| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/17/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Dallas Nursing & Rehabilitation | 3808 S Central Expwy<br>Dallas, TX 75215 |

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) |
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F 0583

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Keep residents' personal and medical records private and confidential.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214

Based on observation, interview and record review the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for one of five residents (Resident #2) reviewed for privacy.

The facility failed to ensure LVN E locked the computer, which showed Resident #2's wound care information, after she walked away and left the computer unattended.

This failure could place residents at risk of having medical information exposed to others, and cause residents to feel uncomfortable and disrespected.

The findings include:

Record review of Resident #2's face sheet, printed on 05/17/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included sequelae of cerebral infarction (history of a stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of the right side), Type II diabetes, atrial fibrillation (irregular and rapid heart rhythm), cellulitis of lower limb and groin, and congenital pancreatic cyst.

Record review of Resident #2's quarterly MDS assessment, dated 04/30/24, reflected Resident #2 had a BIMS score of 15, which indicated he was cognitively intact.

Record review of the physician orders tab of Resident #2's electronic health record reflected an order with a start date of 05/08/24, which read: Clean wound to the Penis with N/s or wound cleanser pat dry and apply house barrier cream twice daily for

18 days two times a day for wound care for 18 Days.

Observation on 05/17/24 at 2:30 PM through 2:38 PM revealed a computer was unlocked and displayed a wound care reminder for Resident #2. No facility nursing staff were observed at the nurse's station. Two residents and a facility visitor passed the nurses station during this time. At 2:38 PM, LVN D, LVN E and a third nurse were observed exiting Resident #2's room. LVN E returned to the computer at the nurse's station, updated the wound care note, locked the computer and left the nurse's station.

(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/17/2024 |
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| South Dallas Nursing & Rehabilitation | 3808 S Central Expwy Dallas, TX 75215 |

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|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 05/17/24 at 2:29 PM, LVN E stated she worked as the facility's 2:00 PM to 10:00 PM, station 1 nurse for roughly 2 weeks. LVN E stated the computer observed unlocked and unattended was used by her. LVN E stated the system showed a wound care reminder for Resident #2 and she left to see if the residents wound was still active. LVN E stated she walked away from the nurse's station to confirm the residents wound but had forgotten to lock the computer. LVN E stated she was trained to protect all resident's information and to lock her computer before leaving it unattended. LVN E stated her actions violated Resident #2's privacy, as his information could have been seen or recorded by individuals who should not have access to his information.<br><br>In an interview on 05/17/24 at 4:49 PM, the DON stated she was not aware Resident #2's records were left open and unattended. The DON stated it was her expectation for facility nursing staff to uphold HIPAA and lock computer screens when they were away from them. The DON stated all staff were to ensure residents charts were protected at all times. The DON stated leaving residents charts open and unattended could give unauthorized access to resident charts. The DON stated she would in-service staff on HIPAA and would do random computer sweeps.<br><br>In an interview on 05/17/24 at 5:24 PM, the ADMIN stated residents' records should be safe by coverings and locks at all times due to HIPAA, as not doing so could expose residents' records and violate their privacy. The ADMIN stated nursing staff who accessed any resident information were to ensure the records were secure and protected. The ADMIN stated she would in-service staff on HIPAA, confidentiality and privacy.<br><br>Record review of the facility's policy entitled Resident Rights, revised in December 2016, read in part:<br><br>. 3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA Compliance Officer |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214<br><br>Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for three of three residents (Residents #2 and #1) reviewed for ADL care.<br><br>The facility failed to ensure Residents #2 and #1 bathed/showered three times a week as per their shower schedule.<br><br>This failure could place residents at risk of skin breakdown, infection and loss of self-esteem.<br><br>The findings include:<br><br>1. Record review of Resident #2's face sheet, printed on 05/17/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included sequelae of cerebral infarction (history of a stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of the right side), Type II diabetes, atrial fibrillation (irregular and rapid heart rhythm), cellulitis of lower limb and groin (bacterial infection), and congenital pancreatic cyst.<br><br>Record review of Resident #2's quarterly MDS assessment, dated 04/30/24, reflected Resident #2 had a BIMS score of 15, which indicated he was cognitively intact.<br><br>Record review of Resident #2's care plan, revised on 04/03/24, reflected the following:<br><br>The resident has an ADL self-care performance deficit r/t obesity. Recent CVA with right sided weakness. Provisions are made to care as needed, when patient is able to assist more, requiring less support of staff, staff allows patient to do so, at other times when<br><br>patient may not be able to assist as much, staff provides more support to ensure that all needs are met. Limited Mobility . Intervention : Bathing/Showering: The resident is totally dependent on 2 staff to provide bed bath and as necessary.<br><br>Record review of the tasks tab of Resident #2's electronic health record, showering/bathing task reflected No data found, for the past 30 days.<br><br>Record review of Resident #2's Shower Sheets from March 2024 through May 2024 reflected Resident #2 received a bed bath on 04/03/24, 04/10/24, 04/24/24, 05/07/24 and 05/13/24.<br><br>In an interview on 05/17/24 at 10:47 AM, Resident #2 stated he was well. Resident #2 stated he had issues getting his bed baths according to his scheduled days, which were Mondays, Wednesdays and Fridays. Resident #2 stated when he asked the facility staff for a shower, he was told there were not enough staff to give him a shower. Resident #2 stated he received his last bed bath on Monday, 05/13/24. Resident #2 stated he reported his shower issues to the ADMIN and DON, but nothing had changed, which upset him.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 3808 S Central Expwy Dallas, TX 75215 | |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Record review of Resident #1's face sheet, printed on 05/17/24, reflected Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses which included acute kidney failure, gastrointestinal hemorrhage, major depressive disorder, extrarenal uremia (functional kidney disease), type 2 diabetes and essential hypertension.<br><br>Record review of Resident #1's MDS assessment, dated 04/07/24, reflected Resident #1 had a BIMS score of 08, which indicated a moderate cognitive impairment. Section GG - Functional Abilities and Goals, question GG0130, reflected Resident #1 required substantial assistance with ADLs of toileting hygiene, showering and dressing.<br><br>Record review of Resident #1's care plan, revised on 03/28/24, reflected the following:<br><br>.Focus: The resident has an ADL self-care performance deficit r/t CVA /c right side hemiparesis. Bed- partial to substantial assist of 1-2 Transfers- partial to substantial assist of 1- 2 Eating- partial assist of 1. Toileting- partial to substantial assist of 1-2 Provisions are made to care as needed, Level of assistance may vary depending on my condition. Interventions . Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated<br><br>Record review of the tasks tab of Resident #1's electronic health record, titled showering/bathing task reflected No data found, for the past 30 days.<br><br>Record review of Resident #1's Shower Sheets from March 2024 through May 2024 reflected Resident #1 received a bed bath on 04/12/24, no other shower documentation was reviewed.<br><br>In an interview on 05/17/24 at 11:37 AM, Resident #1 stated he received his showers but could not indicate when his last shower was or how often he received showers.<br><br>In an interview on 05/17/24 at 12:42 PM, LVN A stated she was the Station 1 nurse, who assigned to Halls 100, 200, and 300. LVN A stated she had not received any complaints regarding residents not receiving their showers. LVN A stated she had not received any reports of Resident #1 or Resident #2 refusing showers.<br><br>In an interview on 05/17/24 at 3:30 PM, the DON stated she was unaware of the lack of shower documentation for Residents #1 and #2. The DON stated the facility aides were responsible for all ADL care and facility nurses were to ensure ADLs were completed. The DON stated if the system showed a task as no data found, it meant the task was not schedule and the system would not alert staff the task needed to be completed. The DON check the electronic care system and confirmed showers were not scheduled, thus unable to be documented when completed. The DON stated she would immediately update the residents' systems. The DON stated aides also documented showers in the facility's shower log book at the nurse's station. The DON stated she was unaware Resident #1 had 1 shower and Resident #2 had 5 showers documented in the Shower Log book for the past month. The DON stated residents should receive showers according to their schedule and as requested. The DON stated she was certain the residents had received their showers or bed baths but possibly staff forgot to document.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 05/17/24 at 4:08 PM, CNA F stated she was Resident #2's 2:00 PM to 10:00 PM aide. CNA F stated as the aide she was responsible for all ADL care, like incontinent care and showers. CNA F stated showers were provided to the residents in even rooms on B-bed during her shift. CNA F stated she believed Resident #2 received a bed bath on Monday, 05/13/24. CNA F stated showers were documented on shower sheets and electronically. CNA F stated she could not recall how often she provided Resident #2 with a shower.<br><br>In a follow-up interview on 05/17/24 at 4:49 PM, the DON stated it was the facility's expectation for residents to be provided showers according to schedule, upon request and the task be documented, regardless of outcome. The DON stated all nursing staff were to ensure showers were provided. The DON stated showers not received regularly could lead to an unclean appearance, behaviors, depression and infections. The DON stated he would in service staff on ADL care and she and the ADON would conduct shower sheet audits to ensure all showers were given and documented.<br><br>In an interview on 05/17/24 at 5:24 PM, the ADMIN stated she was not aware of the lack of showers provided and documented for Residents #1 and #2. She stated showers should be done according to the facility's schooled and documented. The ADMIN stated aides were to complete the showers and nurses were to ensure the shower was provided and documented correctly. She stated not receiving regular showers could lead to skin breakdown. The ADMIN stated she would begin an in service on ADL Care and documentation. The ADMIN stated the Assistant Director of Nursing would be tasked with shower documentation audits to ensure showers were provided and documented as needed.<br><br>Record review of the facility's policy entitled Activities of Daily Living (ADLs), Supporting, revised in March 2018, read in part:<br><br>Policy Statement: Residents will [be] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>42214<br><br>Based on observation, interview and record review the facility failed to ensure the nurse staffing information was posted on a daily basis for one of twenty-one days (05/17/24) reviewed for nursing services and postings.<br><br>The facility failed to update the posting of the daily staffing information on 05/17/24.<br><br>This failure could place residents at risk of not having access to information regarding staffing data and facility census.<br><br>The findings include:<br><br>Observation on 05/17/24 at 9:30 AM of the building revealed the daily nursing staff posting was posted near the dining room with a date of 05/16/24.<br><br>Observation on 05/17/24 at 11:50 AM of the building revealed the daily nursing staff posting was posted near the dining room with a date of 05/16/24.<br><br>Observation on 05/17/24 at 3:05 PM of the building revealed the daily nursing staff posting was posted near the dining room with a date of 05/16/24.<br><br>In an interview on 05/17/24 at 4:49 PM, the DON stated she was not aware the nurse staffing posting was not updated for 05/17/24. The DON stated the ADON was to ensure the posting was updated daily. The DON stated the ADON usually provided daily nurse staffing sheets in two-week increments, at every pay period, but she had not provided the sheets for the current pay period. The DON stated the facility residents would not be provided with nurse staffing if the posting was not updated daily. The DON stated she would in-service staff on required posting updates, train the receptionist to update the posting in the ADON's absence and check the nurse staffing post at the beginning of each shift to ensure it was updated correctly.<br><br>A telephone interview was attempted with the ADON on 05/17/24 at 5:15 PM but was unsuccessful.<br><br>In an interview on 05/17/24 at 5:24 PM, the ADMIN stated she did not know the nurse staffing posted was not updated for 05/17/24, but it should have been updated at the start of the day. The ADMIN stated the ADON and receptionist were responsible for updating the daily nurse staffing posting. The ADMIN stated the ADON worked in the facility last night (05/16/24) and did not leave the sheets for this pay period. The ADMIN stated her residents were not affected, as they did not pay attention to the posting, but they would be misinformed if the post was not updated daily. The ADMIN stated she would in-service staff on the daily posting and monitor the posting area to ensure it was updated.<br><br>A related policy was requested from the ADMIN on 05/17/24 at 5:24 PM but was not provided prior to exit. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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** 42214<br><br>Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for one of five residents (Resident #2) reviewed for storage of medication.<br><br>The facility failed to ensure a 0.9% sodium chloride syringe was not stored at Resident #1's bedside table and failed to ensure it was secured in the medication cart or medication room.<br><br>This failure could place residents at risk of medication misuse.<br><br>The findings include:<br><br>Record review of Resident #2's face sheet, printed on 05/17/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included sequelae of cerebral infarction (history of a stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of the right side), Type II diabetes, atrial fibrillation (irregular and rapid heart rhythm), cellulitis of lower limb and groin, and congenital pancreatic cyst.<br><br>Record review of Resident #2's quarterly MDS assessment, dated 04/30/24, reflected Resident #2 had a BIMS score of 15, which indicated he was cognitively intact.<br><br>Record review of the progress notes tab of Resident #2's electronic health record reflected a progress note, dated 04/23/24, and written by LVN B, reflected the following:<br><br>Resident [#2] readmitted back to facility to room [ROOM NUMBER]B, transported by [company] via stretcher, resident able to roll himself to bed x1 person assist. resident AAO x3 able to make needs known, resident reoriented to his room use of call light and bed control resident acknowledges understanding. Resident has a double lumen central line to his right upper chest flushed patent .<br><br>Record review of the physician orders tab of Resident #2's electronic health record, dated 04/24/24, revealed the following order:<br><br>Flush Central Line With 5ml Normal Saline Pre and Post Medication Administration. Flush With 5ml Of Heparin Post Med Administration Every Day and Night Shift Related to Cellulitis of Left Lower Limb<br><br>Interview and observation on 05/17/24 at 10:27 AM revealed Resident #2 in his room, lying in his bed. There was a packaged syringe labeled 0.9% sodium chloride and several alcohol swabs on Resident #2's bedside table. Resident #2 stated the facility nurses put the saline solution in his port, while pointing at the right side of his chest, and stated they always leaving something in here. Resident #2 stated he did not pay attention to when the syringe was left in his room but the last two nurses who came in his room used a syringe on his port.<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 - Few | In an interview and observation on 05/17/24 at 12:42 PM, LVN A stated she was the nurse for Station 1, which covered the facility's 100, 200 and 300 halls. LVN A stated she was not aware that a syringe was left in a resident's room. LVN A accompanied the State Surveyor to Resident #2's room to observe the syringe left in the room. LVN A stated the syringe was a flush used to flush the resident's central line and it should have been taken out of the room with the nurse who bought it in the room. LVN A stated she did not leave the syringe in Resident #2's room, and it must have been left by the morning or overnight nurse. As the State Surveyor was leaving Resident #2's room, he stated LVN A was not his assigned nurse but the nurse in pink(LVN D) was.<br><br>In an interview on 05/17/24 at 1:24 PM, revealed LVN D was Resident #2's assigned nurse for the 6:00 AM to 2:00 PM shift. LVN D stated the syringe observed in Resident #2's room was a saline flush. LVN D stated she flushed Resident #2's central line before and after his morning medication administration. LVN D stated she did not recall leaving a flush in Resident #2's room or seeing a flush in the room when she entered. LVN D stated it was her responsibility as the nurse to remove all medications and any biologicals from a resident's room. LVN D stated she was uncertain of how leaving the flush in a resident's room could affect them and stated a resident could use the flush inappropriately.<br><br>In an interview on 05/17/24 at 4:49 PM, the DON stated LVN D told her of the saline flush that was left in Resident #2's room prior to her interview with the State Surveyor. The DON stated it was her expectation for medication, biologicals and all medication supplies should not be left in a resident's room. The DON stated the saline syringe could be contaminated and accidentally used if left in residents' rooms. The DON stated she would in-service nursing staff on medication storage to ensure medication items were not improperly stored.<br><br>In an interview on 05/17/24 at 5:24 PM, the ADMIN stated it was the facility's expectation for medications, biologicals and supplies to never be left in a resident's room. The ADMIN stated facility nurses were to ensure medications and supplies were not left in resident's room. The ADMIN stated medications and supplies could be tampered with and harm the resident. The ADMIN stated the resident could have attempted to flush his central line himself, but she did not believe Resident #2 would do so, due to his cognition. The ADMIN stated she would in-service staff on medication storage.<br><br>Record review of the facility's policy entitled Storage of Medications, revised in April 2007, read in part:<br><br>Policy Statement: The facility shall store drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: .2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner . 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts |

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|---|---|
| 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214<br><br>Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for one of twelve rooms (room [ROOM NUMBER]) reviewed for pests.<br><br>The facility failed to ensure an effective pest control program was implemented to prevent the presence of gnats in room [ROOM NUMBER].<br><br>This failure could place residents at risk for the potential spread of infection, cross-contamination and decreased quality of life.<br><br>The findings include:<br><br>Observation and interview on 05/17/24 at 11:37 AM in room [ROOM NUMBER] revealed Resident #1 was lying in his bed shaking his head back and forth. Resident #1 stated he was well, and his room was cleaned daily. When Resident #1 moved in his bed, 8 gnats flew off of him and Resident #1 began to shake his head again. Resident #1 stated yes when asked if he had a gnat and fly problem but could not specify how long he had the problem. Resident #1 stated he told staff about the gnats but could not specify who he reported the issue to. Resident #1 moved in his bed again and an additional 5 gnats flew off of him and landed on his privacy curtain and room door. Resident #1 was nonverbal, but able to answer yes and no questions.<br><br>In an interview on 05/17/24 at 12:42 PM, LVN A stated she was employed as the Station 1 nurse form roughly 4 months. LVN A stated Station 1 covered Halls 100, 200, and 300. LVN A stated she had not received any complaints from residents or their families regarding pests like flies and gnats, LVN A stated she was unaware of the gnats observed in room [ROOM NUMBER]. LVN A stated if they saw pest concerns, staff were to record the concern in the pest control binder at the nurse's station and notify the Maintenance Director. LVN A stated she assisted the residents in room [ROOM NUMBER] earlier in the morning and she did not notice the gnats.<br><br>In an interview on 05/17/24 at 2:13 PM, the DOM stated he was unaware of the gnats observed in room [ROOM NUMBER]. The DOM stated he had not received any reports of pests in the building. The DOM stated a pest control company visited the facility roughly twice a week to spray the facility's interior and exterior for common pests like ants, flies and roaches. The DOM stated flying insects could get into residents' foods, drinks and could accidentally be ingested by the residents. The DOM stated he was solely responsible to the facility pest control, as he would spray for pest control issues and report any affected areas to the pest control company. The DOM stated he expected facility staff to document pest control concerns in the maintenance or pest control logs or to report issues to him directly. The DOM stated he would conduct weekly pest control rounds to ensure no pest control issues were addressed as they occurred.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/17/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Dallas Nursing & Rehabilitation | 3808 S Central Expwy<br>Dallas, TX 75215 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 05/17/24 at 5:24 PM, the ADMIN stated it was the facility's expectation for all pests be controlled. The ADMIN stated it was the DOM's responsibility to ensure pests were controlled in the building. The ADMIN stated pests like flying insects could be an issue for residents, as they could get in their food, mouths and could introduce unsanitary living conditions. The ADMIN stated she would in-service facility staff on pest control reporting and conduct daily pest concerns checks to ensure all pest control concerns were addressed.<br><br>Record review of the facility's pest control binder for the months of February 2024 through May 2024, reflected pest control visited the facility on 02/01/24, 03/07/24, 04/01/24 and 05/01/24 for monthly services.<br><br>Record review of the facility's maintenance logs for the months of February 2024 through May 2024, reflected no reports of pests.<br><br>Record review of the facility's, undated, Pest Control policy read in part:<br><br>Policy: To incorporate Integrated Pest Management (IPM) procedures in order to control structural and landscape pests in a safe, efficient and effective manner within the building and on the grounds of [the facility]. |