

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2022
NAME OF PROVIDER OR SUPPLIER HUNTER WOODS NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER ROAD CHARLOTTE, NC 28213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An onsite complaint survey was conducted 1/12/2022 through 1/13/2022. Additional information was obtained offsite through 1/19/2022. Therefore, the exit date was changed to 1/19/2022. 2 of the 9 complaint allegations were substantiated, but did not result in a deficiency. 1 of the 9 complaint allegations was substantiated which resulted in a deficiency. Event ID# Y42B11.	F 000			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		2/16/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/14/2022

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

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F 636	<p>Continued From page 1</p> <p>(xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete the Care Area Assessment (CAA) on admission that addressed the underlying causes and contributing factors related to the use of scheduled pain medication</p>	F 636	<p>1. Resident #2's Minimum Data Set Assessment (MDS) assessment dated 9/23/21 was modified on 2/9/22 to correct coding in the area of J0100A; coded to indicate resident #2 did receive scheduled</p>		

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F 636	<p>Continued From page 2</p> <p>for 1 of 4 sampled residents reviewed for pain management (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on 9/16/21. Diagnoses included chronic wound of the abdominal wall, right lower quadrant, among others.</p> <p>Review of physician orders dated 9/17/21 revealed an order for Lidocaine Patch 5% to be applied topically, once daily for pain related to a wound of the abdominal wall, right lower quadrant and removed after 12 hours.</p> <p>The September 2021 Medication Administration Record (MAR) for Resident #2 documented administration of the Lidocaine Patch 5% daily.</p> <p>An admission Minimum Data Set (MDS) assessment dated 9/23/21 documented Resident #2 did not receive scheduled pain medication and that a pain CAA did not trigger.</p> <p>An interview with MDS Nurse on 1/13/22 at 1:10 PM revealed she completed the admission MDS for Resident #2 but that she did not document the use of daily pain medication when she completed the MDS. The MDS Nurse stated that she should have reviewed physician orders and the September 2021 MAR and noted that Resident #2 received scheduled pain medication daily for the abdominal wound which would have triggered her to complete a CAA for pain.</p> <p>A phone interview with the Regional MDS Consultant on 1/13/22 at 1:48 PM revealed she expected the MDS Nurse to review physician</p>	F 636	<p>pain medication during the look back period. The Pain Care Area Assessment (CAA) did not trigger after the modification to correct the scheduled pain medication coding because according to the RAI (pg. 4-40, Oct 2019), triggering conditions for the Pain CAA are (any out of the following): 1. J0500A=1; 2. J0500B=1; 3. J0600A>=07 AND J0600A<10; 4. J0600B=3 OR J0600B=4; 5. (J0600=1 OR J0400=2) AND ((J0600A>=04 AND J0600A<=10 OR (J0600B>=2 AND J0600B<=4)) 6. (J0800A=1) OR (J0800B=1) OR (J0800C=1) OR (J0800D+1). Neither of these conditions listed prior were coded as a triggering condition for the Pain CAA for this resident. Residents #2's baseline care plan did address pain and interventions for pain control. This baseline care plan was in effect through the resident's discharge date.</p> <p>2. On 2/10/22 the Regional Case Mix/MDS (Minimum Data Set) Coordinator completed audit through the last 30 days for current resident's to ensure if pain CAA was triggered on their most recent comprehensive assessment, there is a pain Care Plan in place. CAA's were addressed and care plans updated where applicable.</p> <p>3. On 2/10/2022 the Regional Case Mix/MDS Coordinator educated the traveling MDS Nurse on appropriate MDS coding for Section J0100A-Pain Management (scheduled pain medication) as well as completing Pain CAA when triggered. Education will be on-going, no staff will return to work until they have</p>		

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F 636	Continued From page 3 orders and the MAR to determine if a resident received scheduled pain medication when completing the MDS. The Regional MDS Consultant further stated that the MDS Nurse would be responsible to complete the CAA for pain management and that failure to do so could impact the Resident's plan of care. The Director of Nursing stated in an interview on 1/13/22 at 4:00 PM that the MDS Nurse should review physician orders and the MAR when assessing pain management for the MDS and that if a resident received scheduled pain medication the MDS Nurse should complete the CAA for pain and include the pain interventions in the care plan.	F 636	completed the mandatory education. This education will be provided to all new MDS employees as part of new hire orientation, contract staff and agency, this education will be provided prior to starting work. During Clinical Morning meeting with MDS coordinator along with the Interdisciplinary Team (Director of Nursing, Nurse Management, MDS Coordinator, and Social Worker) will review new admissions and readmissions related to the use of scheduled pain medication to ensure accurate coding in the area of section J0100A and triggered CAA is completed. 4. Regional Case Mix/MDS Coordinator will review 5 MDS assessments for Section J0100A-Pain management (scheduled pain medication) to ensure accurate coding weekly x4 weeks then monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing or designee and or until substantial compliance is obtained. Corrective action will be completed by February 16, 2022.		
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 staff interviews and record review, the facility failed to accurately code an admission Minimum Data Set (MDS) assessment related to	F 641	1. Resident #2 Minimum Data Set Assessment (MDS) assessment dated 9/23/21 was modified on 2/9/22 to correct	2/16/22	

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F 641	<p>Continued From page 4</p> <p>scheduled pain medication regimen for 1 of 6 sampled residents reviewed for MDS accuracy (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on 9/16/21. Diagnoses included chronic wound of the abdominal wall, right lower quadrant, among others.</p> <p>A baseline care plan for pain management dated 9/16/21, documented a goal that Resident #2 would maintain comfort at the highest degree possible, staff would monitor for signs/symptoms of pain, administer pain medication as ordered, eliminate/reduce causative factors related to pain with a plan for pain management, use non-drug interventions (reposition as needed), keep the environment calm/relaxed, and provide pain medication as ordered.</p> <p>Review of physician orders dated 9/17/21 revealed an order for Lidocaine Patch 5% to be applied topically, once daily for pain related to an abdominal wall wound, right lower quadrant and removed after 12 hours.</p> <p>The September 2021 Medication Administration Record (MAR) for Resident #2 documented administration of the Lidocaine Patch 5% daily for the wound of the abdominal wall.</p> <p>The admission MDS assessment dated 9/23/21 documented Resident #2 did not receive scheduled pain medication.</p> <p>An interview with MDS Nurse on 1/13/22 at 1:10 PM revealed she completed the admission MDS</p>	F 641	<p>coding in the area of J0100A; coded to indicate resident #2 did receive scheduled pain medication during the look back period.</p> <p>2. On 2/10/22 the Regional Case Mix/MDS (Minimum Data Set) Coordinator completed audit for ARDs (Assessment Reference Date) through last 30 days (beginning with ARD 1/12/22) for current residents to ensure scheduled pain medication was coded accurately on most recent assessment. Any miscoded items were modified appropriately and transmitted to Centers for Medicare & Medicaid Services (CMS) upon completion.</p> <p>3. On 2/10/22 the Regional Case Mix/MDS Coordinator educated the traveling MDS Nurse on appropriate MDS coding for Section J0100A-Pain Management (scheduled pain medication). Education will be on-going, no staff will return to work until they have completed the mandatory education. This education will be provided to all new MDS employees as part of new hire orientation, contract staff and agency, this education will be provided prior to starting work. During Clinical Morning meeting with MDS coordinator along with the Interdisciplinary Team (Director of Nursing, Nurse Management, MDS Coordinator, and Social Worker) will review new admissions and readmissions related to the use of scheduled pain medication to ensure accurate coding in the area of section J0100A and triggered CAA is completed.</p> <p>4. Regional Case Mix/MDS Coordinator</p>		

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F 641	Continued From page 5 for Resident #2 but that she did not document the use of daily pain medication when she completed the MDS. The MDS Nurse stated that she should have reviewed physician orders and the September 2021 MAR and noted that Resident #2 received scheduled pain medication daily for pain related to the abdominal wound. A phone interview with the Regional MDS Consultant on 1/13/22 at 1:48 PM revealed when completing the MDS, she expected the MDS Nurse to review hospital records, progress notes, physician orders and the MAR to determine if a resident received scheduled pain medication and to code the MDS accordingly. The Director of Nursing (DON) stated in an interview on 1/13/22 at 4:00 PM that the MDS should be completely accurately by the MDS Nurse. The DON stated that the MDS Nurse should review hospital records, progress notes, physician orders and the MAR when completing the MDS to ensure accuracy.	F 641	will review 5 MDS assessments for Section J0100A-Pain Management (scheduled pain medication) to ensure accurate coding as well as completing Pain CAA when triggered weekly x4 weeks then monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing or designee and or until substantial compliance is obtained. Corrective action will be completed on February 16, 2022.		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		2/16/22	

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F 812	<p>Continued From page 6</p> <p>safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain clean kitchen tile throughout the kitchen. This practice resulted in unsanitary conditions in the kitchen.</p> <p>The findings included:</p> <p>Observations made of the kitchen tile revealed the following:</p> <p>a. Observation on 1/12/22 at 3:25 PM revealed grayish solid debris approximately 2 cm (centimeters) long observed in the grout lines in the kitchen located in front of the steam table, brownish solid particles approximately 2-3 cm long behind the steam table, grayish white solid matter in front of dishwasher, and scattered grayish white debris ranging from 1- 3 cm long throughout grout lines in the kitchen.</p> <p>b. Observations on 1/13/22 at 9:56 AM revealed particles in the grout in front of the 3-compartment sink, behind the steam table, in front of the steam table, debris noted throughout the kitchen, and in the area by the dishwasher.</p> <p>c. On 1/13/22 at 1:54 PM debris was observed in the grout lines in the kitchen located in front of the steam table, behind the steam table, in front of dishwasher, and scattered throughout grout lines in the kitchen.</p>	F 812	<p>1. The Housekeeping Manager pressure washed the Kitchen floor on 1/14/22 to remove particles and debris from the grout. Additionally on 1/12/22 the Maintenance Director treated the kitchen for pest.</p> <p>2. Pest Control Company treated the kitchen on 1/13/22 for pest. The kitchen was deep cleaned by the housekeeping manager on 1/14/22.</p> <p>3. On 2/8/22 District Dietary Manager educated facility Dietary Manager and Dietary Staff on the following: The kitchen floors are to be swept and mopped after each tray line serving, after dish room, and any area that food is being prepped and/or prepared before leaving that area; Pest Control and Standing Water-if any pest such as gnats, roaches, and spiders are observed in the kitchen, staff must report immediately to the manager and/or maintenance director; Any standing water must be reported to manager. The dietary staff will sign off that floor was swept and mopped at the end of their shift. Also the kitchen floor will be pressured washed/deep cleaned monthly by housekeeping. The Dietary Manager and Administrator will round daily to ensure compliance. Housekeeping staff will</p>		

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F 812	<p>Continued From page 7</p> <p>An interview with Maintenance Director on 1/12/22 at 4:57 PM revealed if the grout needed cleaning it would be dietary's responsibility.</p> <p>A telephone interview with the Dietary Manager (DM) on 1/13/22 at 12:18 PM revealed she had a cleaning schedule that included moping and sweeping the kitchen daily. She revealed that in September 2021, the Housekeeping Director deep cleaned the floor. The DM stated she was unaware of the current debris in the grout lines in the kitchen.</p> <p>An interview with the Administrator on 1/13/22 at 12: 42 PM revealed there was a deep clean done in the kitchen by the Housekeeping Director in late September 2021 and the floor was deep cleaned at that time. He further stated after the deep cleaning, it was dietary's responsibility to maintain the floor clean.</p> <p>A telephone interview with previous Housekeeping Director on 1/13/22 at 1:06 PM revealed he had not deep cleaned the floor in the kitchen since September 2021.</p> <p>An interview and observation with the Corporate Dietary Manager on 1/13/22 at 1:34 PM revealed she did not notice debris in the grout. She further stated that sweeping and moping could help, but it would not get the debris out of the grout. She revealed that the floor would need to be deep cleaned to remove debris in the grout.</p> <p>A telephone interview with current Housekeeping Director on 1/14/22 at 12:55 PM revealed she had been employed since November 2021 and had not provided any deep cleaning to the</p>	F 812	<p>receive education on kitchen floor monthly pressure wash/deep clean schedule by 2/16/22. Education will be on-going, no staff will return to work until they have completed the mandatory education. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work.</p> <p>4. The Administrator or designee will audit 5 resident rooms, nurses' stations, and kitchen to see if rooms/areas are clean and free of visible signs of gnats, water bugs, or other pests and that the kitchen floors are clean and free on debris in grout weekly for 4 weeks then monthly for 3 months. Any concerns identified will be brought to Maintenance Director and/Housekeeping Supervisor as appropriate for corrective action to be taken. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing or designee and or until substantial compliance is obtained. Corrective action will be completed by February 16, 2022.</p>		

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F 812	Continued From page 8 kitchen. A telephone interview with the District Manager of Housekeeping & Dietary on 1/14/22 at 1:40 PM revealed it is the DM responsibility to make sure the kitchen was clean including the floor. She further stated housekeeping can be asked to assist with this, but it is ultimately the DM responsibility for the cleanliness of the floor.	F 812			
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, record review, interviews with residents, staff, and pest control technician, the facility failed to maintain an effective pest control program to prevent gnats in 4 of 22 Residents' rooms (Rooms 310, 601, 604, and 607), in 2 of 2 nurses' stations (#1 and # 2) and the kitchen. The findings included: 1 a. Resident #8 was admitted to the facility 7/5/19. A quarterly Minimum Data Set (MDS) dated 12/30/21 assessed Resident #8 as cognitively intact. In an observation and interview with Resident #8 in room 601 on 1/12/22 at 10:03 AM, revealed 2 small flying insects in her bathroom. The resident revealed she saw gnat activity in her room that morning. Resident further revealed it had been a while since she believed they have sprayed. Resident stated she had reported it to the facility staff. On 1/13/22 at 9:37	F 925	1. Residents' rooms (310, 601, 604, and 607) nurses' stations (#1 and #2) and the kitchen were treated for pest by Maintenance Director on 1/12/2022. Additionally pest Control Company visited facility on 1/13/2022 to spray for insects. Pest control recommendations were addressed. The Kitchen floor was pressure washed by the Housekeeping Supervisor on 1/14/2022 to remove particles and debris from the grout. 2. Current resident rooms were inspected by the Interdisciplinary Team to include: Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS (Minimum Data Set) Nurse, Activities Director, Business Office Manager, Medical Records, Admissions, Housekeeping Manager, Maintenance Director, and Social Worker on date and treated as necessary. The Housekeeping Manager	2/16/22	

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F 925	<p>Continued From page 9</p> <p>AM, two small flying insects were observed in bathroom of room 601.</p> <p>b. Resident #9 was admitted to the facility 10/2/21. A quarterly MDS dated 1/2/22 assessed Resident #9 as cognitively intact. In an observation and interview with Resident #9 in room 604 on 1/13/22 at 9:40 AM, revealed small flying insect observed near resident's face. The resident stated he had noticed gnat activity but had not reported it to the facility staff.</p> <p>c. An observation of room #310 on 1/12/22 at 10:06 AM revealed small flying insects.</p> <p>d. An observation on 1/13/22 at 9:47 AM revealed multiple small flying insects in room 607.</p> <p>2 a. An observation of nurses' station # 1 on 1/12/22 at 11:05 AM revealed multiple small flying insects observed around nurses' station on the 300 hall.</p> <p>b. An observation of nurses' station #2 on 1/13/22 at 10:56 AM revealed multiple small flying insects observed on the wall by the 500/600 hall med room door nurses' station.</p> <p>An interview with Nurse #6 on 1/13/22 at 9:43 AM revealed she had seen small flying insects around her medication cart yesterday but just killed them. Nurse #6 further revealed she did not report the pest activity but was aware she needed to report it to the Director of Nursing (DON) and the Administrator, and she would report it today.</p> <p>An interview with the DON on 1/13/2022 at 3:26 PM revealed prior to today she had not been notified of any pest activity near the nurses'</p>	F 925	<p>and Dietary Manager deep cleaned kitchen on 1/14/2022.</p> <p>3. The Administrator and/or designee will educate facility staff to include: All Nursing Staff (Licensed Nurses, Certified Nursing Assistant, Medication Aides, and Patient Care Assistant), Receptionist, Administrator, Department Managers, Housekeeping, Dietary, Therapy, Agency and Administrative staff on the process for maintaining residents rooms in a clean and orderly manner and reporting to maintenance when gnats or other pests are noted anywhere within the facility. The staff will be educated to document pest activity in the pest sightings book. This education will be completed by 2/16/22. Education will be on-going, no staff will return to work until they have complete the mandatory education. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. The Maintenance Director will review the pest sighting book in stand-up meeting daily. During Morning rounds the Interdisciplinary Team will make observation and interview residents regarding past sightings, in daily stand-up meeting and address. Pest Control will make monthly routine visits and when needed. Additionally daily, in morning meeting, the Administrator will review the Pest Control report with the Department Managers and ensure follow up of items listed.</p> <p>4. The Administrator or designee will audit 5 resident rooms and a common area to</p>		

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F 925	<p>Continued From page 10 stations.</p> <p>3. Review of the pest service records revealed the following pest control program recommendations for 10/21/21, 11/15/21 and 12/6/21 stated debris collecting in gout lines in kitchen. Recommendations to review debris to prevent unsanitary conditions and attraction of pest. The service records further revealed water leak/standing water inside kitchen. Recommendations were to remove water, repair leak to prevent unsanitary conditions and attraction of pest.</p> <p>Observations of pest activity in the kitchen occurred during the following:</p> <p>a. On 1/12/22 at 3:25 PM, 3 small flying insects were observed flying around covered bread in the back of the kitchen near the dry storage area. Grayish white solid debris approximately 2 cm (centimeters) long observed in the grout lines in the kitchen located in front of the steam table, brownish solid particles approximately 2-3 cm long behind the steam table, grayish white solid matter in front of dishwasher, and scattered grayish white debris ranging from 1- 3 cm long throughout grout lines in the kitchen.</p> <p>b. On 1/13/22 at 9:56 AM an observation of particles in grout in front of the 3-compartment sink, behind the steam table, in front of the steam table, debris noted throughout the kitchen, and in the area by the dishwasher. Further observation at 10:00 AM revealed multiple small flying insects observed near dishwasher in the kitchen and 2 small flying insects observed on the wall near the entrance by the front kitchen door.</p> <p>c. Observation on 1/13/22 at 1:54 PM with</p>	F 925	<p>see if rooms are clean and free of visible signs of gnats, water bugs, or other pests weekly for 4 weeks, then monthly for 3 months. Any concerns identified will be addressed. The Administrator will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Performance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. Corrective action will be completed by February 16, 2022.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 925	<p>Continued From page 11</p> <p>Corporate Dietary Manager revealed multiple small flying insects in the kitchen, debris observed in the grout lines in the kitchen located in front of the steam table, behind the steam table, in front of dishwasher, and scattered throughout grout lines in the kitchen.</p> <p>An interview with Maintenance Director on 1/12/22 at 4:57 PM revealed he was unaware of recommendations from contracted pest control company on 10/21/21, 11/15/21, and 12/6/21. He further revealed he was unaware of any current pest activity in the facility since December 2021.</p> <p>A telephone interview with contracted pest control technician on 1/13/22 at 11:05 AM revealed he was the technician for this facility through January 2022. He further revealed that he had previously placed glue traps in the facility. He further revealed that December 2021 was the last time he was inside of the building, and he did not notice many gnats on the traps. He stated he was unaware of any current gnat activity.</p> <p>An interview with the Administrator on 1/13/22 at 12: 42 PM revealed the contracted pest control company recommendations were discussed in the daily meetings and plans to correct would have been discussed. The administrator further revealed he had not been notified of any current pest activity in the resident rooms or nurse's station.</p>	F 925			