STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to ensure that staff were treating 1 of 1 sampled residents (Resident #2) with dignity and in a respectful manner. Findings included: Resident #2 was admitted to the facility on 11/13/12 and re-admitted on 11/18/14. Cumulative diagnoses included rheumatoid arthritis and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 01/13/15 indicated Resident #2 was independent in decision making. An interview was conducted with Nurse #1 on 01/29/15 at 11:30 AM. She stated she was aware of an incident with Resident #2 and the dietary manager. She stated apparently the dietary manager was rude to Resident #2 and it had been reported to Social Worker #1 (SW #1). During an interview with Resident #2 on 01/29/15 at 4:45 PM, she stated she had recently reported a problem with the dietary manager to Social Worker #1 (SW #1). The resident stated she enjoyed ham and cheese sandwiches daily and would always ask dietary staff for them. Resident #2 stated the dietary manager was new and	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F-241 1. Director of Nursing and Social Service Director initiated a preliminary investigation of the allegations made by Resident # 2 and initial findings were sufficient to warrant the filing of a 24-Hour Initial Abuse Investigation Report on 1/30/15. Staff completed a thorough investigation of the allegations put forth by Resident # 2 and filed the required 5-day report on 2/3/15. DHHSR completed their review of the case on 2/4/15 and advised that the allegation did not require any further action on their part. The employee named in the allegation was counseled by	2/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2015

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F 241	Continued From page 1 would always make her wait for the sandwich after she requested it. She stated a few weeks ago she had asked the nurse aide to call the dietary department to inquire about her sandwich. Resident #2 stated shortly afterwards the dietary manager came to her room and informed her she would need to order the sandwiches in advance if she wanted them. She stated the dietary manager told her that if she wanted a sandwich she would need to notify the kitchen by 10:00 AM or by 3:30 PM in order to get it. Resident #2 stated the dietary manager was rude and was "fussing" at her. She stated she made her feel like a child. Resident #2 stated she didn't understand why she couldn't just ask for a sandwich when she wanted it. Resident #2 stated she didn't remember the dietary manager apologizing for her behavior but she had been nicer to her since that incident. Resident #2 also stated other staff overheard the dietary manager being rude but she didn't remember who they were as it had been a few weeks. SW #1 was interviewed on 01/29/15 at 5:30 PM in the Administrator's presence. She stated Resident #2 had come to her to report an issue with the dietary manager. She stated Resident #2 told her that the dietary manager had been rude to her because she had asked for a sandwich. She commented that Resident #2 always asked for sandwiches daily. SW #1 stated she sent an email to the dietary manager asking her to come talk to her about Resident #2's complaint. She stated when she talked with the dietary manager she denied being rude or "ugly" to Resident #2. SW #1 stated one of the nurse aides (NA #1) had overheard the incident so she spoke with her. SW #1 stated NA #1 told her that the dietary manager was "mean" to	F 241	the NHA and subsequently resigned their position with the facility. 2. Residents that reside in the center have the potential to be affected by the alleged deficient practice. NHA and Social Service Staff conducted in-service training sessions for staff members on Resident Rights, Dignity, Respect of Individuality and Abuse Prevention/Prohibition on 1/30, 1/31, 2/2, 2/3, 2/5, 2/6, 2/9 and ongoing to assure 100% of staff receive training. Facility will continue to address grievances at morning staff meetings and will promptly identify report and investigate any episode that might qualify as abuse. Interviews will be conducted with residents other than the complainant to identify a potential pattern that would warrant a more in-depth investigation. 3. Staff have been in-serviced and advised to contact their supervisor or the NHA immediately anytime they suspect abuse may have occurred. Grievances will continue to be reviewed at the morning staff meetings and abuse investigations will be opened promptly for any issue that appears to be abusive or neglectful. 2-3 residents will be interviewed each week for 3 months to assure staff are aware of any potential resident rights violations or unreported/unidentified abuse issues and findings will be reported to the QAPI Committee for 3 months. 4. Facility has a long standing practice of	

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F 241	Continued From page 2 Resident #2 and the resident was upset about it. She commented that NA #1 was unavailable for interview due to being out on leave. SW #1 stated she had informed the dietary manager that she needed to apologize to Resident #2 and if she heard any further complaints she would complete a grievance against her. SW #1 stated she felt that the issue was resolved since she had spoken with the dietary manager and she had followed up with Resident #2. She stated she had no documentation regarding the incident other than the email that she had sent to the dietary manager. The Administrator provided the email for review. The email noted that SW #1 had sent an email to the dietary manager on 01/16/15 at 1:35 PM. The message was as follows: "Please come speak with me about _____ (Resident #2). She was in my office crying and I have staff reporting that you were mean to ____ (Resident #2), telling her she orders ham/cheese sandwiches every day yet she does not want what's on the menu and that it was getting ridiculous." The dietary manager was not available for interview.	F 241	reviewing Grievances and Abuse cases daily during the morning staff meetings. Facility also routinely reviews Grievances and Abuse cases to include analysis and trends during the monthly and quarterly QAPI meetings. This practice will continue.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		2/27/15

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F 312	Continued From page 3 Based on observations, record review and staff interviews, the facility failed to provide cleansing of the resident's skin as evidenced by rinsing stool out into the bath water while providing a complete bed bath to 1 of 2 dependent residents (Resident #7) whose bath was observed. Findings included: Resident #7 was admitted to the facility on 06/19/13. Cumulative diagnoses included hypertension, hand contracture, acute respiratory failure, and subarachnoid hemorrhage. The resident's Annual Minimum Data Set (MDS) assessment of 11/24/14 noted that she was severely impaired decision making skills with long and short term memory deficits. She required total assistance with all activities of daily living and was incontinent of both urine and bowel. Resident #7's care plan, last reviewed on 12/08/14, identified a problem with being dependent for activities of daily living and a problem with incontinence of urine and bowel. A complete bed bath was observed being provided to Resident #7 beginning at 10:15 AM on 01/28/15. Nurse Aide #2 (NA #2) washed her hands and prepared a basin of water. She donned a pair of clean gloves and placed a clean wash cloth into the basin of water. She used a bar of soap to apply soap to the wash cloth and began the bath. She washed the resident's face and upper body. The basin of water was noted to have a large amount of soap suds. She rinsed the cloth out in the soapy water and rinsed the resident's upper body and dried with a towel. She did not wash the resident's contracted left hand. NA #2 washed downward between Resident #7's	F 312	F-312 1. Resident # 7 had a complete bed bath on 01/29/2015 by nursing assistant. 2. Residents that reside in the center that require assistance with bathing have the potential to be affected by the alleged deficient practice. The DON and ADON reviewed the care required by the resident to identify the assistance that the residents required on 01/29/2015. 3. The nursing staff was re-educated on providing peri-care and completing a bed bath on 2/3, 2/6, 2/13, 2/19 and continuing by DON and ADON. " A visual clinical competency validation was completed by Nursing Supervisors on all nursing assistants on providing peri-care and completing a bed bath commencing 2/3 to be completed by 2/24. " The Nursing Supervisors will observe 6 nursing assistants per month for 2 months. 4. The DON will review the audits for trends that are completed by the Nursing Supervisors and present to QAPI monthly for 3 months.	

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legs with the wash cloth while her legs were closed. She rinsed the cloth out in the soapy water and rinsed her skin then dried with a towel. She emptied the basin of water and came back to the bedside with fresh water. She donned a pair of clean gloves and continued with the bath. She rolled Resident #7 onto her left side. It was noted that Resident #7 had a large amount of very soft brownish stool on her lower buttocks and anal area as well as in the perineal region between her legs. NA #2 used the soiled brief to remove a large amount of the soft stool but there was still a lot of stool left on her skin. She sprayed the wash cloth with liquid from a bottle and began to remove a moderate amount of the stool. The cloth was noted to be brown stained as she rinsed the stool out into the basin of water. She used the same stool stained wash cloth to continue removing the stool from the rectal region and partially down into the periarea. She used the same wash cloth to wash the resident's right buttock and midline crease between the buttocks. She dried her skin with a towel and brown stains were noted on the towel as she dried. She assisted the resident to roll back onto her back. NA #2 then placed the stool soiled wash cloth on top of the oxygen unit that was on the floor and went to dump the basin of water. She returned with a basin of fresh water and continued with the bath. She donned a pair of clean gloves and placed a clean wash cloth into the water. She squirted a periwash product onto the cloth and began to wash her pubic and perineal area. She reached downward into the perineal area while the resident's legs were slightly spread apart and then wiped upwards. She did this several times in an effort to remove stool residue. She discarded the soiled wash cloth and used a clean one to continue the bath. NA #2 washed the

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resident's legs and feet. Both feet were noted to have a large amount of dry flaky skin. She washed them several times in an effort to remove the dry skin. NA #2 placed a clean gown onto the resident. NA #2 stated the bath was complete. She was questioned as to washing of the left hand. She was able to extend the fingers partially away from the palm enough to allow her to wash the hand. As NA #2 washed the left hand, there was a slight odor detected and her fingernails were noted to extend beyond the tips of her fingers. She dumped the basin of water and placed her soiled linens into a clear plastic bag.

NA #2 was interviewed following the observation at 11:00 AM on 01/28/15. She stated there was periwash available for use when providing incontinent care. She added that she usually applied it to the wash cloth rather than the resident's skin since it was cold to the touch. She also stated it didn't require rinsing. When questioned as to rinsing the soap residue from Resident #7 using the very soapy water, she reported she usually only had one basin of water. She stated all parts of the resident's body should be washed which included the hands. NA #2 reported she had been trained to always wash front to back when cleansing a female resident. NA #2 stated she should not have rinsed the stool out into the basin of bath water plus she should not have continued to use the soiled water and wash cloth to continue with the bath. NA #2 commented that she didn't have enough wash cloths so she just used the one she had. When questioned about nail care, she stated staff members were going around today cutting fingernails.

The Director of Nurses (DON) was interviewed on

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F 312	Continued From page 6 01/30/15 at 10:10 AM. She stated the aides were expected to use clean wash cloths while providing pericare. She stated it was unacceptable for them to rinse stool out into the basin of water and continue using that water. She also stated she should not have used the soiled wash cloth to continue bathing Resident #7. The DON commented staff should be washing from front to back when cleansing the periarea.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide splinting and/or contracture management services for 1 of 3 residents (Resident #7) who had contractures. Findings included: Resident #7 was admitted to the facility on 06/19/13. Cumulative diagnoses included hypertension, hand contracture, acute respiratory failure, and subarachnoid hemorrhage. The undated MDS Kardex Report for the facility for Resident #7 noted that she was to have a rolled wash cloth in the left hand. The cloth was to be removed for morning care and replaced	F 318	F-318 1. Resident #7 was referred to therapy for contractures evaluation on 01/29/2015 by the DON. Resident # 7 currently receiving O.T. services for splint modifications and ROM 5 x week. 2. An Audit was completed to identify residents that may be affected by the alleged deficient practice by Nursing Supervisors on 02/02/2015. Residents that were identified with contractures had physician orders for splint usage audited by Nursing Supervisors on 02/06/15. Residents that were inedited with a contracture without an order for the use of	2/27/15

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F 318	Continued From page 7 with a clean wash cloth. A note from the occupation therapist (OT) of 05/12/14 noted that the static right hand splint didn't work well and a new splint had been ordered as well for the left hand. It was also noted that no skilled OT services were needed. The resident's Annual Minimum Data Set (MDS) assessment of 11/24/14 noted that she was severely impaired decision making skills with long and short term memory deficits. She required total assistance with all activities of daily living (ADL) and was incontinent of both urine and bowel. It was noted that she had limitations in functional range of motion on both upper and lower extremities. Resident #7's care plan, last reviewed on 12/08/14, identified problems with the following: . The resident exhibited or was at risk for alteration in functional mobility related to decreased range of motion (ROM) due to history of cerebrovascular accident (CVA) with hemiplegia and contractures. An intervention was noted to provide passive ROM with morning and evening care. . The resident demonstrated loss of ROM of her bilateral hands due to contractures with an intervention of passive ROM and to move her joints slowly and gently. During an observation of Resident #7, on 01/27/15 at 9:30 AM, she was resting in bed on her left side. There was no response when spoken to. She was noted to have her left hand closed tightly without any type of protective device in place.	F 318	a splint were referred to therapy for screen on 02/06/2015 by Nursing Supervisors. 3. Re-education was completed by the DON/ADON to nursing staff to include splint application, pain, cleanliness, skin breakdown, nail care and documentation on the Medication Administration record, (MAR) on 02/03/2015. The Nursing Supervisors will ensure that the splints are reflected on the care card/kardex. The Nursing Supervisors will audit the documentation of the MAR weekly to ensure splint application is documented. The Nursing Supervisors will observe residents with contractures 5 days a week for one month then 3 days a week for 2 months to ensure that the splint is applied, resident has no pain related to splint and cleanliness/nail care. 4. The DON will review the audits for trends that are completed by the Nursing Supervisors and present to QAPI monthly for 3 months.	

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Another observation was conducted of Resident #7 on 01/27/15 at 11:45 AM. The left hand was noted to be closed and there was no type of protection noted.

During an observation of personal care being provided to Resident #7, on 01/28/15 at 10:15 AM, the left hand was noted to be closed and no splinting device or rolled wash cloth was in place. Nurse Aide #2 (NA #2) extended the fingers of her closed left hand just enough to visualize her finger tips. She was not able to fully extend them. It was noted that the fingernails on her left hand were long extending beyond the tips of her fingers.

NA #2 was interviewed on 01/28/15 at 11:15 AM. She stated Resident #7 didn't have any splints that she was aware of but she hadn't worked with her recently. She stated she referred to the cardex in the ADL book for care concerns for her.

An interview was conducted with the NP on 01/28/15 at 5:15 PM. She stated she was familiar with Resident #7 and had seen her in the past. She stated if a resident had skin breakdown related to a splint device and the splint was discontinued while the area healed, she would have expected nursing to let her know when the area healed so splinting services could be re-addressed. She also commented that she wouldn't want the same splint re-applied but Resident #7 should have been assessed once the wound had healed. The NP also commented that if the resident had a splinting device before the wound was found then that resident would still need some type of contracture management and/or prevention service. The NP stated she probably should have written on the order for staff

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to notify her when the area resolved so they could re-address the splinting. She felt this issue was missed due to communication issues plus the resident was moved from one station to another.

Resident #7 was observed resting in bed on 01/28/15 at 4:15 PM. There was no rolled wash cloth or splint device noted in her left hand.

Resident #7 was observed resting in bed at 11:30 AM on 01/29/15. A white palm protector was noted in her left hand.

The rehabilitation manager was interviewed on 01/29/15 at 3:15 PM. She stated when splint devices were ordered therapy was responsible for application if that resident was still on their caseload. She commented if the resident had been discharged from therapy, it would be the responsibility of the nursing department to apply the splints. She didn't know what had happened to Resident #7's splints that were ordered last May 2014.

The OT who had written the 05/12/14 note was interviewed on 01/29/15 at 3:30 PM. He stated that he was asked to evaluate Resident #7's contractures this morning at the request of the NP. He stated a palm protector had been placed in her left hand to protect the palm from her fingernails. He stated her fingernails were in need of trimming when he completed the evaluation earlier today. The OT reported the last evaluation that was done for Resident #7 was in 2013. He stated compared with that evaluation there was only a minor change in her ROM today. The OT reported that the 3rd, 4th and 5th digit on her left hand were contracted. When questioned as to what happened to the splints that he

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F 318	Continued From page 10 ordered back in May of 2014, he responded that he didn't know if the splints ever came in or not as he didn't follow-up on it. The OT reported that she wasn't on his caseload and it would have been the responsibility of the nursing staff to follow-up on the splints and apply them when they came in. Nurse #1 reported at 5:00 PM on 01/29/15 that the ADL cardex for Resident #7 had been changed today to reflect the use of the palm protector. She stated the rolled up wash cloth had been crossed out. The Director of Nurses (DON) was interviewed on 01/30/15 at 10:10 AM. She stated she had assessed all of the residents with contractures in the facility yesterday to make sure they had devices, splints and/or services to maintain their ROM. She reported at 12:20 PM on 01/30/15 that if a resident had a splint it was written on the medication administration record (MAR) for monitoring. The DON added that currently there was no restorative program but she planned on implementing one to monitor all the residents with splinting devices. She also stated that nursing should have referred Resident #7 back to therapy once the skin issues resolved to see what was appropriate for her contracture management. The DON also stated therapy should be keeping track of splints when they were ordered and it was the responsibility of both the therapy department and the nursing department to follow-up with splinting needs for Resident #7 and no one did. She commented no one knew if the splints that were ordered for her last year ever came in or not.	F 318		

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F 469	Continued From page 11	F 469		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must 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 resident and staff interviews the facility failed to eradicate and contain common household pests in the facility kitchen. Findings included: Review of the Customer Service Reports from the extermination company dated 09/10/14 showed the facility had structural concerns in the kitchen that could cause pest problems. Review of the facility Work Order Log for September 2014 showed cracks and holes in the kitchen walls had been repaired and sealed on 09/23/14. The newly installed FRB (flame retardant boards) had also been sealed. Review of the Customer Service Reports from the extermination company dated 11/20/14 showed the facility had structural concerns in the kitchen that could cause pest problems. Review of the facility Work Order Log for November 2014 and December 2014 did not show any repairs performed in the facility kitchen. In an observation of the facility kitchen on 01/28/15 at 2:05 PM standing water was noted in a depression under the steam table. The diameter of the area was approximately the size of a dinner plate. Live pests (roaches) were seen scurrying along the floor under the dish machine. On the wall just to the right of the microwave table an insect (roach) was seen scurrying up the	F 469	F-469 1. There were no specific residents identified as having been affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. Maintenance and Housekeeping Managers have responsibility for the facility Pest Control Program. The Maintenance Director surveyed Dietary Department and general facility for sanitation issues that may contribute to undesirable pest, rodent control and structural repairs 02/02/2015. The Maintenance Supervisor has overall responsibility for oversight of the effectiveness of the Pest Control Program and reports findings and recommendations to the NHA as required. The Dietary Staff received training on proper cleaning procedures from the Maintenance Supervisor on 2/2/15 and 2/19/15. " Maintenance will be conducting a series of audits to monitor pest control activity in the Dietary Department and the general facility through May 2015. Initial	2/27/15

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	345126	A. BUILDING _____ B. WING _____	C 01/30/2015

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F 469	Continued From page 12 wall to the silver conduit which ran along the wall close to the ceiling. A small dark brown unmoving insect (cockroach) was seen on the floor behind the microwave table. The stove top contained dry, burned, baked on debris in the corners and around the burners. Observation of the dry storage room showed live pests (roaches) scurrying along the floor and two floor tiles were missing in the corner of the room. Five plastic storage bins containing food products were not sealed tightly. In the corner of the room where two shelving units met perpendicularly, a large, unmoving, dark brown insect (cockroach) was noted with its legs in the air. In an observation of the facility kitchen on 01/29/15 at 12:20 PM multiple small live insects (roaches) were seen scurrying along the floor under the dish machine. A medium size live insect (cockroach) was seen where the wall and ceiling met above the coffee machine. The small dark brown unmoving insect (cockroach) was still on the floor behind the microwave table. On the wall just to the right of the microwave table an insect (roach) was seen scurrying up the wall to the silver conduit which ran along the wall close to the ceiling. In the dry storage room where two shelving units met perpendicularly, a large, unmoving, dark brown insect (cockroach) was noted with its legs in the air. The tiles in the corner of the dry storage room floor had been replaced. Three plastic storage bins containing food products were not sealed tightly. A standing open ladder was noted in front of one of the shelving units. To the right of the ladder, on the floor of the room, a flattened dead rodent was seen. There was a bread storage rack located to the right of the entry into the dry storage room. There was an unmoving insect (roach) on top of a plastic bag enclosed loaf of bread on the bottom	F 469	audits will be daily x 5 days/week for 4 weeks; Three times a week (Mon-Wed-Fri) for 4 weeks; and then weekly for 4 weeks. Findings are discussed daily at the morning staff meeting. Any evidence of increased pest activity will result in reverting back to the previous level of audits. " The facility has made a change in Pest Control Providers effective 2/16/15 and the new provider has made two visits to the facility □ one prior to the effective date to develop a plan of action and another on the 16th to implement the plan which involves reports on the effectiveness of cleaning and the effectiveness of pest control practices. 3. Maintenance Supervisor will continue to monitor areas of the facility for evidence of pest activity. Staff is encouraged to report pest activity so maintenance and housekeeping personnel can address and correct the concern. The Maintenance Director will verify effectiveness of the Dietary Cleaning Schedule weekly for 2 months. 4. Maintenance Director in conjunction with Housekeeping Supervisor and Dietary staff will continue to follow the established PIP to assure established protocols are being followed. Maintenance Director will report findings and recommendations to the facility QAPI committee for 3 months.	

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F 469	Continued From page 13 of the rack. An interview was conducted with the Administrator and the Maintenance Manager (MM) in the dry storage room on 01/29/15 at 12:30 PM. The administrator removed the insect from the loaf of bread and stated it was a roach. The MM indicated he had been working with the ceiling tiles and the rodent must have fallen out when he opened the tiles. He stated he had left the room to see about more ceiling tiles and had not seen the dead rodent on the floor. The MM indicated the exterminator came out to the facility monthly for pest control. In an observation of the facility kitchen on 01/29/15 at 2:10 PM a live insect (roach) was seen scurrying across the tray line table where resident food trays were prepared. The tray line was not in operation at the time the insect (roach) was seen. The area under the steam table that held standing water had been filled with thin set (a patching agent) and no standing water was visible. The dead rodent in the dry storage room had been removed. In an interview on 01/30/15 at 9:35 AM, alert and oriented Resident #5 stated he had recently found a roach in his food. When he went to the kitchen to tell the dietary staff, he was given a fresh tray. He did not remember which dietary staff member he had spoken to. In an observation of the facility kitchen on 01/30/15 at 12:12 PM live insects (roaches) were seen scurrying across the floor under the dish machine. On the wall to the right of the microwave stand an insect (roach) was seen scurrying up the wall to the silver conduit just below the ceiling. In the dry storage room where two shelving units met perpendicularly, a large, unmoving, dark brown insect (cockroach) was noted with its legs in the air. Three plastic bins	F 469		

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F 469	Continued From page 14 containing food products were not sealed tightly. In an interview on 01/30/15 at 2:03 PM Dietary Aide #1 stated that although insects in the kitchen had been an ongoing problem, the past year had been the worst. She indicated the kitchen staff informed the MM and he notified the exterminator to come out to service the kitchen. She stated she had never been approached by a resident who told her they had found a roach in their food. Dietary Aide #1 indicated there was a cleaning schedule in place but the new Dietary Manager had not seemed to know much about it. She stated the kitchen floor should be swept and mopped daily. In an interview on 01/30/15 at 2:07 PM Dietary Aide #2 indicated he had seen a lot of insects in the kitchen. He stated when the kitchen was cleaned the equipment was supposed to be pulled away from the walls and cleaned underneath. In a telephone interview on 01/30/15 the Pest Control Specialist indicated he provided service to the facility monthly. He stated he had not been out to the facility between September 2014 and the end of January 2015 for anything other than the scheduled monthly visits. He indicated he had reported structural issues that could allow entry to pests to the MM in September 2014 and again in November 2014. He stated when he provided service on 01/28/15 the MM was replacing the tiles on the floor in the dry storage room that he had recommended be repaired in a previous report. The Pest Control Specialist indicated that the sealing of the FRB boards needed to be closely monitored because the heat in the kitchen caused the seals to reopen and allowed pests entry. He stated standing water and food debris left on the floor and equipment attracted pests. In an interview on 01/30/15 at 2:20 PM Dietary	F 469		

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F 469	Continued From page 15 Aide #3 stated there were a lot of bugs in the kitchen. He indicated that the cleaning of the kitchen was fit into the normal work day as they were able to get it done. He stated no resident had approached him and told him they had found a roach in their food. In an interview on 01/30/15 at 2:30 PM the Cook stated she had seen bugs in the kitchen. She indicated no residents had told her they had found roaches in their food. She stated the stove had been cleaned on 01/28/15. She indicated she was unsure what she was supposed to clean in the kitchen so she cleaned as she went. She stated there used to be a schedule but the new Dietary Manager was trying to put an updated one in place. She indicated the night shift was supposed to move the racks and clean behind them but it was not being done. In an interview on 01/30/15 at 2:45 PM the MM stated the building was an old building and he was going to spearhead the cleaning of the kitchen. He indicated a new Pest Control Company was going to come in and provide recommendations. He indicated the present Pest Control Specialist came to the facility monthly and would come out between times as necessary. The MM stated he had not recently called the Pest Control Specialist to come out between the monthly service calls. He indicated the kitchen staff was supposed to let him know if any holes were seen in the walls or if the FRB boards had come unsealed. He indicated that if he or his assistant found a problem and repaired it no work order would have been written. The MM stated he and his assistant cleaned the ceiling, the lights, and the hoods in the kitchen. They also did any structural repairs. He indicated the kitchen staff was responsible for cleaning the kitchen nightly and that Housekeeping mopped the kitchen floors	F 469		

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F 469	Continued From page 16 monthly. He stated the kitchen was not being cleaned regularly. In an observation of the kitchen on 01/30/15 at 3:05 PM the FRB was seen to be unsealed at the dirty dish sink in the corner. Dead and live insects (roaches) were still in evidence in the kitchen. In an interview on 01/30/15 at 3:25 PM the Administrator stated it was his expectation that there be no significant evidence of pests in the kitchen. He indicated it was his expectation that his staff be held accountable for cleaning the kitchen as this would help to prevent pests.	F 469		