STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365757	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadview Multi Care Center	5520 Broadview Rd Parma, OH 44134

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility self-reported incidents (SRIs), personnel file review, interviews and review of the facility policy, the facility failed to ensure residents were free from misappropriation. This affected six (Residents #26, #127, #156, #165, #167, and #168) out of seven residents reviewed for misappropriation. The facility census was 160. Findings include:1. Review of the medical record for Resident #127 revealed an admission date of 05/22/25 with diagnoses including chronic renal disease requiring dialysis, diabetes, respiratory failure and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #127 had impaired cognition. Review of the screenshot of Resident #127's phone dated 07/26/25 revealed on 07/26/25 at 12:10 P.M. her credit card was used at 12:10 P.M. for a DoorDash purchase from a restaurant named, Empanadas for $24.39. The screenshot also revealed on 07/26/25 at 12:37 P.M. her credit card was used for an online purchase at [NAME] Secret.com for $79.34. The screenshot revealed the last four digits of the credit card were [####]. Review of the DoorDash receipt (provided by Former Certified Nursing Assistant (CNA) #612) from Empanadas dated 07/26/25 at 1:10 P.M. revealed there was a purchase of one combo meal of chicken stew, white rice, and beans as well as a drink. The amount on the receipt was $24.39 and the last four digits of the credit card were [####], the same amount and last four digit on Resident #127's phone screenshot. Review of the Employee Time Entry Report for CNA #612 revealed she worked at the facility on 07/26/25 from 7:00 A.M. to 6:30 P.M., the date Resident #127 revealed her card was used for DoorDash. Former CNA #612 worked 07/28/25, the date Resident #127 reported the incident, from 7:00 A.M. to 11:00 A.M, the time Assistant Director of Nursing (ADON)/Registered Nurse (RN) #609 had her leave the facility. Review of the email dated 07/28/25 at 12:43 P.M. from ADON/RN #609 to the Administrator revealed the morning of 07/28/25 ADON/RN #609 was sitting in the nursing station when Resident #127 returned from her appointment. Former CNA #612 told Resident #127 that she should tell ADON/RN #609 about someone using her bank card on 07/26/25. Resident #127 then showed ADON/RN #609 a text message alert from the bank that someone had ordered Empanadas using her card. Resident #127 reported to ADON/RN #609 that CNA #620 was eating Hispanic food that day at the facility. ADON/RN #609 called CNA #620, and she denied eating Hispanic food, but stated Former CNA #612 was eating Hispanic food. ADON/RN #609 then had Former CNA #612 come into the office and asked if she ordered Hispanic food from Empanadas and she verified she had. ADON/RN #609 then asked her for the receipt from DoorDash which she provided, and it had the same amount and last four digits of Resident #127's credit card (same as the screenshot). ADON/RN #609 then had Former CNA #612 leave the facility and told her not to return until she heard from someone at the facility. Review of SRI tracking #263396 created on 07/29/25 at 5:07 P.M. by the Administrator revealed facility ADON/RN #609 informed the Administrator of Resident #127's allegation of misappropriation. Resident #127 alleged Former CNA #612 used her bank card without her knowledge. ADON/RN #609 interviewed Former CNA #612 as she was present in the facility, but she refused to participate in the investigation. ADON/RN #609 sent CNA #612 home. The SRI revealed Resident #127 already cancelled her bank cards with replacements ordered. Staff interviews were conducted and identified that Former CNA #612 had Hispanic food but did not confirm the allegation. The police department was notified and was onsite. The SRI revealed at this time the facility suspects the incident occurred but was not able to confirm. The facility unsubstantiated the SRI based on the evidence was inconclusive. Resident #127 was reimbursed and an ongoing investigation with the police department continued. Former CNA #612 was removed from the facility. Additional residents were also named in the SRI as victims: Resident #156, Former Residents #165, and #167. Review of the undated SRI investigation statement completed by the Administrator revealed he met with Resident #127 following the allegation of misappropriation and Resident #127 stated she thought one staff member, Former CNA #612, was responsible for the misuse of her credit card. She stated she did not witness Former CNA #612 using the card. ADON/RN #609 was investigating, and Resident #127 replaced her debit card and felt safe having it in her room. Review of the nursing note dated 07/30/25 at 9:52 A.M. and completed by the Administrator revealed he met with Resident #127 who had no additional concerns, and all her items were secured. Review of the Check Authorization Form dated 08/04/25 and completed by the Administrator revealed a check request for $104.00 was requested for the reimbursement to Resident #127 for staff usage of resident card without her consent. Review of receipt dated 08/04/25 revealed Resident #127 signed that she received

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility self-reported incident (SRI), interview and review of facility policy, the facility failed to ensure an allegation of misappropriation was timely reported to the state agency. This affected one (Resident #127) out of seven residents reviewed for misappropriation. The facility census was 160. Findings include:Review of the medical record for Resident #127 revealed an admission date of 05/22/25 and diagnoses included chronic renal disease requiring dialysis, diabetes, respiratory failure and hypertension. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #127 had impaired cognition. Review of the screenshot of Resident #127's phone dated 07/26/25 revealed on 07/26/25 at 12:10 P.M. her credit card was used at 12:10 P.M. for a DoorDash purchase from a restaurant named, Empanadas for $24.39. The screenshot also revealed on 07/26/25 at 12:37 P.M. her credit card was used for an online purchase at [NAME] Secret.com for $79.34. The screenshot revealed the last four digits of the credit card were [####]. Review of the DoorDash receipt (provided by Former Certified Nursing Assistant (CNA) #612) from Empanadas dated 07/26/25 at 1:10 P.M. revealed there was a purchase of one combo meal of chicken stew, white rice, and beans as well as a drink. The amount on the receipt was $24.39 and the last four digits of the credit card were [####], the same amount and last four digit on Resident #127's phone screenshot. Review of the Employee Time Entry Report for CNA #612 revealed she worked at the facility on 07/26/25 from 7:00 A.M. to 6:30 P.M., the date Resident #127 revealed her card was used for DoorDash. Former CNA #612 worked 07/28/25, the date Resident #127 reported the incident, from 7:00 A. M. to 11:00 A.M, the time Assistant Director of Nursing (ADON)/Registered Nurse (RN) #609 had her leave the facility. Review of the email dated 07/28/25 at 12:43 P.M. from ADON/RN #609 to the Administrator revealed the morning of 07/28/25 ADON/RN #609 was sitting in the nursing station when Resident #127 returned from her appointment. Former CNA #612 told Resident #127 that she should tell ADON/RN #609 about someone using her bank card on 07/26/25. Resident #127 then showed ADON/RN #609 a text message alert from the bank that someone had ordered Empanadas using her card. Resident #127 reported to ADON/RN #609 that CNA #620 was eating Hispanic food that day at the facility. ADON/RN #609 called CNA #620, and she denied eating Hispanic food, but stated Former CNA #612 was eating Hispanic food. ADON/RN #609 then had Former CNA #612 come into the office and asked if she ordered Hispanic food from Empanadas and she verified she had. ADON/RN #609 then asked her for the receipt from DoorDash which she provided, and it had the same amount and last four digits of Resident #127's credit card (same as the screenshot). ADON/RN #609 then had Former CNA #612 leave the facility and told her not to return until she heard from someone at the facility. Review of SRI tracking #263396 created on 07/29/25 at 5:07 P.M. by the Administrator revealed facility ADON/RN #609 informed the Administrator of Resident #127's allegation of misappropriation. Resident #127 alleged Former CNA #612 used her bank card without her knowledge. ADON/RN #609 interviewed Former CNA #612 as she was present in the facility, but she refused to participate in the investigation. ADON/RN #609 sent CNA #612 home. The SRI revealed Resident #127 already cancelled her bank cards with replacements ordered. Staff interviews were conducted and identified that Former CNA #612 had Hispanic food but did not confirm the allegation. The police department was notified and was onsite. The SRI revealed at this time the facility suspects the incident occurred but was not able to confirm. The facility unsubstantiated the SRI based on the evidence was inconclusive. Resident #127 was reimbursed and an ongoing investigation with the police department continued. Former CNA #612 was removed from the facility. Additional residents were also named in the SRI as victims: Resident #156, Former Residents #165, and #167. Interview on 08/20/25 at 10:48 A.M. with ADON/RN #609 revealed on 07/28/25 at approximately 11:00 A.M. Former CNA #612 told Resident #127 to tell her that someone used her credit card on 07/26/25. She revealed she went outside with Resident #127, and she showed her two text messages from her bank on her phone for a DoorDash purchase from Empanadas and an online purchase from [NAME] Secrets. ADON/RN #609 revealed Resident #127 stated she had not given anyone permission to use her credit card. ADON/RN #609 revealed she called CNA #620 who had worked on 07/26/25 to ask if she was eating food from Empanadas and she had denied but stated Former CNA #612 was. Former CNA #612 was on duty and had her come to her office. She asked if she received DoorDash from Empanadas at the facility on 07/26/25, and she stated she had. ADON/RN #609 revealed she asked Former CNA #612 for the DoorDash receipt which she showed her, and it matched the same amount and last four-digit numbers of

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, review of a facility self-reported incident (SRI), interviews and review of the facility policy, the facility failed to ensure alleged incidents of misappropriation were thoroughly investigated. This affected five (Residents #26, #156, #165, #167, and #168) out of seven residents reviewed for misappropriation. The facility census was 160. Findings include:1. Review of the medical record for Resident #127 revealed an admission date of 05/22/25 with diagnoses including chronic renal disease requiring dialysis, diabetes, respiratory failure and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #127 had impaired cognition. Review of the screenshot of Resident #127's phone dated 07/26/25 revealed on 07/26/25 at 12:10 P.M. her credit card was used at 12:10 P.M. for a DoorDash purchase from a restaurant named, Empanadas for $24.39. The screenshot also revealed on 07/26/25 at 12:37 P.M. her credit card was used for an online purchase at [NAME] Secret.com for $79.34. The screenshot revealed the last four digits of the credit card were [####]. Review of the DoorDash receipt (provided by Former Certified Nursing Assistant (CNA) #612) from Empanadas dated 07/26/25 at 1:10 P.M. revealed there was a purchase of one combo meal of chicken stew, white rice, and beans as well as a drink. The amount on the receipt was $24.39 and the last four digits of the credit card were [####], the same amount and last four digit on Resident #127's phone screenshot. Review of the email dated 07/28/25 at 12:43 P.M. from ADON/RN #609 to the Administrator revealed the morning of 07/28/25 ADON/RN #609 was sitting in the nursing station when Resident #127 returned from her appointment. Former CNA #612 told Resident #127 that she should tell ADON/RN #609 about someone using her bank card on 07/26/25. Resident #127 then showed ADON/RN #609 a text message alert from the bank that someone had ordered Empanadas using her card. Resident #127 reported to ADON/RN #609 that CNA #620 was eating Hispanic food that day at the facility. ADON/RN #609 called CNA #620, and she denied eating Hispanic food, but stated Former CNA #612 was eating Hispanic food. ADON/RN #609 then had Former CNA #612 come into the office and asked if she ordered Hispanic food from Empanadas and she verified she had. ADON/RN #609 then asked her for the receipt from DoorDash which she provided, and it had the same amount and last four digits of Resident #127's credit card (same as the screenshot). ADON/RN #609 then had Former CNA #612 leave the facility and told her not to return until she heard from someone at the facility. Review of SRI tracking #263396 created on 07/29/25 at 5:07 P.M. by the Administrator revealed facility ADON/RN #609 informed the Administrator of Resident #127's allegation of misappropriation. Resident #127 alleged Former CNA #612 used her bank card without her knowledge. ADON/RN #609 interviewed Former CNA #612 as she was present in the facility, but she refused to participate in the investigation. ADON/RN #609 sent CNA #612 home. The SRI revealed Resident #127 already cancelled her bank cards with replacements ordered. Staff interviews were conducted and identified that Former CNA #612 had Hispanic food but did not confirm the allegation. The police department was notified and was onsite. The SRI revealed at this time the facility suspects the incident occurred but was not able to confirm. The facility unsubstantiated the SRI based on the evidence was inconclusive. Resident #127 was reimbursed and an ongoing investigation with the police department continued. Former CNA #612 was removed from the facility. Additional residents were also named in the SRI as victims: Resident #156, Former Residents #165, and #167. Review of the undated SRI investigation statement completed by the Administrator revealed he met with Resident #127 following the allegation of misappropriation and Resident #127 stated she thought one staff member, Former CNA #612, was responsible for the misuse of her credit card. She stated she did not witness Former CNA #612 using the card. ADON/RN #609 was investigating, and Resident #127 replaced her debit card and felt safe having it in her room. Review of the Check Authorization Form dated 08/04/25 and completed by the Administrator revealed a check request for $104.00 was requested for the reimbursement to Resident #127 for staff usage of resident card without her consent. Review of receipt dated 08/04/25 revealed Resident #127 signed that she received the reimbursement check for $104.00. Review of the undated additional facility investigation revealed face sheets for Residents #26, #156, Former Residents #165, #167, and #168. There was an undated notebook paper that identified other potentially affected residents on the top of the paper dates and last four digits of credit card numbers for each resident. There were no other witness statements, interviews and/ or any other facility investigation including details for the other named resident victims. Review of the Employee Time Entry Report for CNA #612 revealed she worked at the facility on 07/26/25 from 7:00 A.M. to

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, review of the incident accident log, review of manufacture's guidelines, review of the Medication Omission report, review of the Notice of Corrective Action form, review of the Wrong Dose report, review of the National Library of Medicine and review of the facility policy, the facility failed to ensure residents were free of significant medication errors. This affected three (Residents #29, #34, and #169) out of 11 residents observed or reviewed for medication administration. The facility census was 160. Findings include:1. Review of Resident #29's medical record revealed an admission date of 06/04/24 with diagnoses including schizoaffective disorder, chronic respiratory failure, anemia, human immunodeficiency virus (HIV), gastroesophageal reflux disease (GERD), and end stage renal disease (ERSD) requiring dialysis. Review of the care plan dated 06/13/24 revealed Resident #29 had ESRD with dialysis. Interventions included administering medication as ordered, and monitoring lab work as indicated. Review of the care plan dated 06/13/24 revealed Resident #29 had the potential for gastrointestinal distress related to GERD. Interventions included giving medications as ordered, monitoring for abdominal distention, pain, nausea, vomiting heartburn, or indigestion. Review of the August 2025 physician orders revealed Resident #29's orders included: ferrous sulfate oral solution 300 milligram (mg) per five milliliter (ml) (iron supplement) give 5 ml by mouth two times a day as a supplement, midodrine oral 10 mg tablet (medication to treat orthostatic hypotension) give one tablet by mouth one time a day every Monday, Wednesday and Friday, renal multivitamin (supplement) give one tablet by mouth one time a day due to ESRD, and darunavir-cobicistat oral tablet 800-150 mg (medication to treat HIV) give one tablet by mouth one time a day for HIV. There was no order to crush his medications. Observation of the medication administration on 08/20/25 at 7:59 A.M. completed by Licensed Practical Nurse (LPN) #608 revealed she prepared the following medications for Resident #29: Ferrous sulfate 325 milligram (mg) one tablet, darunavir-cobicistat 800-150mg one tablet, [NAME]-Vite one tablet, and midodrine 10 mg one tablet. She then proceeded to crush the medications and mixed in applesauce. Interview on 08/20/25 at 8:22 A.M. and 08/21/25 at 8:53 A.M. with LPN #608 verified she crushed all Resident #29's medications including the ferrous sulfate tablet, darunavir-cobicistat, [NAME]-Vite, and midodrine. She verified Resident #29 did not have an order to crush his medications and verified the above medications should not have been crushed. She stated, I thought he always got them crushed because when she started at the facility that was what she was told. She verified Resident #29 had an order for ferrous sulfate oral solution 300 mg per five ml give 5 ml by mouth and she administered ferrous sulfate 325 mg one tablet instead. Interview on 08/20/25 at 8:26 A.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON) #609 revealed Resident #29 did not have an order to crush his medications, and he takes his medications whole. Interview on 08/20/25 at 12:25 P.M. with Facility Pharmacist #615 revealed Resident #29 had an order for ferrous sulfate oral solution 300 milligram per five ml give 5 ml by mouth two times a day and not ferrous sulfate 325 mg tablet. She revealed the ferrous sulfate 325 mg tablet should not be crushed as it was coated and would alter the medication release mechanism that could cause gastrointestinal issues. She revealed per recommendations darunavir-cobicistat 800-150 mg tablet should not be crushed. Also, she revealed the [NAME]-Vite was also coated and should not be crushed per recommendations. She revealed the Midodrine 10 mg she was unsure as in her system it did not list if can and/or cannot but would refer to the manufacturer guidelines. Interview on 08/20/25 at 1:04 P.M. with Director of Nursing (DON) verified Resident #29 did not have an order to crush his medications and stated LPN #608 should not have crushed his medications including the darunavir-cobicistat 800-150mg tablet, [NAME]-Vite, and Midodrine 10 mg. He verified Resident #29 had an order for ferrous sulfate oral solution 300 mg per five ml give 5 ml by mouth and not ferrous sulfate 325 mg one tablet as well as ferrous sulfate tablets should not be crushed. Review of the Symtuza, dated 2025, manufacture guidelines for darunavir-cobicistat 800-150 mg tablet revealed the medication had the option to split the pill into two pieces and after splitting the entire dose should be consumed immediately after splitting. There was nothing in the guidelines regarding crushing of the tablet. Review of the National Library of Medicine, dated 10/30/24, revealed ferrous sulfate tablet should not be crushed or chewed. Review of the [NAME]-Vite RX- Uses, Side effects and More, dated 2025, package guidelines revealed do not crush or chew extended-release capsules or tablets as doing so can release all the drug at once increasing the risk of side effects. Review of the Well Wisp, dated 2025, guidelines revealed crushing midodrine was not recommended as it can alter the

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, observation and interview, the facility failed to ensure Resident #29's room was maintained in a clean and sanitary manner. This affected one (Resident #29) out of six residents reviewed for physical environment. The facility census was 160. Findings include:Review of Resident #29's medical record revealed an admission date of 06/04/24 with diagnoses including schizoaffective disorder, chronic respiratory failure, and end stage renal disease requiring dialysis. Review of the care plan dated 06/11/24 revealed Resident #29 was alert and oriented and able to make his needs known. Interventions included encouraging the resident to make a routine, daily decisions, and coach through process if decisions were not forthcoming. There was nothing in his comprehensive care plan regarding hoarding and/or concerns related to not allowing staff to clean/maintain his room in a sanitary manner. Observation during medication administration on 08/20/25 at 7:59 A.M. revealed Licensed Practical Nurse (LPN) #608 entered Resident #29's room and multiple gnats were flying, landing, and/or crawling on his breakfast tray, drink cups, and the straws in his cups that were located on his bedside table next to Resident #29. Also, there were gnats flying around his room, on his bed and on Resident #29. Attempted interview on 08/20/25 at 8:20 A.M. with Resident #29 but he just looked at this surveyor when questions were asked regarding the gnats. Interview on 08/20/25 at 8:22 A.M. with LPN #608 verified there were multiple gnats on his food, cups, and straws as well as flying in his room and on Resident #29. She revealed the gnats were always in Resident #29's room and verified, there were most likely over 40 gnats. She revealed she did not know what the facility was doing regarding the gnats. Interview on 08/20/25 at 8:26 A.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON) #609 verified there were multiple gnats in Resident #29's room on his food, cups, straws, as well as on Resident #29. She revealed the gnats were always in his room as Resident #29 hoards items, but she would let housekeeping know. Observation on 08/21/25 at 8:53 A.M. of Resident #29's room revealed his breakfast tray was on his bedside table with three drinks with straws in each drink. There were multiple gnats climbing all over the leftover food on his tray, up his straws, and on his cups. Gnats were also observed flying throughout the room and on his bed, including on his pillow. On the corner of Resident #29's bedside table, there were five Nutren 2.0 (supplement drink) containers that had multiple gnats crawling on all the containers, especially on the lid area. Interview on 08/21/25 at 9:00 A.M. with LPN #608, who was administering medications in the hallway, revealed Resident #29 had left for dialysis. She verified gnats continued to be in Resident #29's room including on his leftover food, straws, cups, supplement drink containers, and bed. She again stated, they always in there. When asked what the plans were to resolve the concern, she shrugged her shoulders and, in a motion, took her hands and clapped them together as she revealed that was how she tried to get rid of the gnats. She verified there was over 50 gnats in his room. Interview on 08/21/25 at 9:02 A.M. with the Director of Nursing (DON) verified the gnats in Resident #29's room including on his leftover food, straws, cups, and bed. He revealed he was unsure what the facility was doing about the gnats in his room. Interview on 08/21/25 at 9:04 A.M. with Maintenance Director #614 verified the gnats in Resident #29's room and revealed there were most likely over 50 gnats including on his leftover food, drinks, straws, and bed. He was not aware there were gnats in his room. He was not notified on 08/20/25 regarding the gnats observed in Resident #29's room. He stated that staff were to notify him of any pests, and he then addressed any concern. Interview on 08/21/25 at 10:20 A.M. with Housekeeping #607 revealed she sometimes worked on Resident #29's unit and she verified she had routinely seen gnats in his room. She revealed Resident #29 kept food in his room including putting it in his drawers or other spots, but that she had a good rapport with Resident #29 and just had to remind him his room needed cleaned. She revealed Resident #29 never refused to have his room cleaned to her knowledge. Interview on 08/21/25 at 10:45 A.M. with the Administrator revealed the facility did not have an actual pest control policy. This deficiency represents non-compliance investigated under Complaint Number 2583042.