STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

(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 survey was conducted on 06/25/19 through 06/28/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LWIL11.	E 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		7/25/19

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

Electronically Signed | 07/22/2019

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and representative interview the facility failed to notify the Responsible Party (RP) of an increase in behaviors which resulted in the resident being transferred to a hospital for 1 of 3 residents reviewed for hospitalization (Resident #252). The findings included: Resident #252 was admitted to the facility on 12/12/18 with diagnoses that included hypertension and diabetes mellitus. Review of Resident #252's Minimum Data Set (MDS) assessment dated 12/13/18 revealed Resident #252 was severely cognitively impaired. Review of a nurse's note dated 12/13/19 written by Nurse #2 revealed Resident #252 was discharged to a local hospital on 12/13/19 due to behaviors.	F 580	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Resident 252 was discharged from the facility on 12/13/18	

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F 580	Continued From page 2 An interview with Resident #252's Responsible Party (RP) on 6/26/19 at 2:28 PM revealed she was not notified of Resident #252's increase in behaviors or his transfer to the hospital until she visited the facility on 12/13/18. She stated she was informed by an unknown staff member Resident #252 was at a local hospital. She went to the closest hospital and was unable to locate him. The RP stated she was contacted by staff at another local hospital later that night when they were seeking additional information about Resident #252. During an interview with Nurse #2 on 6/27/19 at 11:25 AM she stated she did not contact Resident #252's RP. She stated she stated she attempted contact via phone one time and was unable to leave a message. Nurse #2 stated she made no additional efforts to contact Resident #252's RP. Nurse #2 stated it was her understanding no one else contacted the RP. An interview was conducted with the Administrator on 6/28/19 at 10:00 AM who stated she was not employed at the facility at the time of the transfer. She stated it is her expectation that staff would have notified the RP about the behaviors and the subsequent transfer.	F 580	All resident discharges have been reviewed for the last thirty days by Social Worker and Unit Managers to ensure family/RP has been notified of any changes in condition, behaviors, or discharged to another facility. Nursing staff have been in-serviced by Clinical Competency Coordinator on 7/16/19 and completed on 7/25/19 on notification of resident□s Family/Responsible of any change in condition, behaviors, and/or discharge to the hospital via telephone call or in person. If nurses are unable to contact the family time they need to attempt again and document. If they are not able to contact Family /Responsible Party on their shift, the outgoing nurse should pass the information on to the oncoming nurse for follow-up. If the Family/Responsible Party can still not be contacted, the nurse should make the Director Health Services and the Unit Manager aware and document the multiple attempts. Unit Managers will audit discharges and reason for discharges to include behaviors 3 x weekly x 4 weeks, weekly x 4 weeks and monthly ongoing. Any identified areas of concern will be corrected. Any identified concerns will be reviewed during monthly QA/QAPI meeting to ensure continued compliance These areas will be reviewed during quarterly QA/QAPI meeting to ensure	

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F 580	Continued From page 3	F 580	facility systems remain compliant.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		7/25/19

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F 622	Continued From page 4	F 622		

discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including

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F 622	Continued From page 5 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, and staff interview the facility failed to have written documentation from a resident's physician which specified the reasons that was necessary for a facility-initiated discharge necessary for the resident's welfare and the facility being unable to meet the resident's needs for 1 of 5 residents reviewed for transfers and discharges (Resident #252). The findings included: Resident #252 was admitted to the facility on 12/12/18 with diagnoses that included hypertension and diabetes mellitus. Review of Resident #252's Minimum Data Set (MDS) assessment dated 12/13/18 revealed Resident #252 was severely cognitively impaired. A nurse's note dated 12/13/18 written by Nurse #2 revealed Resident #252 was discharged to a local hospital on 12/13/18 due to exhibiting behaviors which included disrobing, playing with feces and attempting to ride his roommate's oxygen concentrator. During an interview with Nurse #2 on 6/27/19 at	F 622	Resident 252 was discharged on 12/13/18 Residents discharged in the last thirty days have been reviewed by the Social Worker and Unit Managers to ensure the Physician has been made aware of discharge and has documented reason for discharge. 7-25-19 Physician has been in serviced by the Administrator on July 17,2019, as it relates to resident discharges and the need to document the facility has made him aware of discharge and where and why the resident is being discharged. Director of Health Services and Unit Managers will review resident discharges to ensure MD has been made aware of discharge and Physician has documented as such. This will be done 2 x weekly times 4 weeks, weekly x 4 weeks, and then monthly thereafter. Any identified areas of concern will be corrected. Discharges will be reviewed during	

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F 622	Continued From page 6 11:25 AM she reported she cared for Resident #252 on 12/12/18. She stated that he had disruptive behaviors throughout the night and the facility relocated his roommate at the roommate's request because of Resident #252's inappropriate behaviors. Nurse #2 indicated much of her shift was spent attempting to redirect Resident #252. She stated she contacted the physician about Resident #252's behaviors and he gave an order for Resident #252 to be transferred to the hospital. A physician's order dated 12/13/18 revealed an order to transport Resident #252 to a local hospital. A Notice of Transfer/Discharge dated 12/13/18 revealed Resident #252 was discharged on 12/13/18 and the transfer was necessary for his welfare and his needs could not be met in the facility. Resident #252's medical record revealed no documentation by the Physician of specific resident needs the facility could not meet, facility efforts to meet those needs or specific services the receiving facility would provide to meet the needs of the resident. An interview was conducted with the Physician on 6/28/19 at 1:15 PM who indicated he was unaware of the regulation that required documentation by the resident's physician which indicated Resident #252's specific needs the facility could not meet, facility efforts to meet those needs, and specific services the facility would provide to meet the needs of the resident. During an interview with Resident #252's	F 622	monthly QA meeting and any identified areas of concerns will be corrected These areas will be reviewed during quarterly QA/QAPI meeting to ensure systems remain compliant	

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F 622	Continued From page 7 responsible party on 6/26/19 at 2:28 PM she stated Resident #252's behaviors stabilized while he was in the hospital with medication adjustments and after his hospitalization Resident #252 discharged to his own residence. An interview was conducted with the Administrator on 6/28/19 at 10:00 AM. She stated she was not employed at the facility when the discharge occurred. She stated in a similar situation she would have ensured the necessary documentation was completed by the physician.	F 622		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		7/25/19

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F 623	Continued From page 8	F 623		

(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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F 623	Continued From page 9 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge to the resident's representative for a facility-initiated discharge for 1 of 3 residents reviewed for hospitalization (Resident #90). The findings included:	F 623	Resident 90 is no longer in the facility Administrator and Social Worker were in-serviced by Clinical Nurse Consultant on 6-27-19,and a Notice of Discharge and Transfer letter is now in place. This will be mailed to Family/Responsible in	

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F 623	Continued From page 10 Resident #90 was admitted to the facility on 10/15/18 with diagnoses that included dementia and anemia. Review of Resident #90's Minimum Data Set (MDS) assessment, a quarterly assessment dated 4/11/19 indicated he was moderately cognitively impaired. A nurse's note dated 5/2/19 written by Nurse #3 indicated Resident #90 was discharged to the hospital due to aspiration pneumonia. The note indicated the family was notified of the transfer by phone. Resident #90's medical record revealed no information regarding the resident's responsible representative being provided with written notice of the resident's hospital transfer on 5/2/19. An admissions form dated 5/6/19 revealed Resident #90 returned to the facility on 5/6/19. During an interview with the Social Worker on 6/28/19 at 12:50 PM she indicated she did not send written notice of discharge to the resident or resident's representative for Resident #90's transfer on 5/2/19. An interview was conducted with the Administrator on 6/28/19 at 1:00 PM who indicated she did not send written notice of discharge to the resident or resident's representative for the resident's hospital transfer. She stated the previous Administrator sent the written notices of discharge prior for hospital transfers. The Administrator stated she was unaware of the regulation so a written notice of	F 623	addition to bed hold policy, notice that includes appeal rights. In addition to staff notification of family in person or by phone, this information will be mailed to Family/Responsible next business day after discharge by Social Worker and/or Administrator. All discharges will be reviewed by Administrator weekly x 4, bi-weekly x 1 month and then monthly to ensure facility remains compliant. Any identified areas of concern will be corrected All discharges will be reviewed during monthly QA/QAPI meeting to make sure systems remain compliant These areas will be reviewed during quarterly QA/QAPI to ensure any identified areas of concern have been corrected and systems remain in compliance	

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F 623	Continued From page 11 discharge for Resident #90 was not sent. A telephone interview was conducted with Nurse #3 on 6/28/19 at 1:40 PM. She indicated she facilitated Resident #90's transfer to the hospital on 5/2/19. Nurse #3 stated information sent with the resident to the hospital included the resident's face sheet, medication list and code status. She revealed she contacted the facility physician and resident's representative by phone for Resident #90's hospital transfer. Attempts to contact Resident #90's responsible representative were unsuccessful.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) on a quarterly assessment for psychotherapy services and a comprehensive assessment for insulin administration for 2 of 31 residents reviewed for MDS accuracy (Resident #33 and Resident #9). The findings included: 1. Resident #33 was admitted to the facility on 7/8/14 with diagnoses that included hypertension and hypertension. Review of a psychotherapy progress note dated 4/11/19 revealed Resident #33 received	F 641	Resident 33□s assessment has been modified to reflect his psychotherapy visit on 4/11/19. Resident 9□s assessment has been modified to reflect insulin injections as ordered by MD on 6/5/19. 100% audit has been conducted of all MDS assessments by the clinical team to ensure they accurately reflect services provided during the 7 day look back period. Any identified areas of concern will be corrected. The MDS nurses will be in-service by the Clinical Reimbursement Consultant on 7/24/19.	7/25/19

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F 641	Continued From page 12 psychotherapy on 4/11/19. Review of Resident #33's MDS assessment dated 4/11/19 revealed Resident #33 was assessed in Section O, question O0400E as not receiving psychotherapy during the 7 day look back period of the assessment. An interview was conducted with the MDS Coordinator on 6/28/19 at 2:33 PM who stated the psychotherapy note dated 4/11/19 was not received by the agency until 5/23/19. She indicated this was the reason psychotherapy was not coded on the assessment. During an interview with the Administrator on 6/28/19 at 2:51 PM she stated the facility changed psychotherapy agencies due to not receiving psychotherapy notes in a timely manner. She indicated it is her expectation that assessments accurately reflect services received during the 7 day look back period. 2. Resident # 9 was admitted to the facility on 6/05/2019 with diagnoses which included hypertension, cerebral vascular accident, and diabetes mellitus. A review of a care plan updated 6/5/2019 revealed a plan focused on risk for diabetes mellitus complications with the intervention to administer medications as ordered. A review of Physician orders dated 6/5/2019 revealed an order to administer Levemir insulin 20 units at the hour of sleep. A review of Resident # 9 June 2019 medication administration record revealed indicated insulin injections were given as ordered when the	F 641	The IDT team to include CMD, Social Worker, Dietary, Nurse Navigator, and Activity Director will be in-serviced by the Administrator on 7/25/19 on the importance of accuracy of the MDS assessment. The Case Mix Coordinator will review all MDS assessments for accuracy prior to signing as correct. The Social Worker will work with the IDT team to ensure any admissions and/or readmissions are assessed accurately and reflect and behaviors or changes in behaviors and develop and monitor through a behavior management program. The facility Director of Health Services and Senior Nurse Navigator will review new completed assessments weekly x 4 weeks and bi-weekly x 2 months and then monthly or as often as indicated. Any areas of concern will be corrected. The Director of Nursing and Senior Nurse Navigator will track and trend assessments and bring completed tracking to QAPI. These areas will be reviewed during the monthly QA/QAPI meeting to ensure assessments are accurate and any identified areas have been corrected. The systems will be reviewed during quarterly QA/QAPI meeting, monthly until 3 consecutive months of compliance is maintained then quarterly thereafter, to ensure areas remain compliant.	

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F 641	Continued From page 13 resident was in the facility. A review of a discharge Minimum Data Set (MDS) dated 6/9/2019 revealed N0350 space was blank to indicate Resident # 9 had received no insulin injections for the past seven days. Further review of a re-entry MDS dated 6/10/2019 revealed N0350 was also blank. An interview with the MDS nurse on 6/26/2019 at 10:30 am revealed the MDS was done by another nurse, but she had signed for it. She further stated it was an error and the administration of insulin should have been coded on the MDS assessment because the order was in Resident # 9's chart. An interview with the Administrator and the Nurse Consultant on 6/28/2019 at 3:45 pm revealed the MDS assessment should have been coded to reflect that Resident #9 received insulin. The administrator also stated the MDS should be accurate upon admission and thereafter.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview the facility failed to provide pharmaceutical services for one (Resident #302) of six residents whose medications were reviewed. The facility failed to acquire ordered	F 658	Resident 302 is no longer in facility Nurse 3 was in-serviced 1:1 by Clinical Competency Coordinator on 7/7/19	7/25/19

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F 658	Continued From page 14 medication on admission for one sampled resident. Findings included: Resident #302 was admitted to the facility 1/4/19 with diagnoses of coronary (heart) artery disease, sick sinus syndrome (a heart rhythm problem) with pacemaker (an electrical device to help the heart beat) placement and atrial fibrillation (A fib) (a heart rhythm problem) among others. A review of resident's Minimum Data Set assessment, dated 1/11/19 and coded as an admission assessment, indicated Resident #302 was independent for daily decision making. It further revealed she exhibited no behaviors or rejection of care. According to the resident's hospital discharge orders and facility admission orders, dated 1/4/19, the resident was to receive Ticosyn 500 milligrams twice daily for atrial fibrillation. Review of the resident's facility admission note, dated 1/4/19, revealed Resident #302 arrived at the facility on 1/4/19 at 4:30 PM. Review of resident's January 2019 MAR (Medication Administration Record) revealed Ticosyn was transcribed to the MAR to be given on a 9:00 AM and 9:00 PM schedule. Further review of the January 2019 MAR revealed no initials for 1/4/19 at 9:00 PM to indicate the dose had been given. Remaining doses were initialed as given beginning 1/5/19 at 9:00 AM. Review of a physician's consultation note dated 1/11/19 indicated, "Patient on chronic Ticosyn, not	F 658	Licensed Nursing were in-serviced on 6/27/19 and completed on 7/12/19 by the Director of Health Services and the Clinical Competency Coordinator related to administrating 9:00pm medications for new admissions upon arrival of meds from pharmacy. This documentation on the medication administration record will include time meds were administered to resident All new admissions will have this written as an order on admissions. Resident may receive 9:00pm medicine when delivered from Pharmacy. Unit managers will be responsible for writing these orders upon admission. All nurses have been in-serviced as it relates to writing this order for any new admissions. These written orders will exclude medication that are listed as time specific Director of Health Services and /or Unit Managers will audit new admission Medication administration Records to ensure 9:00pm medications are being given upon arrival from Pharmacy and times the medications are given are documented. These audits will be conducted weekly x 4 weeks, bi-weekly x 1 month and then monthly thereafter. Any identified areas of concern will be corrected. The new admission Medication administration record audits will be reviewed during monthly QA/QAPI	

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F 658	Continued From page 15 getting it as ordered." Review of a physician ' s order dated 1/11/19 stated, "Ticosyn must be given exactly at 9:00 AM and 9:00 PM every 12 hours. If not, patient needs a new facility where this is possible." In a telephone interview on 6/26/19 at 3:30 PM Resident #302 indicated she did not receive the 9:00 PM dose of Ticosyn on 1/4/19. She went on to say that she was told by her nurse that the facility did not have the medication available. She further indicated this concerned her at the time because her Cardiologist had stressed to her how important it was to take this medication every 12 hours and not to miss any doses. She indicated she knew the medication was taken to prevent her from having a stroke. On 6/27/19 at 9:18 AM a telephone interview with Nurse #3 indicated she had been responsible for administering medication to Resident #302 on 1/4/19 from the time of her admission to the facility until 11:00 PM that evening. She went on to say that she had been new to the facility and was unsure about the process for obtaining medications. She further indicated she thought that the 1st Floor Nurse Manager was taking care of it. She went on to say that at 9:00 PM on 1/4/19 she did not give Resident #302 her Ticosyn as it was not available. She further indicated she had not notified Resident #302's physician or taken any further action. On 6/27/19 at 9:35 AM interview with the 1st Floor Nurse Manager revealed she did not recall the incident. She further indicated the facility had a process in place to obtain medications for residents 24 hours a day. She went on to say all	F 658	meetings to ensure systems remain compliant. Any identified areas of concern will be corrected Systems will be reviewed during Quarterly QA/QAPI meeting to ensure facility systems remain effective and in compliance	

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F 658	Continued From page 16 new hires were provided with this information and Nurse #3 should have known it. On 6/27/19 at 12:26 PM a telephone interview with the facility consulting pharmacist revealed Ticosyn would not be available in the facility stock supply. He further indicated the facility would have needed to contact the facility pharmacy directly for delivery of the medication the same day. He went on to say he had no record of the facility having done so. He Further indicated with Ticosyn he would have expected the facility to follow this process to prevent the resident from missing a dose. In an interview om 6/27/19 at 12:50 PM the Director of Nursing (DON) indicated the 1st Floor Unit Manager does take care of writing out the MAR and faxing the orders to the facility pharmacy. She went on to say it would be the admitting nurse's responsibility to call the pharmacy to notify them the facility needed a medication that day. She further indicated Nurse #3 had received orientation in this process and she would have expected Nurse #3 to have followed it. She went on to say if after following this process Nurse #3 had not been able to administer Resident #302 her 9:00 PM dose of Ticosyn she would have expected Nurse #3 to notify Resident #302's physician.	F 658		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance	F 687		7/25/19

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F 687	Continued From page 17 with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to prevent long and curled toe nails for 1 of 1 resident (Resident #37) reviewed for foot care. The findings included: Resident #37 was admitted to the facility on 3/23/18 with diagnoses which included Diabetes Mellitus and vascular dementia. A review of the quarterly Minimum Data Set dated 4/18/19 revealed Resident #37 was severely cognitively impaired. He required extensive assistance for activities of daily living (ADLs) and was totally dependent for bathing. A review of Resident #37's care plan last updated 4/18/19 revealed he had ADL deficit related to poor cognitive and communication status and required assistance with ADLs. The approaches were listed as bath or shower as scheduled and as needed, to provide daily grooming and to provide nail care or shampoo as needed. A record review revealed Resident #37 was seen by podiatry services on 5/28/18 and his toe nails were cut. On 6/26/19 at 11:49 AM Resident #37 was	F 687	Resident 37 was seen by the Podiatrist on July 3, 2019 and his toenails have addressed. 100% audit has been conducted on all residents by the RN treatment nurse and completed on 7-18-19, those found to have nails that needed addressing have been trimmed by RN Treatment nurse or referred to the Podiatrist for further evaluation. Resident refusals will be documented. Nurses /CNA□s have been in-serviced by the Director of Health Services and Clinical Competency Coordinator 6/28/19 completed on 7/12/19 on the revised shower schedule which includes nurse documentation for nail care. It will be the responsibility of the responsibility of the nurse to inspect resident toenails to ensure nail care has been provided timely. DON, Nurse Navigator, and Unit Managers will conduct nail care audits weekly x 4 weeks, bi-weekly times 1 month, and monthly ongoing. Any areas of concern will be corrected. These audits will be reviewed during	

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F 687	Continued From page 18 observed in his bed with his feet visible on top of the sheet. The toe nails on both feet were observed to extent greater than ¼ to ½ inch beyond the top of the toes. They were thick and curled outward to the left or right. On 6/28/19 at 10:00 AM the toe nails were observed to remain long and curled. On 6/28/19 at 10:28 AM Social Worker #1 stated she kept the list of residents who needed podiatry services. She stated the contracted podiatry service visited the facility on a quarterly basis. She said she had not been notified Resident #37 needed podiatry services and he was not on the list to be seen by podiatry. She said she did not have any record that he was seen since the 5/28/18 document on his medical record. She added residents were place on the list to be seen by podiatry based on a nurse request for a resident to be seen. On 6/28/19 at 10:39 AM Nursing Assistant (NA) # observed Resident #37's toe nails. She stated the nails were long and curved. On 6/28/19 at 10:39 AM Nurse #4 observed Resident #37's toe nails. She stated his toe nails were long and thick. She said if the resident had diabetes his toe nails should be trimmed by a nurse. She also said Resident #37 received weekly skin checks which included observation of the toes including the toe nails. She added Resident #37's toe nails were so long he would need a podiatry consult. A record review of the Weekly Head to Toe Observation form dated 6/1/19 revealed the skin assessment part of the form was blank. The	F 687	monthly QA/QAPI meeting to ensure system continue to remain compliant Any areas will be reviewed during quarterly QA/QAPI meeting to ensure systems are effective and facility remains in compliance	

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F 687	Continued From page 19 form was completed and signed by Nurse #5. On 6/28/19 at 11:19 AM Nurse #5 reported she completed the Weekly Head to Toe Observation form dated 6/1/19. She stated Resident #37 refused to allow her to observe his feet. She said she should have written refused on the form. On 6/28/19 at 11:29 AM the Director of Nursing stated Resident #37 was referred to the wound nurse to trim his toe nails but he refused to have them trimmed. On 6/28/19 at 11:32 AM first floor Unit Manager stated contracted podiatry services was scheduled to return to the facility on 7/3/19. She said she just noticed Resident #37 needed his toe nails cut. She added anyone could tell the SW to put a resident on the podiatry referral list. She said Resident #37 should have been added to the referral list earlier. On 6/28/19 the Physician Assistant stated she was not aware Resident #37 had not been seen by podiatry or that his toe nails were long. She added she thought Resident #37 should be seen by podiatry and she would follow-up to make sure he was seen.	F 687		
F 843 SS=D	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid	F 843		7/25/19

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F 843	Continued From page 20 programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide accurate medical records to a medical office during a scheduled appointment by placing a do not resuscitate form for another resident in Resident #39's paperwork prior to sending him to his appointment. Findings included: Resident #39 was admitted to the facility on 10/5/18. Review of Resident #39's most recent minimum	F 843	Resident 39 paperwork has been reviewed for accuracy prior to him going out to a medical appointment. All Nurses have been in-serviced by the Director of Health Services and Clinical Competency Coordinator beginning 6/27/19 and completed 7/7/19 on reviewing appointment packets for accuracy prior to giving them to Transport. Facility in-house transporter will also check appointment packets for accuracy of documents included.	

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F 843	Continued From page 21 data set assessment dated 4/16/19 revealed Resident #39 was assessed as cognitively intact and had no moods or behaviors. Review of Resident #39's care plan dated 3/1/19 revealed Resident #39 was care planned to be a full code. The interventions included to perform cardiopulmonary resuscitation in the event of cardiopulmonary arrest, review directives with family and resident quarterly, and notify the physician and significant others of any change. Review of Resident #39's medical record revealed he was documented to be a full code dated 10/5/18. During an interview on 6/25/19 at 2:55 PM Resident #39 stated he did not remember if someone had placed an incorrect do not resuscitate sheet in his chart during a office appointment. During an interview on 6/26/19 at 9:16 AM Resident #39's family member stated she went with Resident #39 to an appointment and when they were at the doctor's office, she noticed there was a yellow do not resuscitate sheet in his chart. She stated this was odd because he was a full code, so she pointed it out to the staff in the office to ensure they knew he was a full code. She stated it was embarrassing to have to tell them she had a sheet from another resident's chart. She further stated when they returned to the facility she informed the Administrator who took her to speak with the Director of Nursing. She stated it had not happened since, but it was concerning. During an interview on 6/26/19 at 12:37 PM the	F 843	Day shift nurses will be responsible for reviewing all appointment packages made by night shift nurses for accuracy-This will be a double check system to ensure accuracy of documents included in packet. Random audits of appointment packets for accuracy buy the Director of Health Services, Nurse Navigator, and/or Unit Managers weekly x 4 weeks, bi-weekly x 1 monthly thereafter. Any identified areas of concern will be corrected These audits will be reviewed during monthly QA/QAPI meeting to ensure systems remain compliant. Systems will be reviewed during Quarterly QA/QAPI meetings to ensure systems remain effective and in compliance	

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F 843	Continued From page 22 Administrator stated Resident #39's family member did approach her and informed her that another resident's do not resuscitate form was with Resident #39's information when he went to one of his oncology appointments a few months back. She further stated she then took her to speak with the Director of Nursing about the issue and it was discovered two residents were going out that same day and the do not resuscitate form was accidentally picked up with his information when he was transported. She further stated they in serviced the staff about the incident but did not do a full plan of correction or have monitoring or educational sign in sheets. During an interview on 6/27/19 at 3:01 PM the Director of Nursing stated it was an isolated incident, so no plan of correction was needed because the issue was corrected immediately, and education was provided to staff later that day. No monitoring or any other part of a plan of correction was completed. No further such incidents had occurred with an incorrect advanced directive being sent with a resident to an appointment. She stated two residents were going out to an appointment and whoever handed the paper over to transportation accidently grabbed the do not resuscitate form from the chart below his.	F 843		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		7/25/19

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F 867	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 7/26/18 in order to achieve and sustain compliance. This was for one recited deficiency on recertification survey on 6/28/19. The deficiency was in the area of pest control at regulatory grouping 483.75. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: CFR 483.75 (F925)- Based on observations, resident and staff interviews and record review the facility failed to maintain an effective pest control program to prevent flies in the dining room during the resident meal service for 6 of 6 sampled residents (Residents #38, #76, #86, #40, #39 and #80). During the recertification survey on 7/26/18 the facility was cited for failure to maintain an effective pest control as evidenced by flies observed in the dining room during meal service. During an interview with the Administrator and the Director of Nursing (DON) on 6/28/19 at 6:17 PM the Administrator stated the concern with the pest control had been identified but a plan of correction had not been written and fully implemented at the time of the survey. She	F 867	Facility failed to maintain the POC that was put in place for annual survey retain to an effective pest control program place during annual survey of July-18. Facility will monitor its pest control program along with any other areas found to be out of compliance through written PIP□s and the QAPI/QAA. Facility will continue to monitor these through monthly QAPI/QAA meeting until compliance is maintained x 3 months. If the area is found to not maintain compliance, new systems will be put in place and monitored until compliance has been achieved. A PIP is being put in place related to pest control with focus on flies in the dining area. This will include Administrative staff will monitor the dining area during meal time 3 meals x 3 times weekly and document their findings. The Administrator will make random observations at least 2 x weekly. An outside pest control company has been contacted related to their fly system and will begin spraying the outside of the facility weekly x 4 weeks, bi-weekly x 2 months and then monthly or as often as indicated thereafter. The Administrator or Maintenance will observe the serviceman spraying to ensure all areas of facility are treated. Facility Ambassadors will be given immediate kill appliances to be used during daily room visits and general areas of the facility.	

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F 867	Continued From page 24 further stated she had begun taking steps to eliminate the flies and would continue to do so with a plan of correction.	F 867	Identified areas of concern will be reviewed weekly during morning meetings x 4 weeks and monthly ongoing to ensure improvement is being maintained. These areas will be reviewed during monthly QAA//QAPI meetings any areas of concern will be addressed and a monitoring system put in place. These areas will be reviewed during quarterly QA/QAPI meetings to ensure facility systems remained compliant.	
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 observations, resident and staff interviews and record review the facility failed to maintain an effective pest control program to prevent flies in the dining room during the resident meal service for 6 of 6 sampled residents (Residents #38, #76, #86, #40, #39 and #80). Findings Included: 1. Review of Resident #38's most recent minimum data set assessment dated 4/19/19 revealed she was documented as cognitively intact. During observation of dining on 6/25/19 at 12:55 PM a fly was observed to land on the rim of Resident #38's sweet tea glass.	F 925	Administrator has interviewed residents 38,76,86,40,39, and 80 on 7-16-19 and again on 7-25-19 related to pest control in the dining area. They stated they did feel it was there was some improvement in the dining area. Administrative staff will monitor the dining room all three meals and document their findings related to pest control. This will be done 3 x weekly x 4 weeks, 1 weekly on going until QA assessment shows compliance have been achieved. Prior to survey-2 new fly lights had been ordered and installed on the front hallway. Bug zappers had been ordered and place on the outside sitting areas of facility	7/25/19

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F 925	Continued From page 25 During an interview on 6/26/19 at 9:01 AM Resident #38 stated the fly problem had been going on for months. She further stated flies would land on her drinks and food which caused her loose appetite and roll out of the dining room once a fly touches her food. During observation of dining on 6/26/19 at 12:35 PM a fly landed on Resident #38's meat balls. She shooed it away, but two more flies were observed circling the table. Resident #38 then left the dining room. During an interview on 06/26/19 05:03 PM Resident #38 stated she had drunk most of her tea and the flies had touched her food multiple times, so she left her lunch half eaten. She further stated she could not stand eating after flies landed on her food. During an interview on 6/26/19 at 3:33 PM Nurse #1 stated most of her cognitively intact residents had complained about flies in the facility. She stated the problem was especially an issue in the dining room with flies landing on residents' food. She stated the concern had been told to the Maintenance Director but flies were still a problem in the dining room. During an interview on 6/26/19 at 4:04 PM Nurse Aide #1 stated multiple residents had reported that flies were an issue in the facility, especially in the dining room. She further stated staff reported this concern to the Maintenance Director, however the flies were still an issue in the dining room. During an interview on 6/27/17 at 12:45 PM the	F 925	6/27/19 and a Contracted Pest Control company was spraying once a month. Fly fans are also on the front and back doors The Contracted Pest Control company has been contacted related to their fly reduction system. The pest control company will be spraying the outside of facility once a week x 4 weeks, bi-weekly x 2 months and then monthly or as often as indicated. Facility Ambassadors have been given hand appliances and will do an immediate kill when making room rounds and monitoring the dining room area. The Administrator will monitor dining area and other areas of the facility 3 x weekly to ensure facility systems are working and compliance is achieved. These findings will be reviewed during monthly QA/QAPI meeting. Any identified areas of concern will be corrected. These systems will be reviewed duri	

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Administrator stated the flies were better than they were, and they were trying to work on it, however, she knew it was still an ongoing problem. She further stated flies landing on resident's food as a common occurrence was not acceptable.

During an interview on 6/27/19 at 12:58 PM the Maintenance Director stated since it had been warm he knew the flies had become an issue in the facility and staff and residents had been complaining about the flies. He further stated he had the pest control company at the facility every thirty days to deal with the flies and some improvement had been made. He further stated it was not acceptable for flies landing on food to be a regular occurrence in the nursing home and he would continue his efforts to reduce the flies in the facility.

2. Review of Resident #76's minimum data set assessment dated 5/13/19 revealed he was documented as cognitively intact.

During observation on 6/25/19 at 12:52 PM a fly was observed to land on the rim of the glass which held Resident #76's tea. Two other flies were observed circling the table. Resident #76's were shoeing the flies away and was heard to comment to the other residents at the table, "you can hardly eat with all these flies." At 12:55 PM a fly was observed to land on Resident #76's food. Resident #76 had to shoo the fly away multiple times.

During an interview on 6/26/19 at 8:57 AM Resident #76 stated could not remember how long the flies had been a problem during lunch but every lunch it was difficult to eat because he

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was always shoeing flies away from his food. He further stated flies would land on his food all the time during lunch and he was tired of it.

During observation on 6/26/19 at 12:41 PM a fly was observed to land on Resident #76's rice during lunch. The resident shooed the fly away.

During an interview on 6/26/19 at 3:33 PM Nurse #1 stated most of her cognitively intact residents had complained about flies in the facility. She stated the problem was especially an issue in the dining room with flies landing on food.

During an interview on 6/26/19 at 4:04 PM Nurse Aide #1 stated multiple residents had reported that flies were an issue in the facility, especially in the dining room. She further stated staff reported this concern to the Maintenance Director, however the flies were still an issue in the dining room.

During an interview on 6/27/17 at 12:45 PM the Administrator stated the flies were better than they were and they were trying to work on it, however, she knew it was still an ongoing problem. She further stated flies landing on resident's food as a common occurrence was not acceptable.

During an interview on 6/27/19 at 12:58 PM the Maintenance Director stated since it had been warm he knew the flies had become an issue in the facility and staff and residents had been complaining about the flies. He further stated he had the pest control company at the facility every thirty days to deal with the flies and some improvement had been made. He further stated it was not acceptable for flies landing on food to be

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a regular occurrence in the nursing home and he would continue his efforts to reduce the flies in the facility.

3. Review of Resident #86's most recent minimum data set assessment dated 5/22/19 revealed she was cognitively intact.

On 5/25/19 at 12:55 PM a fly was observed to land on the rim of Resident #86's glass which held her sweat tea. The fly was shoed away by the resident and the fly left and continued to circle the table with three other flies. At 12:56 PM two flies were also seen circling food the on the table the resident was at and she continued to shoo the flies while eating.

During an interview on 6/26/19 at 3:33 PM Nurse #1 stated most of her cognitively intact residents had complained about flies in the facility. She stated the problem was especially an issue in the dining room with flies landing on food.

During an interview on 6/26/19 at 4:04 PM Nurse Aide #1 stated multiple residents had reported that flies were an issue in the facility, especially in the dining room. She further stated staff reported this concern to the Maintenance Director, however the flies were still an issue in the dining room.

During an interview on 6/27/17 at 12:45 PM the Administrator stated the flies were better than they were and they were trying to work on it, however, she knew it was still an ongoing problem. She further stated flies landing on resident's food as a common occurrence was not acceptable.

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During an interview on 6/27/19 at 12:58 PM the Maintenance Director stated since it had been warm he knew the flies had become an issue in the facility and staff and residents had been complaining about the flies. He further stated he had the pest control company at the facility every thirty days to deal with the flies and some improvement had been made. He further stated it was not acceptable for flies landing on food to be a regular occurrence in the nursing home and he would continue his efforts to reduce the flies in the facility.

During an interview on 6/27/19 at 4:27 PM Resident #86 stated the flies had been a problem since the weather warmed up. They start bothering her in the dining and landing on her food which was annoying as well as landing on her head and making her feel uncomfortable. She concluded she wished the facility could get rid of them.

4. Review of Resident #40's most recent minimum data set assessment dated 4/11/19 revealed she was assessed as cognitively intact.

During observation on 6/26/19 at 12:29 PM Resident #40 was observed to place a napkin over her glass after shooing a fly off the glass. The fly returned and landed on top of the napkin. At 12:32 PM a fly landed on her meatball which she had to shoo away.

During an interview on 6/26/19 at 5:20 PM Resident #40 stated during meals she felt like she had to almost cover her food with a napkin to keep the flies off the food between bites. She further stated the reason she had a napkin over her glass was to keep the flies out of her drinks.

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She further stated the flies had been a problem for as long as she could remember. She stated the kitchen staff would take a smoke break and go out the back door of the kitchen and leave it open. She stated that was how so many flies were entering the facility and the dining room at lunch time in particular.

During an interview on 6/26/19 at 3:33 PM Nurse #1 stated most of her cognitively intact residents had complained about flies in the facility. She stated the problem was especially an issue in the dining room with flies landing on food.

During an interview on 6/26/19 at 4:04 PM Nurse Aide #1 stated multiple residents had reported that flies were an issue in the facility, especially in the dining room. She further stated staff reported this concern to the Maintenance Director, however the flies were still an issue in the dining room.

During an interview on 6/27/17 at 12:45 PM the Administrator stated the flies were better than they were and they were trying to work on it, however, she knew it was still an ongoing problem. She further stated flies landing on resident's food as a common occurrence was not acceptable.

During an interview on 6/27/19 at 12:58 PM the Maintenance Director stated since it had been warm he knew the flies had become an issue in the facility and staff and residents had been complaining about the flies. He further stated he had the pest control company at the facility every thirty days to deal with the flies and some improvement had been made. He further stated it was not acceptable for flies landing on food to be

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a regular occurrence in the nursing home and he would continue his efforts to reduce the flies in the facility.

5. Review of Resident #39's most recent minimum data set assessment dated 4/16/19 revealed Resident #39 was assessed as cognitively intact.

During observation on 6/26/19 at 12:40 PM a fly was observed to land on Resident #39's straw. The fly stayed on the straw sitting on the drinking edge of the straw until 12:44 PM. At 12:47 PM the fly returned and landed on Resident #39's straw in the same location and another fly was circling the table. At 12:48 PM the Administrator was observed to shoo the flies away from Resident #39's plate and straw.

During an interview on 6/26/19 at 1:35 PM Resident #39 stated flies were always a problem in the facility. He stated they were in his room and would always come out and get on food in the dining area. He concluded he wanted the facility to do something about it because it was a nuisance.

During an interview on 6/26/19 at 3:33 PM Nurse #1 stated most of her cognitively intact residents had complained about flies in the facility. She stated the problem was especially an issue in the dining room with flies landing on food.

During an interview on 6/26/19 at 4:04 PM Nurse Aide #1 stated multiple residents had reported that flies were an issue in the facility, especially in the dining room. She further stated staff reported this concern to the Maintenance Director, however the flies were still an issue in the dining

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room.

During an interview on 6/27/17 at 12:45 PM the Administrator stated the flies were better than they were and they were trying to work on it, however, she knew it was still an ongoing problem. She further stated flies landing on resident's food as a common occurrence was not acceptable.

During an interview on 6/27/19 at 12:58 PM the Maintenance Director stated since it had been warm he knew the flies had become an issue in the facility and staff and residents had been complaining about the flies. He further stated he had the pest control company at the facility every thirty days to deal with the flies and some improvement had been made. He further stated it was not acceptable for flies landing on food to be a regular occurrence in the nursing home and he would continue his efforts to reduce the flies in the facility.

6. Review of Resident #80's most recent minimum data set assessment dated 5/21/19 revealed she was assessed as cognitively intact.

During observation on 6/26/19 at 12:43 PM a fly was observed to land on Resident #80's plate and walk on the plate. The resident shooed the fly away after it touched her meatballs. Multiple flies were seen above the table and the resident continued to shoo flies away as they flew to her food.

During an interview on 6/26/19 at 5:06 PM Resident #80 stated the flies had always been a problem in the dining room to the point she would bring her fly swatter to meals in the dining room.

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She further stated it was frustrating to eat with so many flies and she still used her fly swatter in bed. She concluded it was very unsanitary since the flies were landing on her food and it was impossible to keep them off which was why she stopped bringing her fly swatter.

During an interview on 6/26/19 at 3:33 PM Nurse #1 stated most of her cognitively intact residents had complained about flies in the facility. She stated the problem was especially an issue in the dining room with flies landing on food.

During an interview on 6/26/19 at 4:04 PM Nurse Aide #1 stated multiple residents had reported that flies were an issue in the facility, especially in the dining room. She further stated staff reported this concern to the Maintenance Director, however the flies were still an issue in the dining room.

During an interview on 6/27/17 at 12:45 PM the Administrator stated the flies were better than they were and they were trying to work on it, however, she knew it was still an ongoing problem. She further stated flies landing on resident's food as a common occurrence was not acceptable.

During an interview on 6/27/19 at 12:58 PM the Maintenance Director stated since it had been warm he knew the flies had become an issue in the facility and staff and residents had been complaining about the flies. He further stated he had the pest control company at the facility every thirty days to deal with the flies and some improvement had been made. He further stated it was not acceptable for flies landing on food to be a regular occurrence in the nursing home and he

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F 925	Continued From page 34 would continue his efforts to reduce the flies in the facility.	F 925		