| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365601 | A. Building<br>B. Wing | 05/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Alpine Nursing and Rehabilitation Center | 164 Office Park Drive<br>Xenia, OH 45385 |

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|---|---|
| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>Based on record review, staff interview, and review of the facility policy, the facility failed to complete significant change Minimum Data Set (MDS) assessments in a timely manner. This affected one (Resident #7) of 17 residents reviewed for MDS assessments. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #7 revealed an admission date of 11/21/21 with diagnoses including multiple sclerosis, cerebral infarction, and vascular dementia.<br><br>Review of the physician's orders for Resident #7 revealed an order dated 03/04/25 for the resident to be admitted to hospice.<br><br>Review of the significant change MDS assessment for Resident #7 dated 05/01/25 revealed the resident had severely impaired cognition and was dependent on staff for assistance with ADLs.<br><br>Interview on 05/21/25 at 12:35 P.M. with MDS Coordinator #208 confirmed the facility had not completed the significant change MDS assessment for Resident #7 within 14 days as required.<br><br>Review of the facility policy titled Comprehensive Assessments dated March 2022 revealed comprehensive assessments should be conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) manual. |

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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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on record review and staff interview, the facility failed to submit Minimum Data Set (MDS) assessments in a timely manner. This affected one (Resident #59) of 17 residents reviewed for assessments. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #59 revealed an admission date of 10/03/23 with diagnoses including aphasia, dementia, and atrial fibrillation.<br><br>Review of the MDS assessment for Resident #59 revealed the MDS for January had a target date of 01/06/25 and a completion date of 01/27/25, and the MDS for April had a target date of 04/07/25 and a completion date of 04/29/25.<br><br>Interview on 05/21/25 at 01:33 PM with MDS Coordinator #208 confirmed the Resident #59's January 2025 MDS was late and not completed until 01/27/25, and the April 2025 MDS was late and not completed until 04/29/25. MDS Coordinator #208 further confirmed neither of Resident #59's assessments had been transmitted within 14 days as required. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately. This affected one (Resident #66) of 17 residents reviewed for MDS assessments. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #66 revealed an admission date of 03/13/25 with diagnoses including cerebral infarction, chronic obstructive pulmonary disease (COPD), dementia, and anxiety disorder.<br><br>Review of the physician's orders for Resident #66 dated 03/16/25 revealed an order for oxygen two liters per minute (LPM) via nasal cannula (NC) as needed to keep oxygen saturation above 92 percent (%).<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #66 dated 04/04/25 revealed the resident had severe cognitive impairment and required staff supervision and assistance with activities of daily living (ADLs.) Review of section O for special treatments and procedures for the MDS assessment for Resident #66 dated 04/04/25 revealed the resident was not coded for use of oxygen therapy.<br><br>Interview on 05/21/25 at 12:50 P.M. with MDS Coordinator #208 confirmed section O of Resident #66's MDS assessment dated [DATE] was not coded correctly as it did not reflect the resident's use of oxygen therapy.<br><br>Review of the facility policy titled MDS Assessment Coordinator dated November 2019 revealed a licensed nurse should be responsible for conducting and coordinating the development and completion of the resident assessment (MDS). Each individual who completed a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on medical record review, staff interview, and review of the facility, the facility failed to ensure staff monitored tube feeding residuals. This affected one (Resident #40) of one resident reviewed for tube feeding. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #40 revealed an admission date of 08/23/24 with diagnoses including dysphagia following cerebral infarction, atherosclerotic heart disease, chronic obstructive pulmonary disease, and type two diabetes mellitus.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #40 dated 04/02/25 revealed the resident had severely impaired cognition and required substantial staff assistance with activities of daily living (ADLs.)<br><br>Review of the physician's orders for Resident #40 revealed an order dated 04/30/25 to check tube for residual before each feeding with instructions: if residual is above 60 milliliters (ml) hold for one hour and recheck, and if still above 60 ml to call the doctor.<br><br>Review of the care plan for Resident #40 revised 05/07/25 revealed the resident required a feeding tube related to dysphagia. Interventions included administering enteral feedings and fluids as ordered, checking placement of tube, flushing tube as ordered, and notifying physician for increased amounts of residual.<br><br>Review of the Medication Administration Record (MAR) for Resident #40 dated 05/01/25 to 05/21/25 revealed there was no documentation of monitoring the resident for tube feeding residuals.<br><br>Interview on 05/21/25 at 12:30 P.M. with Assistant Director of Nursing (ADON) #207 confirmed there was no documentation of tube feeding residuals being checked for Resident #40 for 05/01/25 to 05/21/25. ADON #207 confirmed Resident #40 had a physician's order to the check the residual before each feeding.<br><br>Review of the facility policy titled Checking Gastric Residual Volume (GRV) dated November 2018 revealed staff should measure GRV to assess the resident's tolerance of enteral feeding and minimize the potential for aspiration. The person performing the procedure should record completion of the task on the administration record. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on review of the medical record review, observation, staff interview, and review of manufacturer's guidelines, the facility failed to ensure the medication error rate was below five percent (%). There were two errors out of 29 medication opportunities resulting in a medication error rate of 6.9%. This affected one (Resident #17) of seven residents reviewed for medication administration. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #17 revealed an admission date of 07/08/24 with diagnoses including type two diabetes mellitus, generalized anxiety disorder, and peripheral vascular disease.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 04/15/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.)<br><br>Review of the physician's orders for Resident #17 revealed an order dated 05/02/25 Humalog insulin 22 units subcutaneously before meals and an order dated 05/06/25 for Glargine insulin 54 units subcutaneously in the morning.<br><br>Observation on 05/20/25 at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #245 administered 22 units of Humalog insulin and 54 units of Glargine insulin to Resident #22 with priming the insulin pens prior to administration.<br><br>Interview on 05/20/25 at 7:47 A.M. with LPN #245 confirmed she did not prime the insulin pens prior to administration to Resident #17.<br><br>Review of the manufacturer's guidelines for Glargine insulin revised November 2018 revealed a safety test should always be performed prior to each injection. After applying a needle to the pen, the nurse should select a dose of two units by turning the dosage selector and hold the pen with the needle pointing upwards. The nurse should then tap the insulin reservoir so that any air bubbles rise up towards the needle and then press the injection bottom all the way in and ensure insulin came out of the needle tip.<br><br>Review of the manufacturer's guidelines for Humalog insulin revised 2023 revealed priming the pen meant removing the air from the needle and cartridge that might collect during normal use and ensure the pen was working correctly. If you did not prime before each injection, you might get too much or too little insulin. To prime the pen, turn the dose knob and select two units. Hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top. Push the dose knob in until it stops and zero was seen in the dose window. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on review of the medical record review, observation, staff interview, and review of manufacturer's guidelines, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #17) of seven residents reviewed for medication administration. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #17 revealed an admission date of 07/08/24 with diagnoses including type two diabetes mellitus, generalized anxiety disorder, and peripheral vascular disease.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 04/15/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.)<br><br>Review of the physician's orders for Resident #17 revealed an order dated 05/02/25 Humalog insulin 22 units subcutaneously before meals and an order dated 05/06/25 for Glargine insulin 54 units subcutaneously in the morning.<br><br>Observation on 05/20/25 at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #245 administered 22 units of Humalog insulin and 54 units of Glargine insulin to Resident #22 with priming the insulin pens prior to administration.<br><br>Interview on 05/20/25 at 7:47 A.M. with LPN #245 confirmed she did not prime the insulin pens prior to administration to Resident #17.<br><br>Review of the manufacturer's guidelines for Glargine insulin revised November 2018 revealed a safety test should always be performed prior to each injection. After applying a needle to the pen, the nurse should select a dose of two units by turning the dosage selector and hold the pen with the needle pointing upwards. The nurse should then tap the insulin reservoir so that any air bubbles rise up towards the needle and then press the injection bottom all the way in and ensure insulin came out of the needle tip.<br><br>Review of the manufacturer's guidelines for Humalog insulin revised 2023 revealed priming the pen meant removing the air from the needle and cartridge that might collect during normal use and ensure the pen was working correctly. If you did not prime before each injection, you might get too much or too little insulin. To prime the pen, turn the dose knob and select two units. Hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top. Push the dose knob in until it stops and zero was seen in the dose window. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure medications were dated upon opening and discarded on or before the expiration date. This affected eight (Residents #6, #8, #10, #24, #28, #44, #49, and #122) and had the potential to affect all of the residents residing in the facility. The facility census was 69 residents.<br><br>Findings include:<br><br>1.Review of the medical record for Resident #28 revealed an admission date of [DATE] with diagnoses including type two diabetes mellitus, chronic kidney disease, and heart failure.<br><br>Review of the physician's orders for Resident #28 revealed an order dated [DATE] for artificial tears eye drops to both eyes twice daily.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #28 dated [DATE] revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.)<br><br>Review of the physician's orders for Resident #28 revealed orders dated [DATE] for prednisone eye drops to the left eye twice daily and bromfenac solution eye drops to the left eye at bedtime.<br><br>Observation on [DATE] at 10:36 A.M. revealed the prednisone eye drops, artificial tears eye drops, and bromfenac eye drops were opened and had not been dated upon opening.<br><br>Interview on [DATE] at 10:38 A.M. with Licensed Practical Nurse (LPN) #219 confirmed the prednisone eye drops, the artificial tears eye drops, and the bromfenac eye drops for Resident #28 had been opened but had not been dated upon opening.<br><br>2.Review of the medical record for Resident #6 revealed an admission date of [DATE] with diagnoses including major depressive disorder, type two diabetes mellitus, and chronic obstructive pulmonary disease (COPD).<br><br>Review of the physician's orders for Resident #6 revealed an order dated [DATE] for Refresh liquid gel eye drops to the left eye once daily.<br><br>Review of the MDS assessment for Resident #6 dated [DATE] revealed the resident had intact cognition and required staff assistance with ADLs.<br><br>Observation on [DATE] at 10:40 A.M. revealed the Refresh liquid gel eye drops for Resident #6 were opened on [DATE].<br><br>Interview on [DATE] at 10:41 A.M. with LPN #219 confirmed the Refresh liquid gel eye drops for Resident #6 were expired and should have been discarded.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3.Review of the medical record for Resident #24 revealed an admission date of [DATE] with diagnoses including chronic kidney disease, type one diabetes mellitus, and bipolar disorder.<br><br>Review of the MDS assessment for Resident #24 dated [DATE] revealed the resident had severe cognitive impairment and required substantial staff assistance with ADLs.<br><br>Review of the physician's orders for Resident #24 revealed an order dated [DATE] for insulin glargine inject 28 units subcutaneously at bedtime.<br><br>Observation on [DATE] at 10:42 A.M. revealed Resident #24's bottle of glargine insulin was opened but had not been dated.<br><br>Interview on [DATE] at 10:43 A.M. with LPN #219 confirmed the bottle of insulin for Resident #24 had been opened but had not been dated.<br><br>4. Review of the medical record for Resident #122 revealed an admission date of [DATE] with diagnoses including COPD, type two diabetes mellitus, and glaucoma.<br><br>Review of the MDS assessment for Resident #122 dated [DATE] revealed the resident had intact cognition and required set up and supervision with ADLs.<br><br>Review of the physician's orders for Resident #122 revealed an order dated [DATE] latanoprost eye drops to both eyes once daily.<br><br>Observation on [DATE] at 10:50 A.M. revealed the latanoprost eye drops for Resident #122 were opened but had not been dated.<br><br>Interview on [DATE] at 10:51 A.M. with LPN #239 confirmed the latanoprost eye drops for Resident #122 were opened but had not been dated.<br><br>5.Review of the medical record for Resident #8 revealed an admission date of [DATE] with diagnoses including cerebral infarction, major depressive disorder, and dry eye syndrome.<br><br>Review of the physician's orders for Resident #8 revealed an order dated [DATE] revealed artificial tears eye drops to both eyes three times daily.<br><br>Review of the MDS assessment for Resident #8 dated [DATE] revealed the resident had intact cognition and required staff assistance with ADLs.<br><br>Observation on [DATE] at 11:01 A.M. revealed the bottle of artificial tears eye drops for Resident #8 were opened but had not been dated.<br><br>Interview on [DATE] at 11:02 A.M. with LPN #245 confirmed the artificial tears eye drops for Resident #8 were opened but had not been dated.<br><br>6. Observation on [DATE] at 11:03 A.M. of the north hall medication cart revealed a bottle of docusate sodium with an expiration date of [DATE].<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on [DATE] at 11:04 A.M. with LPN #245 confirmed the docusate sodium in the north hall medication cart had expired and should have been discarded. LPN #245 further confirmed Residents #10, #44, and #49 had orders for docusate sodium.<br><br>Review of the facility policy titled Administering Medications dated 2001 revealed medications should be administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label should be checked prior to administering. When opening a multi-dose container, staff should record the date opened on the container. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure foods were labeled and dated properly. This had the potential to affect all of the residents residing in the facility. The facility census was 69 residents.<br><br>Findings include:<br><br>1.Observation on 05/18/25 at 9:09 A.M. of the walk-in refrigerator revealed it contained four pre-made salads and one pitcher of orange liquid which were not labeled or dated.<br><br>Interview on 05/18/25 at 9:15 A.M. with Dietary [NAME] (DC) #342 confirmed the salads and the pitcher of orange liquid were unlabeled and undated. DC #342 confirmed foods should be labeled and dated upon opening.<br><br>2.Observation on 05/20/25 at 10:47 A.M. of the walk-in refrigerator revealed it contained two trays of cups filled with orange liquid which were unlabeled and undated.<br><br>Interview on 05/20/25 at 10:47 A.M. with Kitchen Manager (KM) #334 confirmed the trays of cups filled with orange liquid were unlabeled and undated. KM #334 confirmed foods should be labeled and dated upon opening.<br><br>Review of facility policy titled Food Receiving and Storage dated November 2022 revealed dry foods and refrigerated/frozen foods should be labeled and dated. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff completed proper hand hygiene during medication administration. This affected one (Resident #30) of seven residents observed for medication administration. The facility also failed to ensure staff cleaned glucometers as appropriate after use. This affected one (Resident #3) of one resident with orders for blood sugar checks. Based on medical record review, observation, staff interview, review of the facility policy, and review online guidance per the Centers for Disease Control (CDC) the facility also failed to ensure staff disposed of personal protective equipment (PPE) properly. This affected one (Resident #123) of 15 residents with orders for enhanced barrier precautions (EBP.) The facility census was 69 residents.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #30 revealed an admission date of 10/31/22 with diagnoses including schizoaffective disorder, type two diabetes mellitus, and anxiety disorder.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #30 dated 03/06/25 revealed the resident had intact cognition and required setup and supervision with activities of daily living (ADLs.)<br><br>Observation on 05/19/25 at 7:41 A.M. revealed Licensed Practical Nurse (LPN) #219 did not perform hand hygiene before or after medication administration to Resident #30.<br><br>Interview on 05/19/25 at 7:41 A.M. with LPN #219 confirmed she did not perform hand hygiene before or after medication administration for Resident #30.<br><br>Review of the facility policy titled Hand Washing Guidelines dated August 2019 revealed staff should perform hand hygiene before and after providing routine resident care.<br><br>2. Review of the medical record for Resident #3 revealed an admission date of 12/07/23 with diagnoses including chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, and congestive heart failure (CHF).<br><br>Review of the MDS assessment for Resident #3 dated 03/07/25 revealed the resident had moderate cognitive impairment and required staff assistance with ADLs.<br><br>Observation on 05/19/25 at 7:45 A.M. revealed LPN #219 did not clean the glucometer after use for Resident #3.<br><br>Interview on 05/19/25 at 7:47 A.M. with LPN #219 confirmed she did not clean the glucometer after use for Resident #3 and she should have done so.<br><br>Review of the facility policy titled Medication Administration dated 2001 revealed staff should follow established facility infection control procedures when administering medications.<br><br>3. Review of the medical record for Resident #123 revealed an admission date of 05/07/25 with diagnoses including type two diabetes mellitus, CHF, and COPD.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Alpine Nursing and Rehabilitation Center | 164 Office Park Drive<br>Xenia, OH 45385 |

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) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the care plan for Resident #123 dated 05/19/25 revealed the resident had two venous/stasis ulcers to the right leg and was placed in enhanced barrier precautions.<br><br>Observation on 05/21/25 at 11:00 A.M. revealed there was a used yellow disposable gown on an entry table in Resident #123's room.<br><br>Interview on 05/21/25 at 11:02 A.M. with LPN #238 confirmed Resident #123 was on EBP, and she had used a disposable gown for the resident's care earlier in the day but had not discarded the disposable gown after use and instead left the contaminated gown inside the resident's room.<br><br>Interview on 05/21/25 at 01:19 P.M. with Assistant Director of Nursing (ADON) #207 confirmed that gowns were to be disposed of after each use and not left anywhere in a resident's room for reuse.<br><br>Review of the facility policy titled Personal Protective Equipment (PPE) revised May 2023 revealed gowns should be removed and discarded in a dedicated container for waste or linen before leaving the resident room or care area.<br><br>Review of online guidance per the Centers for Disease Control (CDC) titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) on 05/21/25 at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html revealed for residents on EBP revealed staff should position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365601 | A. Building<br>B. Wing | 05/21/2025 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>Based on medical record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure resident rooms were free from pests. This affected one (Resident #23) of 17 residents reviewed for the physical environment. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #23 revealed an admission date of 01/17/25 with diagnoses including e muscular dystrophy, depression, and opioid dependence.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #23 dated 04/23/25 revealed the resident #23 had intact cognition and required set up and supervision with activities of daily living (ADLs.)<br><br>Observation on 05/18/25 at 2:46 P.M. of Resident #23's room revealed there were five ants on bedside table and four ants on windowsill and wall.<br><br>Observation on 05/20/25 at 9:45 A.M. of Resident #23's room revealed there were 10 ants in total on the bedside table, wall, and windowsill.<br><br>Interview on 05/20/25 at 9:46 A.M. with Resident #23 confirmed he had ants present in his room for weeks, he had reported it, but the facility had not responded to his concern.<br><br>Interview on 05/20/25 at 9:49 A.M. with Maintenance Director (MD) #360 confirmed the presence of ants in Resident #23's room. MD #360 further confirmed he would have to call the pest control come out and spray, because he was not allowed to do so.<br><br>Review of the facility policy titled Pest Control/Pest Surveillance dated 01/03/25 revealed the facility had a policy which promoted pest eradication and the factility would use an outside pest control company for monthly and emergency treatments. |