STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015060	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Rehabilitation & Senior Living	4201 Bessemer Super Highway Bessemer, AL 35020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408 Based on observation, interviews, record review and review of a facility policy titled, Promoting/Maintaining Resident Dignity, the facility failed to ensure Certified Nursing Assistant (CNA) #7 did not stand while feeding Resident Identifier (RI) #6 the lunch meal on 07/30/2024. This deficient practice affected RI #6; one of one resident observed being fed by facility staff. Findings Include: Review of a facility policy titled, Promoting/Maintaining Resident Dignity, with a Copyright date of 2023, revealed the following: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity . Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity . RI #6 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of Cognitive Communication Deficit, Dysphagia, Need for Assistance with Personal Care and Contracture, Unspecified Joint. Review of RI #6's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 07/06/2024, identified RI #6's Brief Interview for Mental Status (BIMS) was 00 of 15 which indicated that RI #6 had severely impaired cognition. The MDS also indicated that RI #6 had impairment of the upper extremities, and needed substantial/maximal assistance with eating. On 07/30/2024 at 12:30 PM, CNA #7 was observed standing while feeding RI #6 the lunch meal. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/02/2024 at 9:25 AM, an interview was conducted with CNA #7. When asked what position she should be in when feeding the resident, CNA #7 said sitting. CNA #7 said when she fed RI #6 the lunch meal on 07/30/2024, she should have been seated and was not. CNA #7 said standing over a resident while feeding the resident could cause the resident to feel rushed. CNA #7 said when assisting a resident with a meal, staff should be seated at the level of the resident. On 08/03/2024 at 1:55 PM, an interview was conducted with the Director of Nursing (DON). The DON said staff should not stand when feeding the resident because that was a dignity issue. On 08/03/2024 at 2:20 PM, an interview was conducted with the Regional Director of Clinical Operations (RDCO)/Infection Control Nurse. The RDCO said staff should not stand while feeding the resident and should be positioned at the eye level of the resident. The RDCO said the concern of staff standing while feeding the resident could signal to the resident that staff are not taking their time and are in a hurry.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408 Based on observations, interviews, record review and review of a facility policy titled, Safe and Homelike Environment, the facility failed to ensure: 1) the privacy curtain in Resident Identifier (RI) #14's room was not stained and dirty, 2) the smoke detector in RI #25's room was not detaching from the ceiling, 3) there was not a hole in the wall on Station II adjacent to RI #24's room, 4) two tiles were not missing from the floor outside of RI #25's room. These deficient practices affected RI #14, RI #24, and RI #25, three of 26 sampled residents: one of one medication room and one of two units at the facility. This deficiency was cited as a result of the investigation of complaint/report numbers AL00048404 and AL00048134. Finding Include: Review of a facility policy titled, Safe and Homelike Environment, with a Copyright date of 2024, revealed the following: Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . Definitions: . Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, . Policy Explanation and Compliance Guidelines: 3. Housekeeping and maintenance services will provide as necessary to maintain a sanitary, orderly and comfortable environment . 1) On 07/30/2024 at 11:35 AM, the surveyor observed the privacy curtain in RI #14's room to have a stain and a brown substance on the curtain. Surveyor asked Licensed Practical Nurse (LPN) #10 what the substance was, and she stated she was not sure. On 07/31/2024 at 12:35 PM, the surveyor again observed the privacy curtain and the stain, and the brown substance remained on the curtain. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2024 at 5:38 PM, the surveyor was accompanied by the Housekeeping Supervisor (HSK) to RI #14's room. When asked what the stain and brown substance looked like the HKS said bowel movement. The HSK said the stain should not be on the curtain; it should be clean and unstained. The HSK said the stained curtain could cause contamination. 2) RI #25 was admitted to the facility on [DATE] and readmitted on [DATE]. On 07/30/2024 at 5:15 PM, the surveyor made an observation in RI #25's room. The smoke detector was noted detaching from the ceiling. On 07/31/2024 at 8:37 AM, the surveyor made observation and noted the smoke detector remained detaching from the ceiling. On 07/31/2024 at 6:15 PM, the MTD stated a resident could get shocked due to the detaching smoke detector. 3) On 07/28/2024 at 5:36 PM surveyor observed a hole the size of a baseball in the hallway outside of RI #24's room next to a couch in the hallway. On 07/31/2024 at 6:00 PM, the hole was observed with the MTD. The MTD said there should not be a hole in the wall. When asked how the wall should be, the MTD replied smooth and painted. The MTD said the appearance was not homelike. 4) On 07/31/2024 at 8:37 AM, surveyor observed the floor outside RI #25's room and noted two (2) pieces of tile missing. On 07/31/2024 at 5:52 PM, the surveyor and the MTD observed the floor with two missing tiles. Surveyor asked the MTD should the tiles be missing, and MTD replied, No. The MTD stated the tile should be secured. The MTD stated that someone could trip if their shoe got caught in an empty slot.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on interview, record review and review of the Centers for Medicare & (and) Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, the facility failed to ensure Resident Identifier (RI) #12's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date of 07/02/2024, was coded to reflect RI #12 receive an anticoagulant medication during the assessment period. This deficient practice affected RI #12, one of 26 sampled residents whose MDS assessments were reviewed. Findings Include: A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, dated 10/2019, revealed the following: . SECTION N: MEDICATIONS . Coding Instructions . N0410E, Anticoagulant . Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . RI #12 was admitted to the facility on [DATE]. RI #12 had a diagnosis of Pulmonary Embolism without Acute Cor Pulmonale. An Order Summary Report (Physician's Order) for RI #12, Eliquis (an anticoagulant) Oral Tablet 5 mg (milligrams) two times a day for atria fibrillation had been ordered for RI #12 to receive since 03/25/2024. RI #12's June and July 2024 Medication Administration Record revealed the resident had received the anticoagulant, Eliquis twice daily as ordered. RI #12's Quarterly MDS assessment, with an ARD of 07/02/2024, revealed RI #12 was not coded for receiving an anticoagulant medication during this assessment period. On 08/03/2024 at 5:37 PM, an interview was conducted with the MDS Coordinator (MDSC). The MDSC said according to RI #12's Physician Orders RI #12 was receiving RI #12 was receiving an anticoagulant medication which was Eliquis. The MDSC said the Eliquis should have been coded on RI #12's Quarterly MDS assessment dated [DATE], but it was not coded accurately. The MDSC said the lookback period for coding mediations was seven days and RI #12 was receiving an anticoagulant medication during the lookback period. The MDSC said it was important for the MDS to be coded accurately so everyone would know the medication the resident received. The MDSC said the anticoagulant not being coded was an oversite.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on observation, interviews, record review and review of a facility policy titled, Pressure Injury Prevention Guidelines, the facility failed to ensure there was not an unidentified Stage II pressure injury to the back of Resident Identifier (RI) #12's right leg when the Treatment Nurse completed a body audit for RI #12 on 08/01/2024 with the surveyor. This deficient practice affected RI #12, one of five residents sampled for pressure injury. This deficiency was cited as a result of the investigation of complaint/report #AL00048404. Findings Include: Review of a facility policy titled, Pressure Injury Prevention Guidelines, with a copyright date of 2023, revealed the following: Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or have pressure injury present . Preventive Skin Care: 1. Inspect skin while providing care . RI #12 was admitted to the facility on [DATE]. RI #12's Quarterly Minimum Data Set assessment with an Assessment Reference Date of 07/02/2024, assessed RI #12 as being at risk for developing pressure ulcers. A review of RI #12's Shower Audit/Skin Assessment forms revealed a form dated 07/29/2024 which did not document any injury or area of concern to the back of RI #12's right leg during this shower audit/skin assessment. On 08/03/2024 at 4:33 PM, a telephone interview was conducted with CNA #22, the CNA assigned to care for RI #12 on 07/31/2024 on the 11 PM to 7 AM shift. CNA #22 said she would have inspected RI #12's skin whenever she checked RI #12 to see if he/she was soiled. CNA #22 said she did not recall looking at the back of RI #12's right leg when she provided care for RI #12 on her shift. On 08/01/2024 at 12:05 PM, an observation of Licensed Practical Nurse (LPN) #10/Treatment Nurse and LPN #11 performing a body audit on RI #12. LPN #11 was the nurse assigned to provide care to RI #12 for the 7 AM to 3 PM shift. LPN #10 identified a Stage II to the back of RI #12's right leg. Both LPN #10 and LPN #11 said they had not been informed of the open area but should have been. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note completed by the Certified Registered Nurse Practitioner (CRNP), dated 08/01/2024, documented the following: . I was asked to see patient for new wound assessment . According to staff, patient has a new wound to leg and some redness to buttocks. Upon assessment open area with redness noted to back of leg which appears to be a stage II pressure ulcer . wound care orders were given . A Physicians Order dated 08/01/2024, documented the following: . wound care: Right lower outer leg clean area with wound cleanser, pat dry, apply calcium alginate to wound bed, cover with 4x4 gauze and border dressing every day as needed . On 08/01/2024 at 6:16 PM, an interview was conducted with Registered Nurse (RN) #21, the RN supervisor. RN #21 said the Certified Nursing Assistants (CNAs) should be inspecting the resident's skin during care. RN #21 said the evidence this was being done would be on the resident's shower sheets. RN #21 said she was not aware the treatment nurse had identified new skin concerns on RI #12, and the CNAs should have identified the areas before the treatment nurse did. On 08/03/2024 at 2:20 PM, the surveyor conducted an interview with the Director of Nursing (DON). The DON said the CNAs should be inspecting or observing the resident's skin when they are providing peri-care and when taking the resident to the shower. The DON said the CNAs should be inspecting all areas on the resident's body including arms, legs, buttocks, back, etcetera. The DON said there should never be an unidentified pressure ulcer on a resident if the CNAs were inspecting the resident's skin as they should be.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408 Based on interviews, record review and review of facility policies titled, Fall Prevention Program, and Safe and Homelike Environment, the facility failed to ensure Resident Identifier (RI) #7 did not have a fall due to water being on the floor from a leaking air conditioner (AC) unit in RI #7's room. This deficient practice affected RI #7, one of five residents sampled for Falls. This deficiency was cited as a result of the investigation of complaint/report number AL00048404. Findings Include: Review of a facility policy titled, Fall Prevention Program, with a Copyright date of 2023, revealed the following: . A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level . The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . Review of another facility policy titled, Safe and Homelike Environment, with a Copyright date of 2023, revealed the following: Policy: In accordance with resident's rights, the facility will provide a safe . environment . Definitions: . Environment refers to an environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms . RI #7 was admitted to the facility on [DATE], with diagnoses to include Other Reduced Mobility, Muscle Weakness and Unspecified Abnormality of Gait and Mobility. Review of a facility form (Incident Report) titled Un-witnessed Fall, dated 06/24/2024, documented: Resident: (RI #7's name) Incident Location: Resident's Room . Incident Description (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Description: This RN (Registered Nurse) called to resident's room for a fall. Resident seen on floor beside bed. Code purple called immediately. Resident lifted back to wheelchair by nursing staff. Resident denies hitting (his/her) head. (He/She) said (he/she) slipped on water on the floor from water leaking from AC unit. (He/She) denies hitting (his/her) head. (He/She) endorses soreness to (his/her) bottom and redness to left elbow. Resident does not have any broken skin areas . Resident Description: I slipped on water and fell . Predisposing Environmental Factors . (Wet Floor was checked) . On 08/01/2024 at 7:20 PM, a telephone interview was conducted with Certified Nursing Assistant (CNA) #23, the CNA assigned to care for RI #7 on 06/24/2024 when RI #7 fell . CNA #23 said she went to RI #7's room after the nurse called her. CNA #23 said RI #7 was on the floor next to the bed and there was a sheet on the floor to catch the water that was leaking from the AC in RI #7's room. CNA #23 said when RI #7 was lifted from the floor you could see water on the floor. When asked should there have been water on the floor, CNA #23 said no. CNA #23 said the water was on the floor because RI #7's AC had been leaking. On 08/02/2024 at 2:10 PM, a telephone interview was conducted with RN #24, the former RN supervisor who prepared the incident report. RN #24 said when she entered RI #7's room RI #7 was on the floor and there was water on the floor due to RI #7's AC leaking. RN #24 said RI #7's fall was avoidable because if water had not been on the floor, RI #7 might not have fallen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408 Based on observation, interviews, record review and review of a facility policy titled, Hand Hygiene, the facility failed to ensure Certified Nursing Assistant (CNA) #7 performed hand hygiene after removing her gloves after feeding Resident Identifier (RI) #6 the lunch meal and leaving RI #6's room on 07/30/2024. This deficient practice affected CNA #7; one of three staff observed for infection control practices. Findings Include: Review of a facility policy titled, Hand Hygiene, with a Copyright date of 2023, revealed the following: Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: . 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . RI #6 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of Dysphagia and Need for Assistance with Personal Care. Review of RI #6's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 07/06/2024, identified RI #6 needed Substantial/maximal assistance with eating. On 07/30/2024 at 12:30 PM, CNA #7 was observed wearing gloves while feeding RI #6 the lunch meal. After feeding RI #6, CNA #7 removed her gloves, and exited RI #6's room without performing hand hygiene. On 08/02/2024 at 9:25 AM, an interview was conducted with CNA #7. When asked what she should have done after removing her gloves after she fed RI #6 the lunch meal on 07/30/2024, CNA #7 said she should have sanitized her hands. CNA #7 said the concern of not sanitizing her hands after removing her gloves would be cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/03/2024 at 1:55 PM, the surveyor conducted an interview with the Director of Nursing (DON). The DON said staff should immediately sanitize their hands after removing their gloves. The DON said the concern with staff not sanitizing their hands after removing their gloves would be infection and cross contamination. On 08/03/2024 at 2:20 PM, an interview was conducted with the Regional Director of Clinical Operations (RDCO)/Infection Control Nurse. The RDCO said staff should sanitize their hand after removing their gloves. The RDCO said the concern with staff not sanitizing their hands after removing their gloves would be contamination.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on observations, interviews, record review, review of facility policies titled, Pest Control Program and Safe and Homelike Environment, review of complaints received by the Alabama State Survey Agency, the facility failed to ensure: 1) rodent droppings were not observed in the Dietary Manager's (DM) office, dry storage room in the kitchen, and in the nurses medication room, 2) an adhesive strip with multiple size roaches was not in Resident Identifier (RI) #24's bathroom, and adhesive strips with dead roaches were not in the kitchen, 3) an exit door near RI #'s 26 room did not have a gap beneath the door; and 4) there were not numerous complaints from residents about roaches/rodents being in the facility. These deficient practices affected four of 24 sampled residents including RI #3, RI #24, RI #26, and RI #28 and had the potential to affect all 55 residents residing in the facility. Observations were made on 07/29/2024, 07/30/2024, 07/31/2024 and 08/01/2024. These deficiencies were cited as a result of the investigation of complaint/report numbers AL00048404, AL00048134, AL00046118 and AL00045643. Finding Include: Review of a facility policy titled, Pest Control Program, with a Copyright date of 2023, revealed the following: Policy: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Definition: Effective pest control program is defined as measures to eradicate and contain common household pests (e. g. [for example] . roaches . mice and rats) . Review of another facility policy titled, Safe and Homelike Environment with a Copyright date of 2023, revealed the following: Policy: In accordance with resident's rights, the facility will provide a safe, clean, comfortable homelike environment . (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Definitions: . Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the resident's rooms, bathrooms, hallways . On 08/14/2023, the Alabama State Survey Agency received an anonymous complaint alleging the facility had a rat infestation. On 10/25/2023, the Alabama State Survey Agency received an anonymous complaint alleging there were rats in the facility. On 05/14/2024, the Alabama State Survey Agency received an anonymous complaint alleging there were rat/mouse feces in the kitchen, hallways and closet areas in the facility. On 07/24/2024, the Alabama State Survey Agency received an anonymous complaint alleging that while working on the night shift there have been plenty times that mice had been seen running up and down the hallways; and there were roaches of all shapes and sizes in the facility. 1) During an observation of the kitchen on 07/29/2024 at 5:20 PM, the surveyor observed a small oval shaped substance in the DM's office. The DM said it looked like a rat dropping. The DM said the concern of there being rat droppings was contamination. The surveyor and DM entered the dry storage room and multiple small oval shaped substances were observed. The DM also identified the substances as being rat droppings and said rat droppings should not be in the dry good area and could cause contamination. On 07/30/2024 at 3:40 PM, the surveyor toured the medication room on Station Two. There was a small oval shaped black substance observed in the storage cabinet in the medication room. The Maintenance Director (MTD) identified the substance as a rodent dropping. On 08/01/2024 at 11:23 AM, the surveyor again toured the kitchen. The small oval shaped black substance remained in the DM's. The DM said the dropping being in the area was not homelike and sanitary. 2) On 07/29/2024 at 4:20 PM, the surveyor observed a large pest adhesive strip on the floor underneath the sink in the bathroom of RI #24. There was a large dead cockroach and multiple small water bugs and slugs on the strip. On 07/29/2024 at 5:30 PM, the surveyor continued the kitchen observation with the DM. There were six adhesive strips under the sink with large dead roaches on the strips. The DM said roaches being in the kitchen would be a concern of contamination. On 07/31/2024 at 6:05 PM, the surveyor observed the bathroom of RI #24 with the MTD. The adhesive strip remained beneath the sink in the bathroom. The MTD said roaches should not be in the resident's bathroom. The MTD said the concern of roaches being in a resident's bathroom would be germs or the roaches could possibly get in the resident's bed or food. 3) RI #26 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015060	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Rehabilitation & Senior Living	4201 Bessemer Super Highway Bessemer, AL 35020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RI #26's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/22/2024, identified RI #26 as scoring 15 of 15 on the Brief Interview for Mental Status (BIMS) indicating RI #26 was cognitively intact. On 07/31/2024 at 6:20 PM, RI #26 said he/she saw two rats in the hallway outside his/her door three nights ago. On 07/31/2024 at 6:25 PM, the surveyor and MTD observed a gap underneath the employee entry/exit door across from RI #26' room. The MTD said rodents could crawl under the gap and this might be where rodents were entering the building. 4) On 08/02/2024 at 10:00 AM, the surveyor conducted a Resident Council Group Meeting with residents at the facility. The group said they had seen mice/rats off and on over the past six months and they were not completely gone. The group said they had seen mice/rats in their rooms, bathrooms, and hallways; and multiple residents said they had seen roaches or bugs in their rooms. RI #28 was admitted to the facility on [DATE]. RI #28's Annual MDS assessment with an ARD of 06/07/2024, identified RI #28 as scoring 12 of 15 on the BIMS indicating RI #28 had moderately impaired cognition. During the Resident Group Council Meeting on 08/01/2024, RI #28 said he/she saw a big roach on yesterday. RI #3 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #3's Annual MDS assessment with an ARD of 06/30/2024, identified RI #3 as scoring 13 of 15 on the BIMS indicating RI #3 was cognitively intact. During the Resident Group Council Meeting on 08/01/2024, RI #3 said he/she saw a huge live roach in his/her bathroom last night.