STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 000	INITIAL COMMENTS On 6/26/18 - 6/27/18 and 6/29/18, a complaint investigation was conducted. The survey continued on 6/29/18 to obtain vital interviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, family member and resident interviews the facility failed to accommodate the need of 1 of 3 residents (Resident #3) by not providing the resident a bed to fit the resident which resulted in the resident's right toes pressing against the foot board. Findings included: Resident #3 was readmitted to the facility on 6/19/18 with cumulative diagnoses which included Type 2 diabetes, Peripheral vascular disease, left below the knee amputation and blindness. Review of the quarterly Minimum Data Set assessment dated 4/16/18 coded a BIMS score of 15 (which indicated the resident was cognitively intact), required extensive assistance of 1 staff member for bed mobility, and limited range of motion on both lower extremities. The resident's height was recorded as 75 inches. Record review of the "Wound Observation and Assessment Form" revealed on 6/23/18 Resident #3 developed an inhouse sacral excoriated skin area. The skin excoriation measured 0.3	F 558	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Process that lead to the Deficiency: Resident #3 was re-admitted on 6/19/2018, the staff did not report the resident□s toes pressed against the footboard to the Administrative staff. Root Cause Analysis: Failure to communicate the resident□s needs to facility management team. Nursing Aide (NA# 2) failed to	7/25/18

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

Electronically Signed | 07/20/2018

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F 558	Continued From page 1 centimeters (cm) in length by 0.2 cm in width with no depth. Interview on 6/26/18 at 1:35 PM with the Restorative Aide (staff member responsible for obtaining weights) revealed the resident's current weight for June 2018 (no specific date stated) was 228 pounds. Interview on 6/26/18 at 2:30 PM with Resident #3 who stated his right foot hits the foot board since his newly replaced bed. "I am 6 feet 2 inches tall and am a big sized man." With the previous bed my foot never touched the foot board. Resident #3 stated the mattress on the bed was uncomfortable and had complained to various staff, the Director of Nurses (DON) and the administrator. Observation on 6/26/18 at 2:45 PM revealed Resident #3 had a large body frame and was positioned up in the bed with his head elevated at a 35-degree angle. Although, there was a right knee contracture, the resident's right great toe was pressing on the foot board frame of the bed. Interview on 6/27/18 at 10:52 AM with a family member revealed family members visit almost every day and have noticed his foot touching the footboard and my family members have verbally complained to the facility staff and administration but nothing happens. Observation and interview on 6/27/18 at 11:01 AM with NA #2 (familiar with resident) revealed the resident's foot was pressing against the foot board. NA #2 indicated on several occasions she had noticed the resident's foot pressing on the footboard. Continued interview with NA #2 who stated, "sometimes I would change his position but the foot would still press against the foot board when he straightened his leg out." NA #2 indicated she had not informed the nurse about the foot pressing against the foot board.	F 558	communicate/notify the Director of Health Services (DHS), Administrator or a supervisor that the resident□s foot was pressing against the foot board. Process for implementing the acceptable plan of correction for specific deficiency. On 6/27/2018, resident #3 was immediately provided an extender on the bed to ensure the right toes did not press against the footboard. All other residents were reviewed on 6/27/2018 and 6/28/2018 by the Director of Health Services and the Nurse Managers to ensure they did not have their toes pressing against the footboards. Nurse Managers and charges nurses will observe and notify the DHS of any resident whose toes press against the footboard while lying in bed daily using a resident observation tool. All licensed nurses and certified nursing aides are responsible for reporting to the Administrator and the DHS any resident whose toes are pressing against the footboard. In-service for all licensed nurses and certified nursing aides on reporting residents□ needs to include discomfort while lying in bed was initiated on 6/27/2018 and will be completed by 7/20/2018. Licensed nurses and certified nursing aides who have not completed the in-service will not be allowed to work until they are in-serviced. All newly hired licensed nurses and certified nursing aides will be educated on reporting residents□ needs to include discomfort while lying in bed during new hire	

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F 558	Continued From page 2 Interview on 6/27/18 at 2:21 PM with the administrator who stated he had numerous conversations with Resident #3 and his family members regarding the bed. The administrator indicated his expectation was for staff to use a "stopper" (a foam wedge) if the mattress was uncomfortable and attach a foot extender to the bed. Interview on 6/27/18 at 3:24 PM with another family member revealed Resident #3 was uncomfortable laying in the bed and the current bed was shorter than the previous bed which caused his right foot to hit the foot board. Continued interview revealed family has been "back and forth" with the administrator about the current bed problems.	F 558	orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Monitoring procedure to ensure that the plan of correction is effective. The Director of Health Services and the Clinical Competency Coordinator in-serviced all licensed nurses and certified nursing aides. The Administrator and the Director of Health Services will ensure all new hired licensed nurses and certified nursing aides are educated during orientation. Nurse Managers and charges nurses will observe and, notify the DHS of any resident whose toes press against the footboard while lying in bed using the resident observation tool. The Administrator and the Director of Health Services verified presence of extenders and will ensure the facility has extra bed extenders whenever needed. All new admissions will have their height reviewed by the Admissions Director to ensure the facility has an appropriate bed so the resident□s toes do not press against the footboard. Using resident observation tool, all residents will be reviewed weekly by Unit Managers for 4 weeks, then monthly for 3 months and, the quarterly until compliance is maintained. Unit Managers will report any findings of non-compliance to the DHS and the DHS will report these findings to the Administrator. The Administrator will report any findings of non-compliance to the QAPI/QAA committee for recommendations as	

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F 558	Continued From page 3	F 558	needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 7/25/2018	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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: Based on observations, resident interview, record review and staff interview the facility failed to cleanse Resident #3 skin during perineal care when a urinary incontinence episode had occurred in 1 of 3 residents reviewed for activities of daily living (ADL). Findings included: Resident #3 was readmitted to the facility on 6/19/18 with cumulative diagnoses which included type 2 diabetes, peripheral vascular disease, left below the knee amputation and blindness. Review of the quarterly Minimum Data Set assessment dated 4/16/18 coded the BIMS score as 15 (which indicated the resident was alert and oriented), extensive assistance of 1 staff for bathing, extensive assistance of 1 staff for toilet	F 677	Process that lead to the Deficiency: Resident #3 was re-admitted on 6/19/2018. On 6/26/ 2018, while providing ADL, facility failed to cleanse resident□s skin during perineal care when a urinary incontinence episode had occurred. Root Cause Analysis: Failure by the Nursing Assistant (NA) #1 to follow proper procedure while providing perineal care has been identified as the root cause. Process for implementing the acceptable plan of correction for specific deficiency. The Nursing Assistant (NA) #1 was immediately educated by the Clinical Competency Coordinator on proper procedure for perineal care before 6/27/2018 before her next scheduled work	7/25/18

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F 677	Continued From page 4 use, always incontinent of bowel and bladder and at risk for the development of pressure ulcers. Review of the revised care plan dated 5/8/18 revealed a potential problem with alteration in skin integrity related to incontinence of bowel and bladder and decreased mobility. The goal included being free from skin breakdown. Another problem identified was self-care deficit related to blindness and impaired mobility requiring extensive assistance for the completion of ADL. In part, one intervention for the (2) problems was incontinent care (perineal care) after each incontinence episode. Record review of the "Wound Observation and Assessment Form" revealed on 6/23/18 Resident #3 had developed an in-house sacral excoriated skin area which measured 0.3 centimeters (cm) in length by 0.2 cm in width with no depth. On 6/26/18 at 2:50 PM an observation during perineal care and interview with Nursing Assistant (NA) #1 was conducted. On Resident #3's bedside table were 2 opened bottles of Peri-wash incontinent spray product for cleansing the skin. While the resident was positioned on his back, NA #1 removed the soiled brief and the resident had experienced a urinary incontinence episode. Resident #3 was then positioned on his left side and a white colored cream was applied to the skin near his coccyx area. NA # 1 stated the white colored cream was a barrier cream to protect the skin. Resident #3's perineal area nor the buttocks had been cleansed of urine residue. Interview on 6/27/18 at 9:58 AM with NA #1 who stated "I could not find the pre-moistened wipes to cleanse his skin, so I asked the resident if he	F 677	shift. The Nursing Assistant (NA) #1 was observed doing a return demonstration to ensure she learned to follow the right procedure while providing perineal care to residents. All residents that are incontinent of bowel and bladder were observed by the DHS, the Clinical Competency Coordinator and, Unit Managers on 6/28/2018 and 6/29/2018 to ensure they receive proper perineal care from Nursing Assistants. Certified Nursing Assistant are responsible for providing proper perineal care among other activities of daily living and Licensed Nurses are responsible for monitoring Nursing Assistants to ensure proper care is provided. In-service by the Clinical Competency Coordinator and the DHS for all certified nursing aides on following proper procedures while providing perineal care was initiated on 6/27/2018 and will be completed by 7/20/2018. Certified Nursing Assistants who have not completed the in-service will not be allowed to work until they are in-serviced. All newly hired Certified Nursing Assistants will be educated on following proper procedures while providing perineal care during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Director of Health Services ensured that in-service on following proper procedures while	

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F 677	Continued From page 5 wanted me to use soap and water and he denied. "An inquiry was made about using one of the 2 bottles of incontinence spray located at the resident's bedside and the response was "I could have used the spray." Interview on 6/27/18 at 10:15 AM with the Director of Nurses (DON) who stated she expected the NA to use the Peri wash solution or obtain another package of pre-moistened wipes to cleanse the resident's skin. Interview on 6/27/18 at 10:31 AM with Co-unit coordinator #4 who stated she expected the resident's skin be cleansed after a urinary incontinence episode. Co-unit coordinator #4 stated if the pre-moistened wipes were not in the room, NA #1 could have used the Peri- wash solution or have left the room to obtain another package of pre-moistened wipes to cleanse the resident's skin. Further interview revealed NA #1 did not notify her about not having pre-moistened wipes or that the skin was not cleansed. Interview with the resident at 11:15 AM on 6/27/18 who stated he never told NA #1 not to wash him with soap and water. "There was never a discussion about that. I did not realize she had not washed my skin."	F 677	providing perineal care was conducted for all Certified Nursing Assistants. The Nursing Assistants that are not in-serviced by 7/20/2018 will not be allowed to work until they have received the in-service. A return demonstration was observed by the Clinical Competency Coordinator. Based on the weekly schedule for Nursing Assistants, 20% of all Certified Nursing Assistants including Nursing Assistant (NA) #1 will be observed performing perineal care weekly by the Clinical Competency Coordinator and Unit Managers for 6 weeks and then monthly for 3 months, and then quarterly for 2 quarters to ensure proper procedure for perineal care is followed. The Director of Health Services and the Clinical Competency Coordinator will ensure all shift are covered. The Clinical Competency Coordinator and Unit Managers will report to the DHS any findings of non-compliance and Nursing Assistants will be assigned a course on ADL care on Pruitt University. The Director of Health Services will report to the Administrator any findings of non-compliance. The Administrator will review and report any findings of non-compliance to the QAPI committee quarterly for recommendations as needed until compliance is maintained. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 677	Continued From page 6	F 677	Date of Compliance: 7/25/2018	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff and	F 726	Process that lead to the Deficiency:	7/25/18

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F 726	Continued From page 7 resident interviews the facility failed to demonstrate Nursing Assistant (NA) competency when performing perineal care despite training for 1 of 3 residents reviewed for activities of daily living. (Resident #3) Findings included: Resident #3 was readmitted to the facility on 6/19/18 with cumulative diagnoses which included type 2 diabetes and blindness. Review of the quarterly Minimum Data Set assessment dated 4/16/18 coded the BIMS score as 15 (which indicated the resident was alert and oriented), required extensive assistance of 1 staff for bathing, extensive assistance of 1 staff for toilet use, always incontinent of bowel and bladder and at risk for the development of pressure ulcers. Review of the revised care plan dated 5/8/18 revealed a potential problem with alteration in skin integrity related to incontinence of bowel and bladder and decreased mobility. The goal included being free from skin breakdown. Another problem was self-care deficit related to blindness and impaired mobility requiring extensive assistance for the completion of ADL. In part, one intervention for these (2) problems was incontinent care (perineal care) after each incontinence episode. Observation on 6/26/18 at 2:50 PM during perineal care performed by NA #1 revealed Resident #3's had experienced urine incontinency. During the observation the perineal area nor the buttocks had been cleansed of urine residue. NA #1 applied a white colored barrier cream on the skin that was not cleansed of urine residual then a clean brief was placed on the resident. Interview and record review on 6/27/18 at 4PM with the Director of Nurses (DON) was	F 726	During observation, the facility failed to demonstrate Nursing Assistant competency when performing perineal care while assisting with ADLs for resident #3. Nursing Assistant #1 failed to demonstrate competency while performing perineal care. Root Cause Analysis: Lack of education for Nursing Assistants (NA) #1 on competency for perineal care is the root cause of the deficiency. Process for implementing the acceptable plan of correction for specific deficiency. The Nursing Assistant (NA) #1 was immediately educated by the Clinical Competency Coordinator on proper procedure for perineal care before 6/27/2018 before her next scheduled work shift. The Nursing Assistant (NA) #1 was observed doing a return demonstration to ensure she learned to follow the right procedure while providing perineal care to residents. Resident #3 still resides in the facility and continues to receive proper perineal care. All residents that are incontinent of bowel and bladder were observed by the DHS, the Clinical Competency Coordinator and, Unit Managers on 6/28/2018 and 6/29/2018 to ensure they receive proper perineal care from Nursing Assistants. Certified Nursing Assistant are responsible for providing proper perineal care among other activities of daily living and Licensed Nurses are responsible for monitoring Nursing Assistants to ensure proper care is provided. In-service for all certified nursing aides on following proper	

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F 726	Continued From page 8 conducted. The DON indicated Performance reviews were done quarterly then annually. Review of the quarterly performance review last done on 2/26/18 indicated NA #1 fully achieved the performance criteria. Review of NA #1 's training transcript for the 11/2018 ending cycle revealed an accrual of 4.5 hours. NA #1 participated in the skills competency training conducted on 1/4/18 and the skills competency checklist indicated NA #1 had perineal care training. Interview on 6/27/18 at 10:15 AM with the Director of Nurses (DON) who stated she expected NA #3 skin to be cleansed after a urine incontinence. Interview on 6/27/18 at 10:31 AM with Co-unit coordinator #4 who stated she expected the resident's skin be cleansed after a urinary incontinence episode. Interview with Resident #3 at 11:15 AM on 6/27/18 who stated he never told NA #3 not to wash him with soap and water. "There was never a discussion about that. I did not realize she had not washed my skin." At the time of the survey, the staff development coordinator was not available.	F 726	procedures while providing perineal care was initiated on 6/27/2018 and will be completed by 7/20/2018 Certified Nursing Assistants who have not completed the in-service will not be allowed to work until they are in-serviced. All newly hired Certified Nursing Assistants will be educated on following proper procedures while providing perineal care during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Director of Health Services ensured that in-service on following proper procedures while providing perineal care was conducted for all Certified Nursing Assistants including Nursing Assistant (NA) #1. The Nursing Assistants that are not in-serviced will not be allowed to work until they are in-serviced. A return demonstration was observed by the Clinical Competency Coordinator. Based on the weekly schedule for Nursing Assistants, 20% of all Certified Nursing Assistants including Nursing Assistant (NA) #1 will be observed performing perineal care weekly by the Unit Managers for 6 weeks and then monthly for 3 months and, then quarterly for 2 quarters to ensure proper procedure for perineal care is followed. The Director of Health Services and the Clinical Competency Coordinator will ensure all shift are covered. The Clinical	

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F 726	Continued From page 9	F 726	Competency Coordinator and Unit Managers will report to the DHS any findings of non-compliance and Nursing Assistants will be assigned a course on ADL care on Pruitt University. The Director of Health Services will report to the Administrator any findings of non-compliance. The Administrator will review and report any findings of non-compliance to the QAPI committee for recommendations as needed until compliance is observed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 7/25/2018	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		7/25/18

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F 732	Continued From page 10 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to retain a minimum of 18 months of daily posted staffing data. This was evident in 2 of 3 months of posted staffing data reviewed. (April 2018. May 2018 and June 2018) Findings included: Review of the retained "Daily Nursing Hours for Healthcare Centers Form" (DNHHC) provided at the facility and via email on 7/10/18 from the administrator revealed no retained DNHHC form for 4/8/18, 4/20/18, 4/22/18, 5/4/18, 5/12/18, and 5/26/18.	F 732	Process that lead to the Deficiency: Based on record review and staff interview the facility failed to retain a minimum of 18 months of daily posted staffing data. The facility could not account for 6 days in a 3-months period of posted staffing data that was reviewed. Root Cause Analysis: Lack of training for Unit Managers and the Nursing Management team to post daily staffing hours led to the facility□s failure	

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	345061	A. BUILDING _____ B. WING _____	C 06/29/2018

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F 732	Continued From page 11 An interview on 6/27/18 at 3:20 PM with the Director of nurses (DON) was conducted. The DON stated the facility had multiple DNHHC forms missing especially on the weekends because the weekend nurse and myself were multitasking and sometimes staff posting was not the priority or either we forgot to post.	F 732	to properly file and retain all posted staff data for a minimum of 18 months. Process for implementing the acceptable plan of correction for specific deficiency. The Administrator, the scheduler and, the Director of Health Services reviewed daily posted staffing data/records to ensure there is a minimum of 18 months of data retained and properly filed. The Administrator and the Director of Health Services educated Unit Managers and the scheduler on posting daily staffing hours and properly filing the data for a minimum of 18 months. Newly hired Unit Managers and scheduler will be educated on posting and retaining a minimum of 18 months of daily posted staffing data during new hire orientation by the Director of Health Services. The Director of Health Services will be responsible for ensuring that staffing hours are posted daily. The Administrator and the Director of Health Services will review the posted daily staffing hours daily for 4 weeks and then weekly for 3 months to ensure compliance is maintained. The Weekend Supervisor and/or the designated charge nurse will be responsible for posting daily staffing hours on the weekend. The Administrator will report any findings of non-compliance to the QAPI committee for further recommendations as needed until total compliance is maintained. Monitoring procedure to ensure that the plan of correction is effective. The Director of Health Services will be responsible for ensuring that staffing	

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F 732	Continued From page 12	F 732	hours are posted daily and will report/inform to the Administrator of any designated Unit Managers responsible for posting daily staffing hours when the Director of Health Services is out of the facility. The Administrator will receive and review the posted daily staffing hours daily for 4 weeks and then weekly for 3 months to ensure compliance is maintained. The Administrator will report any findings of non-compliance to the QAPI committee for further recommendations as needed until total compliance is maintained. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 7/25/2018	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to promote an insect free environment throughout the facility's main kitchen area. Findings included:	F 925	Process that lead to the Deficiency: Based on observation and staff interviews conducted on 6/27/2018 the facility failed to promote an insect free environment throughout the facility's main kitchen area. Root Cause Analysis:	7/25/18

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F 925	Continued From page 13 A kitchen worker was interviewed on 6-27-18 at 10:00am who stated she saw live roaches yesterday (6-26-18) behind the bread rack in the kitchen. She also stated, "I see them but I only work 4 days a week." The kitchen worker stated when she saw the roaches yesterday she reported it to her supervisor. The dietary manager was interviewed on 6-27-18 at 10:05am who stated she was made aware yesterday that there were roaches behind the bread rack and she informed maintenance. She also stated they have had roaches in the kitchen before but felt the roaches were brought in by outside vendors and could not remember when the last time she had a complaint that an employee saw any roaches. An observation of the kitchen was conducted on 6-27-18 at 10:05am. There was one dead cockroach noted in the dry storage room and one dead cockroach noted behind the ice machine. The maintenance supervisor was interviewed on 6-27-18 at 10:15am who stated he was informed of the roaches in the kitchen yesterday and he immediately called the exterminator who came out and sprayed. He also stated the exterminator came regularly every month but did not know what areas were treated monthly. A review of the pest control contract specified the company that provided the facility's pest control would treat the kitchen area every month. A review of the pest control log revealed the exterminator was at the facility on 5-30-18 but did not reveal what areas were treated.	F 925	The contracted vendor did not treat the kitchen area monthly as stipulated in the contract/service agreement. The pest control vendor and the facility did not review the contract on a regular basis to ensure Process for implementing the acceptable plan of correction for specific deficiency. The main kitchen and all kitchenettes were deep cleaned by housekeeping on 6/28/2018. The contracted vendor for Pest Control was contacted by the Administrator on 6/28/2018 and requested for a pest control technician to return and treat the kitchen area again and treat all kitchenettes. The technician came to the facility on 7/2/2018 and treated the kitchen area again and treated all three kitchenettes. After every treatment, the treated areas will be checked 24 hours after by the Maintenance Director to ensure no residual insects/cockroaches. On 7/2/2018, the Administrator in-serviced the Maintenance Director and the Housekeeping Manager on ensuring that the pest control technician services all areas as stated in the service agreement/contract and as needed. In-service was initiated on 7/2/2018 for all dietary staff to ensure the kitchen is cleaned daily as required to help keep insects/cockroaches away. In-service for all other staff from all departments on observing and reporting any pests including cockroaches was initiated on 7/23/2018 by the Administrator, Director of Health Services, Dietary Manager and the Maintenance Director and will be	

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F 925	Continued From page 14 An interview with the exterminator occurred on 6-27-18 at 2:06pm. The exterminator stated he was at the facility yesterday for their monthly treatment and he did spray the kitchen because he was informed there were roaches in the kitchen. He also stated he only sprayed the hallways, stairways and entry points every month and he only sprayed the kitchen and or kitchenettes if he was informed there were issues. He stated he did remember there were issues with roaches in the kitchen but could not remember when that occurred or the last time he treated the main kitchen area. The Administrator was interviewed on 6-27-18 at 2:30pm who stated he expected the exterminator to be called as soon as any bugs were seen. He also stated the facility's pest control contract stated the exterminator was supposed to treat the main kitchen area every month. A telephone conference was conducted on 6-29-18 at 10:05am with the pest control company's Area Vice President (AVP) for cooperate accounts, the pest control company's area manager and the Administrator of the facility. The area manager discussed the company being a "day service" and the exterminator could and did not treat the kitchen area every month because the kitchen was in operation. He also stated the company had a "night service" that could work with the day service to make sure the kitchen was treated every month. The Administrator for the facility stated he was attempting to retrieve invoices showing when the last treatment was provided to the kitchen area and the area manager for the company stated he could not provide a date of the last treatment because he had not spoken with the	F 925	completed by 7/25/2018. Staff who will not be in-serviced by 7/25/2018 will be in-serviced before they allowed return to work. The Dietary Manager will maintain a daily cleaning schedule for the kitchen. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Maintenance Director reviewed the contract/agreement and discussed with the pest control vendor of the expectation and commitment to keep the kitchen and kitchenettes free of insects. After every treatment, the treated areas will be checked 24 hours after by the Maintenance Director to ensure no residual insects/cockroaches. Any dead insects/cockroaches will be removed and discarded immediately. If live insects/cockroaches are observed, 24 hours after treatment, the pest control vendor will be called back by the Administrator, Maintenance Director or the Housekeeping Manager to administer further treatment for effective pest control. The housekeeping manager will maintain a monthly schedule to ensure the kitchen and kitchenettes are stripped and cleaned regularly and as needed. The Maintenance Director, the Housekeeping Manager and/or the Dietary Manager will check the kitchen area and the kitchenettes for insects/cockroaches weekly for 4 weeks and then monthly for 3 months until compliance is maintained. The Administrator will review and report any findings of non-compliance to the	

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F 925	Continued From page 15 exterminator.	F 925	QAPI committee for recommendations as needed until compliance is maintained. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 7/25/2018	