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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>045474 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>05/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Green House Cottages of Northwest Arkansas |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1303 NE Legacy Parkway<br>Bentonville, AR 72712 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46723</p> <p>Based on observation, interview, and record review, the facility failed to ensure the separately locked compartment was permanently affixed for storage of controlled drugs. This failed practice had the potential to affect 12 residents residing in [NAME] Cottage.</p> <p>The findings include:</p> <p>On 5/22/2024 at 3:10 PM, the Surveyor was observing the medication storage in [NAME] Cottage with Licensed Practical Nurse (LPN) #13. When checking the refrigerator for medications, the Surveyor noticed the narcotic box was not permanently affixed within the refrigerator.</p> <p>On 05/22/2024 at 3:12 PM, the Surveyor asked LPN #13 if the narcotic box should be permanently affixed to the refrigerator. LPN #13 said, It is behind two locked doors.</p> <p>On 05/22/2024 at 3:14 PM, LPN #13 was asked how many employees have keys to the locked narcotic box. She responded, There are three day nurses and three different night nurses. The nurse on duty is the one who has the key.</p> <p>On 05/24/2024 at 1:03 PM, the Administrator provided a policy titled Medication Storage in the Facility that indicated, .Controlled Substance Storage .Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator .</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03508</p> <p>Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 2 of 2 meals observed. This failed practice had the potential to affect 1 resident who received pureed diets.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On 05/20/2024 at 12:45 PM, in Cottage #4, [NAME] House, pureed food items prepared and served to the residents on a pureed diet were as follows: <ul style="list-style-type: none"> <li>a. Pureed breaded baked chicken. The consistency was lumpy, thick and there were pieces of meat visible in the mixture.</li> <li>b. Pureed cauliflower with red pepper. The consistency was lumpy. There were pieces of red pepper visible in the mixture.</li> <li>c. Pureed english peas. The consistency of the pureed peas was not smooth. It has lumps in it.</li> <li>d. Pureed chocolate chips cookies. The consistency was chunky and not smooth. The Surveyor asked the Dietary Supervisor to describe the consistency of the pureed food items served to the resident on puree diet. She stated, The pureed meat was lumpy. Pureed cauliflower with red. Still has chunks of red pepper in it and I can visibly see pieces of red pepper in it. Pureed english peas were lumpy. Pureed chocolate chips cookies were chunky.</li> </ul> </li> <li>2. On 05/20/2024 at 4:42 PM, Certified Nursing Assistant (CNA) #6 placed one corn dog into a blender, added milk and pureed. At 04:46 PM, CNA #6 poured the pureed corndog into a pan on the steam table. The consistency of the pureed corn dogs was lumpy and not smooth.</li> <li>3. On 05/20/2024 at 4:48 PM, CNA #6 used a 4 ounce spoon to place a serving of squash into a blender, pureed and then poured into a pan on the steam table. The consistency of the pureed squash was not smooth. There were pieces of squash still in the mixture. At 05:35 PM, the Surveyor asked the Dietary Supervisor to describe the consistency of the pureed food items prepared to be served to the resident on a puree diet. She stated, Pureed corndogs still have some chunks and pureed squash has lumps in it.</li> </ol> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03508</p> <p>Based on observations and interview, the facility failed to ensure (1) food items stored in the freezer or refrigerator were sealed, and covered, (2) that expired food items were promptly removed/discarded by the expiration or use by dates, and foods were dated as when received to ensure first in and first out usage to prevent the potential for food borne illness, (3) that 1 of 5 ice machines and 2 of 5 ice scoop holders were maintained in clean and sanitary condition to prevent food and beverage contamination, (4) that staff washed their hands between dirty and clean tasks and before handling clean equipment to minimize the potential for contaminating food items for residents who received meals from 1 of 1 kitchen, (5) that hot food items were maintained at above 135 degrees Fahrenheit on the steam table while awaiting service to prevent potential food borne illness for residents who received meals from the kitchen in House #2. These failed practices had the potential to affect 12 residents who receive meals from the kitchen in House #1; 9 residents who receive meals from the kitchen in House #2; 12 residents who receive meal trays from the kitchen in House #3; 12 residents who receive meal trays from the kitchen in House #4; and 10 residents who receive meal trays from the kitchen on House #5, (Total census: 55).</p> <p>The findings are:</p> <p>[NAME] House #1</p> <p>1. On [DATE] at 11:46 AM, the following observations were made in the kitchen:</p> <p>a. An opened plastic bag of shredded cheese was on a shelf in the refrigerator. The bag was not sealed.</p> <p>b. There was a pitcher on the counter by the refrigerator in the kitchen that contained lemonade where the spout was not covered, exposing it to cross contamination.</p> <p>c. There was a pitcher that contained sweetened tea on the counter in the kitchen where the spout was not covered.</p> <p>On [DATE] at 11:47 AM, the Surveyor asked Certified Nursing Assistant (CNA) # 1 if containers of beverages should be left uncovered. She stated, It should have been covered/closed, I will talk to my team about that.</p> <p>2. On [DATE] at 1:59 PM, there was a pitcher that contained orange juice on a shelf in the refrigerator., where the spout was not covered.</p> <p>3. On [DATE] at 2:00 PM, a can of dented strawberry topping was on a shelf in the storage room where undented cans to be used were stored.</p> <p>4. On [DATE] at 2:09 PM, an opened box of sausage was on a shelf in the freezer. The box was not covered.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>5. On [DATE] at 2:11 PM, the area in the ice machine where the ice forms before dispensing into the ice collect had wet brown residue on it. The Surveyor asked the Dietary Supervisor to wipe out the wet brown colored substances found on the area where ice forms. She wiped it off with tissue paper. The wet brown substances easily transferred on the tissue paper. The Surveyor asked the Dietary Surveyor to describe what was found in the area. She stated, It was brown dirt. The Surveyor asked the Dietary Supervisor who uses ice from the ice machine and how often the ice machine has been cleaned. She stated, We clean it weekly and wipe it down daily. The certified nursing assistant uses it to fill beverages served to the residents at mealtimes.</p> <p>6. On [DATE] at 2:12 PM, the scoop holder on a wall by the ice machine had black/tannish residue at the bottom of it. The Surveyor asked the Dietary Supervisor to wipe off the black/tannish residue at the bottom off the scoop holder with a paper towel. She did so, and the black/tannish substance easily transferred to the paper towel. The Surveyor asked her to describe what was inside the scoop holder. The Dietary Supervisor stated, It was black/tannish color. The Surveyor asked, Who uses the ice machine from the machine and how often do you clean it? The Dietary Supervisor stated, That's the ice the CNAs use to fill the beverages served to the residents at mealtimes. We clean it every day.</p> <p>7. On [DATE] at 8:35 AM, the following dry food items on a shelf in Storage room [ROOM NUMBER] were not covered or sealed:</p> <ul style="list-style-type: none"> <li>a. An opened box of plain cracks.</li> <li>b. An opened box of cheese cracks.</li> <li>c. An opened box of cornbread.</li> </ul> <p>[NAME] House #2</p> <p>1. On [DATE] at 1:44 PM, the following observations were in the kitchen on house #2.</p> <ul style="list-style-type: none"> <li>a. A pitcher that contained sweet tea was on a shelf in the refrigerator where the spout was not covered.</li> <li>b. An opened bottle of soy sauce was in the cabinet. The manufacture's specification on the bottle documented, Refrigerate after opening.</li> </ul> <p>2. On [DATE] at 12:08 PM, the temperatures of the food items when checked and read by the certified nursing assistant #2 before serving them to the residents were.</p> <ul style="list-style-type: none"> <li>a. Ground breaded chicken 126 degrees Fahrenheit.</li> <li>b. English peas 132 degrees Fahrenheit.</li> </ul> <p>[NAME] House #3</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>1. On [DATE] at 12:16 PM, CNA #3 used a spoon to stir gravy on the stove, proceeded by putting her apron on. Without washing her hands, she picked up glasses on their rims, placed them on the counter and poured beverages to be served to the residents with their lunch. The Surveyor immediately asked the CNA #3 what should you have done after touching the dirty equipment and before handling food items. She stated, I should have washed my hands.</p> <p>2. On [DATE] at 12:20 PM, CNA #3 picked up a bottle of coke and emptied it into a glass. Without washing her hands, she picked the glass that contained coke by the rim and gave it to the resident who requested it.</p> <p>3. On [DATE] at 12:23 PM, CNA #3 took out a box of honey thickened water and a box of honey thickened cranberry juice from the refrigerator and placed them on the counter. Without washing her hands, she picked glasses by the rims and placed them on the counter, then poured thickened beverages in them to be served to the residents on thickened liquids. The Surveyor asked the CNA #3 what should have done after touching dirty objects and before handling clean equipment. She stated, I should have washed my hands.</p> <p>4. On [DATE] at 12:30 PM, CNA #4 put on her apron. Without washing her hands, she pulled gloves from the glove box and placed them on her hands, contaminating them. She then used her contaminated gloved hand to pick up slices of buttered bread and placed them on the plates to be served to the residents for the lunch meal. The Surveyor asked the CNA #4 what should you have done after touching dirty objects and before handling food items. She stated, I should have washed my hands.</p> <p>5. On [DATE] at 1:30 PM, the following observations were made in the refrigerator, freezer, and the storage area in the kitchen:</p> <p>a. An opened bag that contained slices of cheese was on a shelf in the refrigerator. The bag was not sealed.</p> <p>b. An open bag that contained cobbler crust was on a shelf in the freezer. The bag was not sealed, exposing it to freezer burn.</p> <p>c. An opened box of short cake was on a shelf in the storage room. The box was not covered or sealed.</p> <p>[NAME] House #4</p> <p>1. On [DATE] at 1:12 PM, an opened box of salt was on a shelf. In the storage room. The box was not covered.</p> <p>a. On [DATE] at 1:16 PM, the scoop holder on a wall by the ice machine had wet brown residue at the bottom of it. The Surveyor asked the Dietary Supervisor to wipe off the brown residue at the bottom of the scoop holder with a paper towel. She did so, and the brown substance easily transferred to the paper towel. The Surveyor asked her to describe what was inside the scoop holder. The Dietary Supervisor stated, It looks like brown dirt. The Surveyor asked, Who uses the ice machine from the machine and how often do you clean it? The Dietary Supervisor stated, That's the ice the CNAs use to fill beverages served to the residents at mealtimes. They ' re supposed to clean it every day.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>b. On [DATE] at 4:50 PM, CNA #7 removed a corndog from the oven and placed it on the plate. She opened the drawer, removed gloves from the glove box and placed them on her hands, contaminated the gloves. Without changing gloves and washing her hands, she sliced the corndog with a knife to be served to the residents who received mechanical soft diets. At 04:52 PM, CNA #7 wore gloves on her hands when she opened a drawer and took out a knife. She picked up a spoon from the drawer and used it to place a serving of macaroni and cheese on the plate that contained diced corndog. Without changing gloves and washing her hands, she held macaroni and cheese with her contaminated gloved hand as she diced the macaroni and cheese with a knife to be served to the resident on mechanical soft diet. As she was ready to serve the meal plated to the resident. The Surveyor stopped immediately and asked CNA #7 what should you have done after touching the dirty objects and before handling the food items? She stated, I should have changed gloves and washed my hands.</p> <p>[NAME] House #5</p> <p>1. On [DATE] at 8:12 AM, CNA #8 opened the cabinet door and removed a bowl and placed it on the counter with thumb inside the bowl. When she opened a packet of instant to empty it inside the bowl. The Surveyor asked CNA #8 what should you do after touching dirty objects and before handling clean equipment? She stated, I should have washed my hands.</p> <p>2. On [DATE] at 8:17 AM, a bag of cheese puffs was on a shelf in the second storage room and with an expiration date of [DATE].</p> <p>3. On [DATE] at 8:43 AM, CNA #9 gave a key to CNA #8. Without washing her hands, she picked up a plate to be used in portioning food items to be served to the residents for breakfast with her fingers inside the plate. The Surveyor asked CNA #9 what should you have done after touching dirty objects and before handling clean equipment? She stated, Washed my hands.</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide and implement an infection prevention and control program.</p> <p>39316</p> <p>Based on record review, observation, and interview, the facility failed to implement enhanced barrier precautions for 1 resident (Resident #16); and failed to ensure hand hygiene/glove changes were implemented during incontinence care for 1 (Resident #34) to prevent the spread of infections.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. A review of an Admission Record, indicated the facility admitted Resident #34 with diagnoses that included hemiplegia and hemiparesis. <ol style="list-style-type: none"> <li>a. The modified 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2024 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Resident #34 was dependent on staff for toileting and was frequently incontinent of bowel and bladder.</li> <li>b. Review of Resident #34's Care Plan, revised on 06/22/2023, revealed the resident had occasional bladder incontinence related to activity intolerance, obstructive and reflux uropathy, benign prostatic hyperplasia, and impaired mobility. Interventions included clean peri-area (perineal) with each incontinence episode, initiated on 04/01/2023.</li> <li>c. On 05/20/2024 at 01:27 PM, Resident #34 was observed in bed with Certified Nursing Assistant (CNA #18) and CNA #19 on each side of Resident #34's bed. CNA #19 wiped down Resident #34's inner left leg with the right gloved hand, using a moistened wet wipe and discarded. CNA #19 obtained a moistened wet wipe, cleaned the Resident #34's genitals, and discarded the wipe. CNA #19 did not change gloves and did not perform hand hygiene.</li> <li>d. On 05/20/2024 at 1:29 PM, CNA #19 used a contaminated glove on the left hand to operate the remote to lower the head of Resident #34's bed. CNA #19 did not change gloves and did not perform hand hygiene. CNA #18 and CNA #19 changed position on each side of Resident #34's bed, and CNA #18 and CNA #19 placed a clean brief under Resident #34.</li> <li>e. On 05/20/2024 at 1:30 PM, CNA #19, with the same contaminated gloved hands, obtained a moistened wet wipe and used the left gloved hand and wiped between Resident #34 buttocks with a result of brown/wet substance and discarded the moistened wet wipe. CNA #19 repeated this process with the same result. CNA #19 did not change gloves and did not perform hand hygiene.</li> <li>f. On 05/20/2024 at 1:32 PM, with contaminated gloves, CNA #19 obtained a spray bottle of perineal wash from the nightstand and sprayed perineal wash spray on a moistened wet wipe. CNA #19 wiped between Resident #34's buttocks with a return of a brown/wet/substance and discarded the wipe. CNA #19 did not change gloves and did not perform hand hygiene. CNA #19 pulled the clean brief from under Resident #34's buttocks and discarded. CNA #19 then placed a clean brief under Resident #34's buttocks. CNA #19 did not change gloves and did not perform hand hygiene.</li> </ol> </li> </ol> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>g. On 05/20/2024 at 1:33 PM, using contaminated gloves, CNA #19 obtained a tube of barrier cream from the nightstand drawer, opened the top, squeezed some cream into the gloved left hand, then rubbed the cream on Resident #34's buttocks. CNA #19 did not change gloves and did not perform hand hygiene. CNA #18 and CNA #19 instructed Resident #34 to roll onto the resident's back. CNA #19 and CNA #18 pulled the brief between Resident #34's legs in the front and secured the brief using self-sticking tabs.</p> <p>h. On 05/20/2024 at 1:34 PM, CNA #19 removed contaminated gloves from hands then applied a new clean pair of gloves. CNA #19 did not perform hand hygiene.</p> <p>i. On 05/20/2024 at 1:36 PM, CNA #18 was asked if there was sanitizer in Resident #34's bathroom. CNA #18 replied, No, just soap and water. CNA #18 and CNA #19 applied a pair of pants onto Resident #34's lower legs and pulled them up over Resident #34's legs and buttocks. CNA #18 and CNA #19 positioned a mechanical lift pad under Resident #34.</p> <p>j. On 05/20/2024 at 1:38 PM, CNA #18 and CNA #19 attached the lift pad to the ceiling lift and lifted Resident #34 up from the bed and transferred him/her into a wheelchair.</p> <p>k. On 05/20/2024 at 1:41 PM, CNA #19 was interviewed and revealed that gloves should be changed after they are soiled. CNA #18 was asked if CNA #18 changed gloves after being soiled with feces and CNA #18 revealed CNA #19 did not change gloves after being soiled with feces and she should have.</p> <p>l. On 05/20/2024 at 1:45 PM, CNA #18 and CNA #19 were observed to wash hands in the kitchen sink in the middle of the cottage. CNA #18 was asked when and why hand hygiene should be performed. CNA #18 stated, Supposed to your hands, before entering and leaving the room because of contamination.</p> <p>m. On 05/22/2024 at 2:17 PM, CNA #18 revealed that gloves should be changed when going from dirty to clean/clean to dirty tasks, to prevent the spread of bacteria, and that she doesn't carry alcohol gel on her, but she didn't think they should use the residents sink in their bathroom, and they wash their hands after they exit the room in the sink on the outside of the kitchen, not the sink inside the kitchen,</p> <p>n. On 05/23/2024 at 8:35 AM, the Administrator revealed the Infection Control Preventionist (ICP) was at an Infection Control Conference and was not available for interview at this time.</p> <p>p. On 05/23/2024 at 8:42 AM, during an interview with the Director of Nursing (DON), the DON revealed the process for hand hygiene was to wash hands before entering the room, don gloves, do peri-care (incontinent care) if the gloves become soiled or if getting clean objects, they should change gloves or if they are damaged. The DON revealed staff should have changed gloves before touching anything clean, because they were just reintroducing feces back onto the elder, the drawer and the tube of skin cream. The DON revealed that staff can wash hands in the resident bathroom and stated, Yes, they know this, and before they leave the room. The DON revealed alcohol gel is good between glove changes and small tasks.</p> <p>(continued on next page)</p> |  |  |

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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |  |  |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>q. Review of a facility policy, Hand Hygiene, May 2022, revealed, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Condition: hands are visibly soiled with blood or other body fluids: soap and water. Condition: after handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves, before and after handling clean or soiled dressings, linens, etc.; after handling items potentially contaminated with blood, body fluids, secretions, or excretions; when, during resident care, moving from a contaminated body site to a clean body site; when in doubt: either soap and water or alcohol based hand rub.</p> <p>49866</p> |  |  |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure an effective pest control program was maintained to keep the facility free of pests. This failed practice had the potential to affect residents according to the list provided by the Dietary Supervisor on 05/21/2024 at 12:16 AM.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On 05/21/2024 at 12:21 PM, the following observations were made in the kitchen in [NAME] House #3:             <ol style="list-style-type: none"> <li>a. There were three flies on the counter by the 3-compartment sinks.</li> <li>b. There were two flies by the sink faucet.</li> <li>c. One fly was on the container of honey by the 3-compartment sink.</li> <li>d. There were two flies on the cabinet above the food preparation counter.</li> <li>e. One fly on the handle of a saucepan on the stove.</li> <li>f. One was on the handle of a pot on the stove that contained gravy.</li> <li>g. Two flies on the exhaustion above the stove.</li> </ol> </li> <li>2. On 05/20/2024 at 4:32 PM, the following observations were made in the kitchen on [NAME] House #3:             <ol style="list-style-type: none"> <li>a. There were three flies on the counter by the 3-compartment sink.</li> <li>b. Two flies on the menu board on the counter.</li> <li>c. Two flies on the cabinet door above the stove and two flies on the wall interface leading to the kitchen.</li> </ol> </li> <li>3. On 05/20/2024 at 4:37 PM, the surveyor informed Certified Nursing Assistant (CNA) #5 that a fly was on a spoon on the counter by the stove. She removed the spoon and stated, We normally shoo them away. We cannot swat them around the food area. We have killed 10 flies already.</li> <li>4. On 05/21/2024 at 8:00 AM, there were four flies on the counter by the 3-compartment sink. Two flies on the menu board and two other flies on the interfacing wall leading to the kitchen. The surveyor asked the Dietary Surveyor how many flies she observed. She stated, There were 8 of them.</li> <li>5. On 05/21/2024 at 8:03 AM, CNA #4 stated, I think because they prop the back door open. We have a resident that likes to go outside and sit to read her book.</li> </ol> <p>(continued on next page)</p> |  |  |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>6. On 05/21/2024 at 08:05 AM, Dietary Supervisor stated, We killed lots of them yesterday and we still have 8 flies in the kitchen.</p> <p>7. In [NAME] House #4, on 05/20/2024 at 4:43 PM, there were three flies on the counter by the 3-compartment sink. Three flies were on the cabinet. Three other flies were crawling on the cabinet below the food preparation counter.</p> <p>8. On 05/21/2024 at 12:18 PM, the Dietary Supervisor stated, We called the pest people on Monday, and they have not been able to make it.</p> |