

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265683	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Windsor Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 West Benton Windsor, MO 65360	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906</p> <p>Based on interview and record review, the facility failed thoroughly investigate all allegations of possible misappropriation and failed to take steps protect all residents during an investigation process when staff failed to document a thorough investigation of an allegation of possible misappropriation of resident's (Resident #2) property and when the alleged involved staff members (Nurse Assistant (NA) D, NA F, and NA G) continued to work independently with all residents. The facility census was 34.</p> <p>Review of the facility policy titled, Abuse Policy, undated, showed the following:</p> <p>-It is the policy of this facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, physical abuse, misappropriation of resident property and exploitation, and corporal punishment or involuntary seclusion;</p> <p>-All employees who have been alleged to commit abuse will be suspended immediately pending investigation;</p> <p>-The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse, neglect or exploitation or mistreatment while the investigation is in progress.</p> <p>1. Review of Resident #2's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included depression, muscle weakness, diabetes mellitus, and high blood pressure.</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 04/13/24, showed the following:</p> <p>-Cognitively intact;</p> <p>-Verbal behaviors on one to three days of review period.</p> <p>During an interview on 07/25/24, at 10:30 A.M., the Administrator said the following:</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Sometime during 2023, the resident's family came up with a plan to rent the resident's house to an employee of the facility, NA F;</p> <p>-Recently, the resident's family member reported NA F was not paying rent, a vehicle was allegedly missing from the property, and the resident received a citation from the city regarding trash, tall grass, and animals on the property;</p> <p>-The renter of the resident's property was an employee of the facility, NA F;</p> <p>-NA F allegedly moved two other employees into the resident's home, NA D and NA G;</p> <p>-All three NAs were currently employed by the facility;</p> <p>-The Administrator instructed the three staff, NA D, NA F, and NA G, to avoid any interaction with the resident;</p> <p>-The resident was upset the day his/her family member came in to the facility and told the resident about the issues with the property;</p> <p>-The resident's family member alleged the tenants of the resident's home (NA D, NA F, and NA G) were not paying rent;</p> <p>-NA F alleged initially he/she was paying off a large back utility bill owed by the resident and performing some type of work at the property in lieu of paying the resident rent;</p> <p>-The arrangements for NA F to rent the resident's property were allegedly made between the former facility Social Service Director (SSD), who was a relative of NA F, and the resident's family member;</p> <p>-The three alleged perpetrators, NA D, NA F, and NA G, were currently working in the facility and were not suspended pending an investigation;</p> <p>-A documented investigation of the allegation had not been completed.</p> <p>During an interview on 07/25/24, at 1:00 P.M., the resident said the following:</p> <p>-He/she owned a property in the town of Windsor;</p> <p>-The property was supposed to be rented, but he/she did not know what was going on currently with the property.</p> <p>During an interview on 07/30/24, at 12:03 P.M., the resident's family member said the following:</p> <p>-He/she was not responsible for the resident's finances, as the resident was his/her own responsible party;</p> <p>-He/she never collected any money for rent of the resident's property;</p> <p>-NA F was supposed to pay rent to the resident, but that did not appear to be happening;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The NA moved more staff members into the resident's home and they were tearing up the resident's property and piled trash up in the yard;</p> <p>-NA F took the resident's antique truck that was located at the property;</p> <p>-NA F contacted the resident's family member and wanted to make an arrangement to exchange work and paying on a gas bill instead of paying rent, but the family member did not agree to any such arrangement;</p> <p>-The resident and the family member wanted the staff to vacate the resident's home.</p> <p>Review of facility provided records showed the following:</p> <p>-A copy of a rental agreement, dated 07/10/23, between tenant Nurse Aide (NA) F and owner of property (Resident #2) for monthly rent of the resident's property;</p> <p>-The tenant was to pay 350.00 dollars per month in rent commencing on 07/10/23, and in the event the rent was not paid by the 15 th of the month, the tenant agreed to pay a 25.00 dollar late charge;</p> <p>-The rental agreement showed amount received 350.00 dollars.</p> <p>Review of facility provided records showed a copy of a postal money order, dated 10/10/23, from NA F paid to the resident's family member in the amount of 350.00 dollars for rent.</p> <p>Review of the facility provided records showed the following:</p> <p>-A copy of a letter from the City of Windsor to Resident #2, dated 05/14/24, to advise the resident that his/her personal residence was in violation of a municipal code due to the residence containing a substantial accumulation of trash, garbage, and other material susceptible to fire of constituting or providing a harboring place for vermin or other obnoxious animals of insects;</p> <p>-Abate the unsafe condition within 10 days of a public hearing will be set which could result in the City abating the nuisance and placing a special tax bill on the property for the cost of the abatement.</p> <p>Review of the facility's records showed a copy of a notice to vacate the resident's property, dated 06/17/24, signed by the resident. Reason listed as no rent being paid and trash-like living conditions around and inside house.</p> <p>During an interview on 07/25/24, at 11:30 A.M., NA F said the following:</p> <p>-He/she worked at the facility for approximately one and a half years;</p> <p>-Several months ago, he/she needed a place to live. His/her family member worked as the facility SSD at that time and said the resident's family member was looking for someone to live in the resident's home and offered to rent the house to NA F;</p> <p>-He/she worked to clean up the home and paid on a previously owed gas bill instead of paying rent;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The SSD and resident typed up an eviction notice, on the advice of the local law enforcement, and the SSD placed the notice on the front door of the resident's home on 06/17/24;</p> <p>-This was a 30-day notice to the three NAs (NA D, NA F, and NA G) to vacate the premises within 30 days;</p> <p>-The resident's family member was given 350.00 dollars in rent money for the property in July of 2023, and nothing further;</p> <p>-The resident's family member asked about an antique truck that was at the property and NA F said the truck was moved to a friend's house. The resident's family member told the NA to return the vehicle;</p> <p>-On 06/17/24, the SSD went to the facility Administrator with the issue and the Administrator was aware NA D resided in the resident's home;</p> <p>-The previous SSD said the monthly rent money would be placed in the resident's account, but that did not occur;</p> <p>-Staff member NA F, had not compensated the resident per the rental agreement for living in the resident's home;</p> <p>-The Administrator reported the concern to the state elder abuse hotline, but did not conduct a full investigation into the allegation, or suspend alleged perpetrators, because the facility corporation said this was a community issue and not a facility issue.</p> <p>During interviews on 07/25/24, at 3:00 P.M., and on 07/29/24, at 2:13 P.M., the interim Director of Nursing (DON) said the following:</p> <p>-He/she became aware of staff members living in the resident's home approximately two months ago when the City of Windsor called the facility concerned about the condition of the resident's property;</p> <p>-The Administrator contacted the corporate director of operations at that time regarding the situation and he/she advised the Administrator the staff members living in the resident's home did not need to be suspended from work;</p> <p>-He/she was not involved in the plan for the three staff to avoid caring for the resident, He/she was not asked to investigate the allegation of misappropriation;</p> <p>-An allegation of misappropriation of property was when a resident suffered a financial or property loss;</p> <p>-He/she was unsure if staff living in the resident's home would constitute as an allegation of misappropriation of property, because the NA had a contract with the resident to rent to resident's property and at that time the resident was aware of what he/she was doing;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If the facility received an allegation of misappropriation of resident property, the facility should initiate an investigation, interview the resident and staff, suspend alleged perpetrators and self-report the issue to the state survey agency, the family, and police.</p> <p>During an interview on 07/29/24, at 3:16 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> -In June of 2023, he/she was aware NA F moved into the resident's home; -In June of 2024, the City of Windsor called the facility to speak with the resident about citations at the property; -The resident was crying and yelling about the situation; -The SSD called the resident's family member about the situation and the family member reported he/she had not received rent money for the property; -The resident said he/she did not realize the NAs were not paying any rent; -The facility's Director of Operations advised to hotline the issue and to ensure the NAs residing in the resident's home were not caring for the resident; -He/she did not investigate the allegation of misappropriation of resident property, due to issue occurred in the community and not in the facility; -If the facility had an allegation of misappropriation of resident property in the facility, he/she would suspend the alleged perpetrators pending the outcome of the investigation, report the allegation to the state, police, and responsible parties, and conduct an investigation. <p>MO00238090</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906</p> <p>Based on interview and record review, the facility to provide care for all residents consistent with standards of practice when staff failed to implement physician ordered changes for one resident's (Resident #1's) treatment order for affected areas on his/her bilateral (both sides) lower extremities. The facility census was 34.</p> <p>Review of the facility policy titled, Physician Orders, dated March 2015, showed the following:</p> <ul style="list-style-type: none"> -Current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors; -Treatment orders should specify what is to be done, location and frequency, and duration of the treatment. <p>Review of the facility policy titled, Wound Care and Treatment, dated July 2015, showed the physician will specifically order the treatment to be provided (including cleansing, ointments, gauze, dressing type, and frequency of treatments).</p> <p>1. Review of Resident #1's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included cellulitis (skin infection) of both lower extremities, schizophrenia (a mental disorder characterized by reoccurring episodes of psychoses that are correlated with a general misperception of reality), osteoarthritis, muscle weakness, edema (swelling), and pain. <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 04/23/24, showed the following:</p> <ul style="list-style-type: none"> -Cognitively intact; -Application of non-surgical dressings other than to feet; -Application of dressings to feet. <p>Review of the resident's Physician Order Sheet (POS), dated 06/25/24 to 07/25/24, showed the following;</p> <ul style="list-style-type: none"> -An order, dated 06/13/24, for bilateral lower extremities to be cleansed with Hibiclens (an antibacterial and antimicrobial skin cleanser), pat dry, apply baking soda paste (1/2 cup of baking soda, 2 tablespoons (TBSP) of white vinegar, than add a small amount of water until it is a paste) to toes, bottom of foot and top of foot, cover will ABD (absorbent gauze) pads, wrap with Kling (soft rolled gauze) wrap and ACE (an elastic bandage) wraps, change daily. The order was ended on 07/08/24. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated of 07/08/24, for bilateral lower extremities areas from knee down to be cleansed with soap and water, pat dry, apply A&D (protective barrier) ointment, and then apply ABD pads, and wrap with Kling wrap, and then apply ACE wrap, change daily and as needed.</p> <p>Review of the resident's July 2024 Treatment Flowsheet showed the following:</p> <p>-An ordered, dated 06/13/24, to cleanse bilateral lower extremities with Hibiclens, pat dry, apply baking soda paste (1/2 cup of baking soda, 2 tablespoons of white vinegar, than add a small amount of water until it is a paste) to toes, bottom of foot and top of foot, cover will ABD pads, wrap with kling wrap and ACE wraps, change daily;</p> <p>-Nurses initialed completion of this treatment every day from 07/01/24 to 07/21/24;</p> <p>-Nurses did not discontinue the treatment as ordered or update the treatment flowsheet with the new treatment ordered on 07/08/24, as directed by the physician.</p> <p>Review of the resident's weekly skin assessment, dated 07/18/24, showed the following:</p> <p>-Existing non-foot issue with no edema;</p> <p>-Existing issues with left and right foot and ankle;</p> <p>-Bilateral lower extremities remain red, weeping (oozing of clear fluid from the skin), dry patches of skin throughout bilateral lower extremities from knees to toes. Treatment in place.</p> <p>During an interview on 07/29/24, at 12:37 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The nurse who worked on 07/08/24 probably failed to place the treatment order on the treatment flowsheet;</p> <p>-He/she called the Assistant Director of Nursing (ADON) for clarification of the treatment order and the ADON said facility staff were no longer using the Hibiclens, baking soda, and vinegar treatment. The ADON informed the LPN of the current treatment order.</p> <p>During an interview on 07/29/24, at 1:46 P.M., LPN B said the nurse that received the physician's order on 07/08/24 to change the resident's skin treatment should have placed the order into the computer, printed off a new treatment flowsheet, and discontinued the previous treatment order.</p> <p>During an interview on 07/29/24, at 2:06 P.M., Registered Nurse (RN) C said the following:</p> <p>-He/she performed the resident's skin treatment as directed on the treatment flowsheet;</p> <p>-He/she used Hibiclens to clean and applied the baking soda/vinegar treatment to the resident's legs.</p> <p>(continued on next page)</p>		

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>34906</p> <p>Based on interview and record review, the facility failed to have a system in place to ensure nurse aides (NA) completed their training, competencies, and testing in a timely manner when four NAs (NA D, NA F, NA G, and NA H) failed to complete a state approved certified nursing assistant (CNA) training program, competency evaluation, and certification test timely and continued to work providing direct care to residents. The facility's census was 34.</p> <p>Review showed the facility did not provide a policy related to training and certification of NAs/CNAs.</p> <p>1. Review of NA D's personnel file showed the NA hired to work at the facility on 12/28/23 in the nursing department as a NA.</p> <p>During an interview on 07/25/24, at 11:15 A.M., NA D said he/she worked full-time at the facility for approximately six to seven months continuously as a NA. He/she was currently in online CNA class and needed to take his/her last test in class.</p> <p>2. Review of NA F's personnel file showed the NA hired to work at the facility on 03/02/23 in the nursing department as a NA.</p> <p>During an interview on 07/25/24, at 11:30 A.M., NA F said the following:</p> <ul style="list-style-type: none"> -He/she worked at the facility for approximately one and one-half years as a NA, four to five months of which he/she worked part-time and the rest of the time, he/she worked full-time; -He/she was currently in online CNA class and needed to take two more tests to complete the class. <p>3. Review of NA G's personnel file showed the NA hired to work at the facility on 12/20/23 in the nursing department as a NA.</p> <p>During an interview on 07/30/24, at 9:58 A.M., NA G said the following:</p> <ul style="list-style-type: none"> -He/she finished his/her CNA class tests, but he/she was waiting for the facility to check off his/her competency sheets; -He/she spoke with the Assistant Director of Nursing (ADON) and Administrator about the need to complete the competency sheets and he/she was informed they would assist him/her with the sheets when they had time. <p>4. Review of NA H's personnel file showed the following:</p> <ul style="list-style-type: none"> -Hired as a housekeeper on 07/27/23; -Transferred to nursing department on 01/01/24 to work as a NA. <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Windsor Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 West Benton Windsor, MO 65360	
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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/25/24, at 2:58 P.M., NA H said he/she said he/she worked as am NA at the facility since January 2024.</p> <p>5. During an interview on 07/29/24, at 1:46 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <ul style="list-style-type: none"> -He/she was a clinical instructor and volunteered to help some of the NAs get their competencies completed for that portion of the CNA requirement; -NA D and NA F never brought their competency sheets to work with them; -NA G only brought competency sheets one day and did not complete any competencies in front of the nurse. <p>6. During an interview on 07/25/24, at 3:00 P.M., the interim Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> -NAs should become certified within four months of the date of hire; -The facility currently had four NAs working that had worked at the facility for longer than four months; -He/she emailed the online CNA instructor on 07/19/24 to inquire about completing the NAs' testing for CNA class. <p>7. During an interview on 07/29/24, at 3:16 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> -NAs should become certified within four months of hire; -He/she was aware there were four NAs working in the facility had had worked for over four months; -The interim DON would need to complete the competency sheets for the NA competencies; -The DON and ADON should be tracking the CNA class progress of the NAs; -He/she asked the interim DON and ADON to get in touch with the CNA instructor to inquire on the status of the NAs. 		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>34906</p> <p>Based on observation, interview, and records review, the facility failed to implement an effective pest control program to control flies within the facility. The facility census was 34.</p> <p>Review showed the facility did not provide a policy regarding pest control.</p> <p>1. Review of the pest control company's summary of service, dated 04/24/24, showed the following facility recommendations:</p> <p>-Insect Light 001- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Insect Light 4- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Insect Light 003- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Needs new bulb.</p> <p>Review of the pest control company's summary of service, dated 05/22/24, showed the following facility recommendations:</p> <p>-Insect Light 001- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Insect Light 4- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Insect Light 003- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Needs new bulb.</p> <p>Review of the pest control company's summary of service, dated 06/26/24, showed the following facility recommendations:</p> <p>-Insect Light 001- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Insect Light 4- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</p> <p>-Insect Light 003- Insect light trap is not working properly. Please schedule service to ensure effective flying insect control;</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 - Many</p>	<p>-Needs new bulb.</p> <p>During an interview on 07/25/24, at 11:15 A.M., Nurse Assistant (NA) D said flies were sometimes an issue in the facility. Several residents go in and out the door at the end of 300 hall to smoke and the flies enter the building.</p> <p>Observation and interview on 07/25/24, at 1:07 P.M., of Resident #3 showed the following:</p> <ul style="list-style-type: none"> -The resident said the flies in the facility buzz his/her face; -The resident said, I kill 50 flies a day; -Four to five flies buzzed around the resident, landing on his/her legs and bedding. <p>During an interview on 07/25/24, at 1:15 P.M., Resident #4 said the following:</p> <ul style="list-style-type: none"> -The flies have been bad in the facility for the last month and bother the resident; -The flies buzz his/her face and land on his/her skin. <p>Observation and interview on 07/25/24, at 4:40 P.M., of Resident #5 showed the following:</p> <ul style="list-style-type: none"> -The resident in his/her room with three flies buzzing around the resident; -The resident said the flies buzz his/her face and land on his/her skin; -The resident said he/she and other residents told the nurses about the fly issue, but nothing changed. <p>Observation and interview on 07/25/24, at 4:35 P.M., of Resident #7 showed the following:</p> <ul style="list-style-type: none"> -The resident lying on his/her bed while two flies crawled on the resident's blankets; -The resident said, Flies are terrible; -The facility fly issue started about one month ago; -He/she informed staff and they brought the resident a flyswatter; -The flies buzz the resident's face and land on him/her. <p>Observation and interview on 07/25/24, at 4:45 P.M., of Resident #6 showed the following:</p> <ul style="list-style-type: none"> -The resident sat in his/her room and a fly buzzed around the resident's room; -The resident said he/she usually had one to two flies in his/her room at all times; -The resident said he/she used a flyswatter to kill the flies; <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 - Many</p>	<p>-The resident said there were flies in the resident dining room.</p> <p>During an interview on 07/25/24, at 2:15 P.M., the Social Service Director (SSD) said the following:</p> <p>-The facility had a fly issue due to staff and residents going in and out of the facility all the time;</p> <p>-Staff go in and out the exit door located in the dining room. Residents use the external door across from the dining room (the gazebo door), and the exit doors at the ends of 100 and 300 halls.</p> <p>During an interview on 07/25/24, at 4:00 P.M. the Maintenance Director said the following:</p> <p>-The facility had an issue with flies;</p> <p>-When the facility had a fly problem, he/she contacted the pest control company;</p> <p>-The pest control company came to the facility at least monthly and more often, if needed;</p> <p>-The facility had three bug lights located on three of the resident halls, but he/she did not think the bug lights worked;</p> <p>-In April 2024, the pest control company said the facility needed to replace the bug lights located on the hallways;</p> <p>-He/she spoke to the Administrator about the bug lights, but the Administrator said corporate did not want to replace the bug lights;</p> <p>-The pest control company said the bug lights would help control the flies in the facility.</p> <p>During an interview on 07/29/24, at 12:37 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The facility had a fly issue;</p> <p>-The flies were bad in Resident #1's room due to odors in the room;</p> <p>-Staff were in and out the doors all day and the flies entered the building;</p> <p>-All the staff were aware the flies were bad. One of the nurses kept a flyswatter at the nurse's desk to kill flies.</p> <p>During an interview on 07/29/24, at 1:23 P.M., Certified Nurse Assistant (CNA) E said the following:</p> <p>-Resident #1 had a lot of flies in his/her room, the flies buzzed the resident and landed on his/her legs;</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 - Many</p>	<p>-He/she talked with housekeeping about cleaning the room to help with the flies;</p> <p>-He/she talked with several of the charge nurses about the flies;</p> <p>-The pest control company comes to the facility on a regular basis.</p> <p>During an interview on 07/29/24, at 1:46 P.M., LPN B said the following:</p> <p>-The facility had a fly issue because staff and residents were constantly going in and out of the facility;</p> <p>-The facility tried different things over the years to control the flies and he/she had seen the pest control company at the facility;</p> <p>-He/she had suggested plug in fly light, but the Director of Nursing (DON) said no.</p> <p>During an interview on 07/29/24, at 2:13 P.M., the interim DON said he/she had not observed a fly problem in the facility and staff had not reported an issue with flies.</p> <p>During an interview on 07/29/24, at 3:16 P.M., the Administrator said the following:</p> <p>-He/she observed a few flies in the facility;</p> <p>-A pest control company visited the facility at least monthly;</p> <p>-The pest control company said the facility bug lights (located on the resident halls) were not working and they could not obtain parts for the bug lights and therefore would have to replace the entire system;</p> <p>-He/she had sent multiple requests to the facility corporation to notify the bug lights need to be repaired or replaced, but the facility corporate office denied the requests;</p> <p>-He/she tried to educate staff not to go out the dining room door to smoke.</p> <p>MO00239315</p> <p>MO00239350</p>		