

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Spencer County		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Taylorsville Rd Taylorsville, KY 40071	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49360</p> <p>Based on observation, interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment for three of 34 sampled residents (Resident [R]29, R44, and R67).</p> <p>The findings include:</p> <p>Review of the facility's policy, titled Resident Rights, effective 06/20/2005, revealed a resident had the right to care in an environment that promoted maintenance or enhancement of each resident's quality of life. Continued review of the facility's policy revealed the resident had the right to a safe, clean, comfortable, and homelike environment, including, but not limited to receiving treatment and support for daily living safely.</p> <p>Observation during initial facility rounds on 07/30/2024 at 10:50 AM, revealed R29 and R44's room shared a bathroom with R67 ' s room. A strong urine odor was noted in the bathroom.</p> <p>Observation of R29 and R44 and R67's shared bathroom on 07/31/2024 at 11:36 AM and on 08/01/2024 at 2:56 PM revealed a strong odor of urine was still present in the shared bathroom.</p> <p>During an interview with the Social Services Director (SSD) on 08/02/2024 at 3:19 PM, she stated the department heads did ambassador rounds daily in resident rooms. The SSD stated the ambassador rounds covered things such as foul odors, clean rooms, and checking for ice in water. The SSD stated she believed all residents had the right to a clean, homelike environment, which meant rooms, especially bathrooms, should not stink. The SSD stated she felt the strong urine odor in the bathroom was caused by the urine being soaked into the floor.</p> <p>During an interview with the Environmental Services Director (ESD) on 08/02/2024 at 3:45 PM, she stated she did not normally smell odors in the facility but had noticed the shared bathroom between R29 and R44's room and R67's room did have urine smell at times. The ESD stated the housekeepers cleaned the bathroom at least twice a day to keep the odors down but stated it did not always work very well.</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 08/02/2024 at 5:24 PM, she stated she was aware of the bathroom issue but had housekeeping cleaning the room daily and as needed for any urine odors. The DON stated the strong urine odor was where the male resident missed the commode and it hit the floor.</p> <p>During an interview with the Administrator on 08/02/2024 at 5:53 PM, she stated she expected all rooms to be comfortable and homelike for all residents in her facility. The Administrator stated she expected the facility to be free from odors and did not expect any odors during resident care to linger. The Administrator stated she had smelled the urine odor in the shared bathroom and considered it to be a lingering odor. The Administrator stated housekeeping had an ongoing issue with the shared bathroom and cleaned it a couple of times a day.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49360</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained free of accident hazards. On 07/30/2024, chemical products were noted underneath the sink of two bathrooms located near the back nurse's station. Additionally, the doors to both bathrooms were noted to be open with eight residents sitting in wheelchairs near the bathrooms and other residents walking near the bathrooms.</p> <p>The findings include:</p> <p>The facility did not produce an Accident/Supervision Policy upon request from the Administrator on 08/02/2024 10:54 AM .</p> <p>Review of the facility's Resident Rights Policy, revised 09/15/2023, revealed it was the facility's policy all residents would be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life.</p> <p>Observation, on 07/30/2024 at 9:05 AM, revealed two public bathrooms near the back nurse's station with open doors. Further observation revealed chemical products underneath the sinks of both bathrooms. These products included Dermafungal cream, Hydrogel wound gel, and Disinfectant Wipes. Further observation revealed eight residents sitting in wheelchairs near the bathrooms and other residents walking near the bathrooms. No staff were observed at the nursing station.</p> <p>Review of the Safety Data Sheet (SDS) for the Dermafungal cream, issued 08/18/2014, revealed health hazards could occur including irritation if the product was placed in the eyes or ingested. Further review revealed an emergency and first aid procedure to flush eyes with water for 15 minutes; if ingested, drink large amounts of water and notify the physician.</p> <p>Review of the SDS for the Hydrogel wound gel, issued 08/18/2014, revealed health hazards could occur including irritation if the product was placed in the eyes or ingested. Further review revealed an emergency and first aid procedure to flush eyes with water.</p> <p>Interview with the Administrator, on 08/02/2024 at 10:54 AM, revealed the facility was unable to provide SDS sheets as an exact match for the disinfectant wipes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the disinfectant wipes, located on the store website, effective date of 07/21/2020, revealed a hazard statement that it may cause an allergic skin reaction. Further review revealed if on skin, wash with plenty of water; if skin irritation or rash occurs, get medical advice/attention; wash contaminated clothing before reuse; contaminated work clothing must not be allowed out of the workplace, dispose of contents/container to hazardous or special waste collection point, in accordance with local, regional, national, and/or international regulation. Continued review revealed first aid measures after skin contact to remove affected clothing and wash all exposed skin area with mild soap and water, followed by warm water rinse; if skin irritation or rash occur, rinse skin with water/shower; get medical advice if skin irritation persists. Additionally, after eye contact, rinse eyes with water as a precaution; if eye irritation persists, get medical advice/attention. Further review revealed first aid measures after ingestion were to rinse mouth, do not induce vomiting, if feeling unwell, seek medical advice.</p> <p>During an interview with the Environmental Services Director (ESD), on 08/02/2024, at 3:45 PM, she stated housekeeping sometimes checks under the common bathroom sinks, probably once every two weeks, and if chemicals are present, they should be poured out and thrown away because they would be harmful and could kill a resident. She further stated her department is not responsible for any creams, lotions or disinfectant wipes.</p> <p>During an interview with the Administrator, on 08/02/2024 at 5:55 PM, she stated the facility should have SDS for all chemicals in the building. She further stated the chemicals found under the sinks were not products that should be stored there and must have been left by staff members in the common bathrooms. She continued to state the chemicals could be hazardous to residents including making them sick or causing death.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44974</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to provide food at palatable temperature for hot foods and at a palatable point of service temperature for three of 34 sampled residents (Residents [R]19, R60 and R13). A test tray was requested on 08/02/2024 and the eggs were 90.7 degrees Fahrenheit (F).</p> <p>The findings include:</p> <p>Review of the facility policy, titled Meal Distribution, revised 02/2023 revealed foods were to be transported to the dining locations in a manner that ensures proper temperature maintenance, protected against contamination, and are delivered in a timely and accurate manner.</p> <p>Interview with R19 on 07/31/2024 at 3:40 PM revealed the food was okay but was often cold. Review of admission record revealed the facility admitted R19 on 07/11/2013 with a diagnoses of cerebral palsy. Review of Minimum Data Set (MDS) with a Assessment Reference Date (ARD) of 01/21/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated resident was cognitively intact.</p> <p>During an interview with R60 on 08/01/2024, at 11:45 AM, the resident stated the food was fair but was frequently cold. Review of R60's Quarterly MDS with an ARD date of 05/23/2024, revealed a BIMS score of 11 of 15 which indicated moderately impaired cognition.</p> <p>Interview with R13 on 08/01/2024 at 12:00 PM revealed the resident was hard of hearing but he was able to communicate that the food was often cold. Review of R13's admission record revealed the facility admitted the resident on 05/13/2024 with diagnosis of cervical disc disorder with myelopathy, quadriplegia, and cervical fusion.</p> <p>Review of R13's Admission MDS with ARD dated 05/31/2024 revealed a Brief Interview for Mental Status (BIMS) score of fourteen of fifteen, which indicated R13 was cognitively intact.</p> <p>A test tray was requested and observation on 08/02/2024 at 8:26 AM revealed the last food cart was loaded by dietary staff and taken to the 300 Wing. At 8:35 AM, the last resident tray was served and the test tray was removed by the District Dietary Manager (DDM). The tray was immediately placed at the nurse's station and temperatures checked by the DDM. The food was noted to be served in a Styrofoam container with lids. The temperatures were as follows: Scrambled eggs 90.7 degrees Fahrenheit (F), Oatmeal 129.3 degrees F, muffin 104.8 degrees F milk 37.9 degrees F, coffee 146 degrees, and orange juice 37 degrees.</p> <p>During an interview with the DDM on 08/02/2024 at 8:35 AM she stated the food should be served at a temperature that is palatable to the residents. She is not sure why the eggs temperatures were so low. She further stated that food that was not kept at appropriate temperatures could cause foodborne illnesses.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/02/2024 at 5:55 PM, with the Administrator, revealed she did a test tray every two weeks for two different meals and had not identified any concerns. She stated she expected foods to be at an appropriate temperature when foods were served to the residents. She further stated she expected the dietary staff to be trained, educated and to follow the food code policy to ensure safety with food served to the residents.</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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44974</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to prepare, distribute, and serve food in a sanitary manner and in accordance with professional standards for food service safety.</p> <p>Dietary staff failed to wash hands and wear gloves prior to cooking resident foods and checking food temperatures on the steam table during the lunch meal on 07/30/2024. A cook, who was crying, was observed to stand at the tray line for approximately five minutes with no face covering and a contract staff member, who was not wearing a hair net, walked through the kitchen three times by the food cart which was being filled with resident food trays.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Food: Preparation revised 02/2023, revealed all foods were prepared in accordance with the Food and Drug Administration (FDA) Food Code. Per the policy, all staff would practice proper hand washing techniques and glove use and the staff would be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.</p> <p>Observation on 07/30/2024 at 11:55 AM in kitchen revealed [NAME] 1 was at the tray line and began plating foods for the lunch meal. [NAME] 1 informed the District Dietary Manager (DDM), that he did not have mashed potatoes prepared yet. The DDM, without first washing her hands, went to the back of the kitchen, brought back a kettle of water and placed it on the stove to boil. She also brought out a plastic bag of potato flakes. The tray line was held up while waiting on the mashed potatoes to be cooked. Continued observation revealed the DDM poured the potato flakes from the bag into the container that she had pulled from steam table and added boiling water, stirred, and placed the mashed potatoes onto the steam table. All tasks were completed without handwashing or gloves. After mixing the potatoes with the boiling water, the DDM checked the temperature of the potatoes.</p> <p>Continued observation at the steam table revealed [NAME] 1 started to cry while standing in front of the tray line while serving food. He had no mask covering his mouth or tears on his face. After approximately five minutes, another staff member came and relieved him.</p> <p>On 07/30/2024 at 12:15 PM, after some resident meals had been plated, the surveyor requested the food temperatures for the foods on the steam table for the lunch meal. The DDM was unable to find or provide the food temperatures. The DDM, without wearing gloves, proceeded to check the food temperatures for the foods on the steam table.</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>Observation on 07/30/2024 at 12:40 PM in the kitchen revealed a contract staff member who services the fish tank entered the kitchen without wearing a hair net. The contact staff was carrying a five-gallon bucket and he passed by a resident food cart which was currently being filled with foods from the tray line. He was noted to fill the bucket in the washroom area of the kitchen three times and take the bucket of water out of the kitchen. Further observation revealed he was noted to be filling the fish tank. An attempt to interview the contract staff was unsuccessful as the contract staff had already left the facility.</p> <p>Interview on 08/02/2024 at 3:45 PM, with the DDM, revealed the facility's dietary manager was responsible for oversight to ensure that staff were wearing appropriate personal protective equipment (PPE) and abiding by guidelines to ensure appropriate food service to residents. Per the DDM, the dietary manager had quit on Sunday prior to the survey and the DDM was currently filling in. She further stated she was in the facility last month but had not been to the facility until 07/30/2024 upon arrival of SSA. Per the DDM, she expected staff to follow the food handling guidelines to ensure safety of food served to residents. She further stated hand washing should be completed anytime a staff member stepped away from the steam table while serving or touched anything else not directly on the steam table. She further stated if appropriate guidelines were not followed the resident goals for nutrition would not be met and could cause an adverse effect to the resident.</p> <p>Interview on 08/02/2024 at 5:55 PM, with the Administrator, revealed she expected the kitchen supervisory staff to educate all the food service staff on sanitation, and handwashing policy and procedures. She stated she expected the Dietary Manager to ensure all the kitchen staff followed the facility's and food code policy and to maintain a clean and sanitary kitchen environment. She further stated the facility has a contract with the fish tank cleaning company and he comes monthly to clean the fish tank. She stated she was not aware he had been utilizing the kitchen area to fill the buckets to refill the fish tank.</p> <p>50828</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47852</p> <p>Based on observation, interview, and facility policy review, it was determined the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>The facility failed to follow the Legionella Water Management Plan. Additionally, laundry staff were observed on 08/01/2024 to fold linen which touched the laundry room floor and the laundry worker's body. A contractor was observed, on 07/30/2024, cleaning the inside of a fish tank with bare hands, then carrying a bucket into the kitchen to obtain water while meal trays were being prepared.</p> <p>The findings include:</p> <p>Review of facility policy Infection Control, dated 01/23/2024, revealed the facility infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Further review revealed facility infection control polices and procedures applied equally to all personnel, consultants, and contractors.</p> <p>1. Review of facility policy Legionella Water Management Plan, dated 01/26/2024, revealed the facility had identified areas where Legionella could grow and Spread to include the Unit Two (2) ice machine. Further review revealed the control measures and monitoring included weekly and monthly testing. However, there was no evidence the Unit Two ice machine had been monitored between 01/05/2024 and 07/06/2024.</p> <p>Review of facility policy Water Management Program, dated 07/24/2024, revealed the facility identified areas where biofilms might be present and areas where opportunistic pathogens of premise plumbing might grow and spread to include ice machines. Further review revealed the facility had identified residents that were immunocompromised, at-risk, taking drugs that weaken the immune system, had renal disease, had diabetes, or had chronic lung disease in the facility. Continued review revealed the facility assessed the need to operate ice machines solenoid valves to check hammer arrester monthly and replace as needed. Additionally, the facility assessed the need to clean and disinfect the ice machines no less than quarterly. However, there was no evidence the facility assessed the Unit Two (2) ice machine between 01/05/2024 and 07/06/2024.</p> <p>During an interview with the Plant Operation Director (POD), on 08/02/2024 at 4:00 PM, he stated he checked all required areas for Legionella either weekly or monthly and documents on the checklist. However, he was unable to provide any evidence on his weekly or monthly checklists that he checked the Unit Two ice machine. He further stated it was important to monitor water sources identified by the facility as areas where biofilms might be present because biofilms could cause residents to become sick.</p> <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 - Many</p>	<p>During an interview with the Administrator, on 08/02/2024 at 5:55 PM, she stated she expected all staff to follow the facility's policies and procedures. She further stated if the policies and procedures for checking water were not followed, it could lead to bacteria in the water and residents could get sick.</p> <p>2. Review of the job description for Laundry Worker, undated, revealed the laundry worker performed laundry activities within well established guidelines to ensure that quality standards, safety guidelines and customer service expectations were met. Further review revealed an essential function of the job was to follow infection control and universal precautions policies and procedures to ensure that a sanitary environment was maintained at all times.</p> <p>Observation, on 08/01/2024 at 3:30 PM, revealed Laundry Worker #1 (LW1), folding a sheet by holding it in the air and folding it. Further observation revealed the edge of the sheet touched the laundry room floor and LW1's body while folding the sheet.</p> <p>During an interview with the Environmental Services Director (ESD), on 08/02/2024 at 3:45 PM, she stated laundry staff should utilize the folding table to fold linens and it was not appropriate to allow the linens to touch the floor or a worker's body while folding the linen. She further stated the floor could have dirt or bacteria on it which could cause bacteria to get on the linen, allowing it to be transferred to a resident and potentially making them sick. She continued to state laundry workers did not typically change clothes throughout the shift and could have bacteria from another room or resident on their clothing, which could transfer to the linen.</p> <p>During an interview with the Administrator, on 08/02/2024 at 5:55 PM, she stated she expected all staff, including contractors, to follow the facility's policies and procedures. She further stated if the policies and procedures for proper laundering were not followed, it could lead to bacteria getting on the linens, transferring to residents, and potentially causing the residents to become ill.</p> <p>3. Observation, on 07/30/2024 at 12:40 PM, revealed a person contracted by the facility to maintain the facility's fish tank, used a cloth and no gloves to clean the inside of the fish tank, then entered the kitchen with a bucket to obtain water. Further observation revealed he did not wash his hands or put on a hair net when entering the kitchen. Continued observation revealed the kitchen was preparing meal trays for facility residents and he walked by a food cart containing resident trays. However, he exited the facility prior to being able to obtain an interview.</p> <p>During an interview with the Administrator, on 08/02/2024 at 5:55 PM, she stated contracted staff were given education on facility Infection Control Policies and Procedures. However, she stated the facility had not provided education to the contracted persons who maintained the fish tank. She further stated they should have been educated on infection control to prevent the spread of germs from the fish tank to the kitchen. She continued to state he should have used a different water source and not entered the kitchen to fill the water bucket.</p>		

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<p>F 0922</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have enough backup water supply for essential areas of the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974</p> <p>Based on observation, interview and review of facility policy, the facility failed to ensure that safe drinking water was available when there was a loss of normal water supply for all residents. The census was 89 residents.</p> <p>The findings include:</p> <p>Review of the Dietary Services Agreement dated [DATE], revealed the contracted company was responsible for following state guidelines, for maintaining an adequate supply of emergency water.</p> <p>Review of the contracted company policy titled Guidelines for Water, not dated, revealed the contract company was to establish a contract with a local vendor to supply bottled water. The inventory guide revealed for non-potable water the amount was to be one gallon per person per day.</p> <p>Observation on [DATE] at 4:20 PM of the facility's emergency water supply revealed the emergency potable water was stored in an approximate 10 foot by 10 foot metal storage building located outside to the back of the facility. The storage building did not have a locking device and floor of the building was a dirt floor covered with gravel. Observation inside the storage building revealed numerous boxes of plastic gallon jugs of water. The boxes of water were sitting on the gravel/dirt flooring of the building. The cardboard boxes were torn open, not intact, with gallon jugs of water lying in different areas of the building, and partially covered with a tarp. The water was not expired; however, there was no heating or cooling device noted to control the temperature of the building.</p> <p>Interview on [DATE] at 9:00 AM with the Maintenance Director revealed the contract company for the kitchen was responsible for provision of non-potable water. He further stated he was not responsible for anything to do with the non-potable water. The Maintenance Director stated he only knew the water had always been stored in the outside building.</p> <p>Interview on [DATE] at 5:55 PM with the Administrator revealed the emergency water was provided by the contracted dietary company but the facility was responsible for the storage of the water. The water should have been in a temperature controlled environment due to the potential for harm of the plastic being to hot or cold which could contaminate the drinking water.</p> <p>49360</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Spencer County		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Taylorsville Rd Taylorsville, KY 40071	
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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<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>49360</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure the facility was free of pest in for four of 34 sampled residents (Resident [R]11, R29, R44, and R67).</p> <p>The findings include:</p> <p>Review of the facility's policy, titled Pest Control, undated, revealed the facility would establish a program for the control of insects and rodents and all areas would be monitored regularly for any signs of pest/vermin.</p> <p>Observation during initial facility rounds on 07/30/2024 at 10:50 AM, in the room shared by R29 and R44 and in R67's room revealed multiple gnats flying around in the room. Continued observation during facility rounds on 07/30/2024 at 11:01 AM revealed R29 and R44's room shared a bathroom with R67 and there were multiple gnats flying in the bathroom.</p> <p>Observation of Resident (R)11's room on 07/31/2024 at 9:18 AM revealed one gnat flying around the breakfast tray while R11 was attempting to eat breakfast.</p> <p>Observation of R29 and R44's room, R67's room and the shared bathroom between the rooms on 07/31/2024 at 11:36 AM and on 08/01/2024 at 2:56 PM revealed gnats still in the room.</p> <p>During an interview with Licensed Practical Nurse (LPN)3 on 07/31/2024 at 8:52 AM, she stated the gnat issue had been bad in the past. LPN3 stated the pest company came and sprayed in resident rooms, but the gnats kept coming back into resident rooms.</p> <p>During an interview with the Social Services Director (SSD) on 08/02/2024 at 3:19 PM, she stated the department heads did ambassador rounds daily in resident rooms. The SSD stated the ambassador rounds covered things such as foul odors, clean rooms, and checking for ice in water. The SSD stated she saw gnats every once in a while, but it was due to residents leaving food items opened and not in a sealed container.</p> <p>During an interview with the Environmental Services Director (ESD) on 08/02/2024 at 3:45 PM, stated she saw gnats every now and then but did not consider it to be a major issue. The ESD stated the housekeepers used a product called Finito, which was sprayed daily to prevent gnats and flies from being in the facility.</p> <p>During an interview with the Plant Operation Director (POD) on 08/02/2024 at 4:00 PM, he stated gnats and flies have been issues. The POD stated he had seen gnats and flies in the facility over the past week and had notified the pest company to come and spray the facility. The POD stated the spray Finito should kill gnats and flies, but stated the residents kept opened food in the facility, which drew gnats and flies to those areas. The POD stated he would not want gnats to be flying around resident's food during meals.</p> <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>During an interview with the Director of Nursing (DON) on 08/02/2024 at 5:24 PM, she stated she expected the residents to have a homelike environment, which meant no gnats or flies in the facility. The DON stated she did not expect to see gnats and flies in the facility.</p> <p>During an interview with the Administrator on 08/02/2024 at 5:53 PM, she stated she expected all rooms to be comfortable and homelike for all residents in her facility. The Administrator stated gnats and flies had been seen some this week.</p>		