. NA #1 stated that she noticed the presence of flies had gotten worse within the past week, and she had reported this issue to the Maintenance Manager. NA #1 further stated the Maintenance Manager was trying to do something about the flies, but she was not sure what.

An interview with Nurse #4 on 9/18/24 at 11:05 AM revealed she had noticed some flies hovering around the nurses' station on the West hall and in

F 925

weeks, 2 times per week for 4 weeks, and weekly for 4 weeks by Administrator, Director of Nursing, Maintenance Director, or designee with areas of observation to include rooms were clean, residents were clean, and there were no signs of pests, or food debris in resident rooms. Staff should correct or report areas of concern to the maintenance director or administrator for correction. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.

Completion Date: 10/16/2024

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the West hallway, and the presence of flies had been recently getting worse within the past month. Nurse #4 stated that she had no idea where they were coming from, but she had reported it to the Maintenance Manager. Nurse #4 also stated that she didn't know what the next steps were to control the flies.

An interview with the Maintenance Manager on 9/18/24 at 10:29 AM revealed he did rounds every day to check for pests inside the facility and he also had a clipboard on his door where staff could report any pests they observed in the facility. The Maintenance Manager stated that a pest control technician came to the facility on the second Tuesday of each month to spray in the common areas. They also checked the clipboard to address any pests that were reported. The Maintenance Manager stated that he had seen flies inside the facility, but they had fly lights which were posted on each hallway and right by the smoking door. The Maintenance Manager also stated that the presence of flies had been worse this week because it had been wet from the rain. He shared that the flies might have been coming into the building from the smoking door which opened and closed from the smokers coming in and out of this door all the time.

An observation of the smoking area on 9/18/24 at 9:40 AM revealed a fly light mounted on the wall on the hallway leading up to the smoking door. It was on and working. However, the smoking door was observed being opened and closed frequently from smokers coming in and out of the facility. No flies were observed in the area.

A phone interview was attempted with the Pest Control Technician on 9/18/24 at 4:34 PM. He

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stated that he provided general pest control for the facility, but he refused to provide additional details, claiming it was due to confidentiality issues.

A follow-up interview with the Maintenance Manager on 9/18/24 at 4:05 PM revealed there was nothing else they could do about the flies in the facility besides the use of the fly lights. He stated that the only way to completely get rid of the flies was to fumigate the whole building, which meant evacuating all the residents first. He also checked with the Pest Control Technician who told him the same thing.

An interview with the Administrator on 9/18/24 at 4:47 PM revealed the facility had fly lights and she had more on order because during the summer time, the smokers went in and out of the facility several times during the day. They also utilized fly swatters whenever they observed flies. The Administrator stated that they had tried to do a good job with keeping the presence of flies down.

A follow-up interview with the Administrator and the Maintenance Manager on 9/18/24 at 5:14 PM revealed they went in to check room 222 and observed a fly in the room but it was closer to the window near the second bed. The Administrator stated they checked if there were any openings in the room but couldn't find where they were coming from. The Maintenance Manager stated he put up stickers on the window where they could get stuck if they tried to find somewhere to get out of the room. They stated they would continue to investigate and find out where the flies were coming in from.