STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676258	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mememorial City Nursing and Rehabilitation Center	1341 Blalock Houston, TX 77055

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 4 of 4 residents (Resident #1, Resident #2, Resident #3, Resident #4) reviewed for resident rights. The facility failed to ensure staff assisted Resident #1, Resident #2, Resident#3 and Resident #4, by failing to answer call lights in a timely manner to provide assistance. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety. The Findings include: 1. Record review of Resident#1's Face Sheet revealed an [AGE] year-old female admitted to the NF on 7/16/2024 with a diagnosis of hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), type 2 diabetes (body unable to produce insulin). Record review of Resident#1's Baseline MDS assessment dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. Record Review of R#1's Care plan dated 7/16/2024 revealed resident was totally dependent on staff for all her ADL's and staff was to ensure the call light is within reach. (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: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

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Mememorial City Nursing and Rehabilitation Center	1341 Blalock Houston, TX 77055

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/2024 at 9:25 am, during an observation of Resident #1 revealed, she was lying in bed awake. She appeared clean. Her face and hands were not dirty. Her hair was clean. Her call light was on her bed. Observed the commode to be clean without any body fluids. During the attempted interview with Resident #1 who was asked if she could answer a few questions, but she only stared and would not respond. Resident #1's RPOA-A stated Resident #1 didn't feel like talking, but there were some concerns regarding care and cleanliness. RPOA-A stated Resident #1 told him the room had not been cleaned at all on Sunday and Monday. RPOA -A stated he came to the facility yesterday (7/30/2024) evening with a meal during evening mealtime. He stated he personally observed the unclean RM and feces on the floor by Resident #1's bed. RPOA-A stated they were not able to eat because to assist Resident #1 to sit up in bed to eat, would have place him a position to step in the feces that was on the floor by her bed. RPOA -A stated the Commode (bedside toilet seat), which was positioned approximately 3-4 feet from Resident #1's bed, had not been emptied and was full of urine and feces. RPOA -A stated Resident #1 informed him when using commode and wiping afterwards, Resident #1's hand would be dirty of the feces because of the toilet paper filled to the top of the commode for her continuous usage and no one to clean. RPOA -A was informed by Resident #1 that no one answered her call button for assistance, and she tried to get to the commode by herself. However, she had an accident and used the bathroom on the floor. RPOA -A complained, and housekeeping came and cleaned it up. Afterwards they were able to eat the evening meal he came with. RPOA -A did not take any photos. 1. Record review of Resident #2's Face Sheet dated 7/26/2024 revealed a [AGE] year-old male with a diagnosis of Rhabdomyolysis (breakdown of muscle tissue), acute kidney failure, hypothyroidism(thyroid gland does not produce enough thyroid hormone). Record review of Resident #2's baseline MDS dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. Record Review of Resident #2's Care plan dated 7/24/2024 revealed Resident #2 had bowel incontinence. Check resident every two hours and assist with toileting as needed; provide bedpan/bedside commode; provide pericare (washing genitals and anal area) after each incontinent (no control over bowel movement or urination) episode. On 7/31/2024 at 9:40 am, during an observation , Resident #2 was lying in bed, covered and asleep. There was an IV being administered and his call light on his bed. He appeared clean and shaven. There was no attempted interview as Resident was sleeping. Resident #2's RPOA-B was standing next to the bed and had some concerns regarding staffing and cleanliness. In an interview on 7/31/2024 at 9:45 am with RPOA-B revealed some concerns regarding Resident #2's care. RPOA-B stated a FM wrote an email to the HR Department of the facility voicing concerns for the lack of urgency when the call light is pushed. She states it takes over 30 minutes for staff to answer the call lights. 2. Record Review of Resident #3's undated Face sheet revealed a [AGE] year-old male admitted to the NF on 7/10/2024 with a diagnosis to include type 2 Diabetes Mellitus (body doesn't produce enough insulin), Hypertension (high blood pressure) and Poly-osteoarthritis (arthritis in five or more joints at the same time). Record review of Resident #3's MDS dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER: Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1341 Blalock Houston, TX 77055	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #3's Care plan dated 7/10/2024, revealed Resident #3 was at risk for falls r/t weakness The interventions were staff are to be sure call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. In an Interview on 7/31/2024 at 9:50 am with Resident #3 regarding call lights he stated most times the call button goes unanswered and when it is answered, the normal response time is over 30 minutes. Resident #3 states a dissatisfaction with the nursing service. 3. Record review of Resident #4's Face Sheet revealed a [AGE] year-old male admitted to the facility 7/24/2024 with a diagnosis of Epilepsy (Seizures) and Todd's Paralysis (temporary paralysis after epilepsy), hypertension (high blood pressure), schizoaffective disorder (hallucinations and delusions). Record review of R#4's MDS dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. Record Review of Resident #4's Care plan dated 7/24/2024 reveals Resident #4 was at risk for elopement (Leaving the facility without permission or proper discharge) and adverse drug reaction (unintended events attributed to the use of medicines). In an interview on 7/31/2024 at 10:00 am, Resident #4 stated the response time for a call button response is about an hour. He states night shift does not respond at all. 4. Record Review of Grievances listed below revealed concerns in achronological order: 5/15/2024 Resident complained about not being immediately changed. Staff terminated. 5/29/2024 Resident alleged a CNA was rude to him when he told her he needed to use his urinal. Resident was told he could just use his brief. CNA removed from the schedule permanently. Staff in-service on abuse & neglect and customer service. 7/21/2024 Resident alleged call light is on for 1hr & a half and nebulizer was on window seal out of reach. Resident state she couldn't get her nebulizer for over an hour. Facility went over resident medications. Customer service for night shift staff and notified. 7/21/2024 Resident alleged during the 11p-7a shift call lights were on 2hrs. Stated staff changed briefs, but resident told to wait for bed linen to be changed on 7a-3pm. 7/22/224 Facility staff listened to concerns, discussed plan of care regarding briefs, shower schedules and linen change. 7/23/24 resolution revealed, DON had customer service in-service for all night shift staff & notified central supply staff member to keep briefs available and on hand for resident. In an interview on 7/31/2024 at 4:00 pm, the CNA revealed when a call light was on, she has responded quickly to the resident. especially within the first 10 minutes. She stated not every CNA works like her; she did not want to expound on that statement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mememorial City Nursing and Rehabilitation Center	1341 Blalock Houston, TX 77055

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 7/31/2024 at 6:15 pm with Resident #6, she stated she was the RCP and call lights were still an issue even after she filed a grievance. She stated residents are waiting over 20 minutes for their call lights to be answered throughout the day and evening. In an interview on 7/31/2024 at 6:30 pm, R#5 revealed the call light took almost an hour to be answered. In a telephone interview on 7/31/2024 at 7:20pm, RPOA-C revealed nursing services are horrible. Stated her FM is always calling her about how it takes an hour or more for staff to answer their call lights. In an interview on 7/31/2024 at 9:15 pm with the DON, she stated staff were in-serviced on answering calls (she provided documentation of signed in-service). She states she has come to the facility in the early hours to see if staff are doing their jobs. She states she knows this is an issue as residents have continuously complained to her and as a result has been diligently doing the best she can to address. The DON states her two ADON's also come into the facility unexpected during the morning hours (3rd Shift) to see if resident's call lights are on. The DON showed text messages that she has written to her night shift charge nurses telling them they are responsible for getting the call light issues with the nursing staff under control. One of the text messages indicated staff would be disciplined if caught not answering call lights or not doing their jobs. Record Review of Facility's Policy on Resident Rights dated November 2021: Dignity and Respect Page 1 states You have the right to live in safe, decent and clean conditions; be treated with dignity, courtesy, consideration and respect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER: Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1341 Blalock Houston, TX 77055	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 4 of 4 residents (Resident #1, Resident #2, Resident #3, Resident #4) reviewed for resident rights. The facility failed to ensure staff assisted Resident #1, Resident #2, Resident#3 and Resident #4, by failing to answer call lights in a timely manner to provide assistance. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety. The Findings include: 1. Record review of Resident#1's Face Sheet revealed an [AGE] year-old female admitted to the NF on 7/16/2024 with a diagnosis of hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), type 2 diabetes (body unable to produce insulin). Record review of Resident#1's Baseline MDS assessment dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. Record Review of R#1's Care plan dated 7/16/2024 revealed resident was totally dependent on staff for all her ADL's and staff was to ensure the call light is within reach. On 7/31/2024 at 9:25 am, during an observation of Resident #1 revealed, she was lying in bed awake. She appeared clean. Her face and hands were not dirty. Her hair was clean. Her call light was on her bed. Observed the commode to be clean without any body fluids. During the attempted interview with Resident #1 who was asked if she could answer a few questions, but she only stared and would not respond. Resident #1's RPOA-A stated Resident #1 didn't feel like talking, but there were some concerns regarding care and cleanliness. RPOA-A stated Resident #1 told him the room had not been cleaned at all on Sunday and Monday. RPOA -A stated he came to the facility yesterday (7/30/2024) evening with a meal during evening mealtime. He stated he personally observed the unclean RM and feces on the floor by Resident #1's bed. RPOA-A stated they were not able to eat because to assist Resident #1 to sit up in bed to eat, would have place him a position to step in the feces that was on the floor by her bed. RPOA -A stated the Commode (bedside toilet seat), which was positioned approximately 3-4 feet from Resident #1's bed, had not been emptied and was full of urine and feces. RPOA -A stated Resident #1 informed him when using commode and wiping afterwards, Resident #1's hand would be dirty of the feces because of the toilet paper filled to the top of the commode for her continuous usage and no one to clean. RPOA -A was informed by Resident #1 that no one answered her call button for assistance, and she tried to get to the commode by herself. However, she had an accident and used the bathroom on the floor. RPOA -A complained, and housekeeping came and cleaned it up. Afterwards they were able to eat the evening meal he came with. RPOA -A did not take any photos. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 Blalock Houston, TX 77055	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Record review of Resident #2's Face Sheet dated 7/26/2024 revealed a [AGE] year-old male with a diagnosis of Rhabdomyolysis (breakdown of muscle tissue), acute kidney failure, hypothyroidism(thyroid gland does not produce enough thyroid hormone). Record review of Resident #2's baseline MDS dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. Record Review of Resident #2's Care plan dated 7/24/2024 revealed Resident #2 had bowel incontinence. Check resident every two hours and assist with toileting as needed; provide bedpan/bedside commode; provide pericare (washing genitals and anal area) after each incontinent (no control over bowel movement or urination) episode. On 7/31/2024 at 9:40 am, during an observation , Resident #2 was lying in bed, covered and asleep. There was an IV being administered and his call light on his bed. He appeared clean and shaven. There was no attempted interview as Resident was sleeping. Resident #2's RPOA-B was standing next to the bed and had some concerns regarding staffing and cleanliness. In an interview on 7/31/2024 at 9:45 am with RPOA-B revealed some concerns regarding Resident #2's care. RPOA-B stated a FM wrote an email to the HR Department of the facility voicing concerns for the lack of urgency when the call light is pushed. She states it takes over 30 minutes for staff to answer the call lights. 2. Record Review of Resident #3's undated Face sheet revealed a [AGE] year-old male admitted to the NF on 7/10/2024 with a diagnosis to include type 2 Diabetes Mellitus (body doesn't produce enough insulin), Hypertension (high blood pressure) and Poly-osteoarthritis (arthritis in five or more joints at the same time). Record review of Resident #3's MDS dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. Record Review of Resident #3's Care plan dated 7/10/2024, revealed Resident #3 was at risk for falls r/t weakness The interventions were staff are to be sure call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. In an Interview on 7/31/2024 at 9:50 am with Resident #3 regarding call lights he stated most times the call button goes unanswered and when it is answered, the normal response time is over 30 minutes. Resident #3 states a dissatisfaction with the nursing service. 3. Record review of Resident #4's Face Sheet revealed a [AGE] year-old male admitted to the facility 7/24/2024 with a diagnosis of Epilepsy (Seizures) and Todd's Paralysis (temporary paralysis after epilepsy), hypertension (high blood pressure), schizoaffective disorder (hallucinations and delusions). Record review of R#4's MDS dated [DATE] did not reveal a BIMS score nor was there an indication of resident's cognitive level. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #4's Care plan dated 7/24/2024 reveals Resident #4 was at risk for elopement (Leaving the facility without permission or proper discharge) and adverse drug reaction (unintended events attributed to the use of medicines). In an interview on 7/31/2024 at 10:00 am, Resident #4 stated the response time for a call button response is about an hour. He states night shift does not respond at all. 4. Record Review of Grievances listed below revealed concerns in achronological order: 5/15/2024 Resident complained about not being immediately changed. Staff terminated. 5/29/2024 Resident alleged a CNA was rude to him when he told her he needed to use his urinal. Resident was told he could just use his brief. CNA removed from the schedule permanently. Staff in-service on abuse & neglect and customer service. 7/21/2024 Resident alleged call light is on for 1hr & a half and nebulizer was on window seal out of reach. Resident state she couldn't get her nebulizer for over an hour. Facility went over resident medications. Customer service for night shift staff and notified. 7/21/2024 Resident alleged during the 11p-7a shift call lights were on 2hrs. Stated staff changed briefs, but resident told to wait for bed linen to be changed on 7a-3pm. 7/22/224 Facility staff listened to concerns, discussed plan of care regarding briefs, shower schedules and linen change. 7/23/24 resolution revealed, DON had customer service in-service for all night shift staff & notified central supply staff member to keep briefs available and on hand for resident. In an interview on 7/31/2024 at 4:00 pm, the CNA revealed when a call light was on, she has responded quickly to the resident. especially within the first 10 minutes. She stated not every CNA works like her; she did not want to expound on that statement. In an interview on 7/31/2024 at 6:15 pm with Resident #6, she stated she was the RCP and call lights were still an issue even after she filed a grievance. She stated residents are waiting over 20 minutes for their call lights to be answered throughout the day and evening. In an interview on 7/31/2024 at 6:30 pm, R#5 revealed the call light took almost an hour to be answered. In a telephone interview on 7/31/2024 at 7:20pm, RPOA-C revealed nursing services are horrible. Stated her FM is always calling her about how it takes an hour or more for staff to answer their call lights. (continued on next page)

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No. 0938-0391

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/31/2024 at 9:15 pm with the DON, she stated staff were in-serviced on answering calls (she provided documentation of signed in-service). She states she has come to the facility in the early hours to see if staff are doing their jobs. She states she knows this is an issue as residents have continuously complained to her and as a result has been diligently doing the best she can to address. The DON states her two ADON's also come into the facility unexpected during the morning hours (3rd Shift) to see if resident's call lights are on. The DON showed text messages that she has written to her night shift charge nurses telling them they are responsible for getting the call light issues with the nursing staff under control. One of the text messages indicated staff would be disciplined if caught not answering call lights or not doing their jobs. Record Review of Facility's Policy on Resident Rights dated November 2021: Dignity and Respect Page 1 states You have the right to live in safe, decent and clean conditions; be treated with dignity, courtesy, consideration and respect.

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F 0925

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47277

Based on observation, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for two (hall 100 & 300) of three halls, in that:

The facility continues to have an infestation of roaches in residents' rooms, nursing stations, on medication carts, hallways and reception area.

This failure placed residents, visitors, facility, and staff at risk of pest infestation, and a negative impact on the physical environment and cleanliness of the facility.

The findings were:

Record Review of Pest Control Dates:

February 2, 2024-Treated all rooms in wing 300, cleaned and checked rodent bait stations and replaced bait.

February 16, 2024-Treated every room in 300 and 400 hallway and therapy room in 200 hall for small cockroach activity.

March 1, 2024 - Treated rooms in 300 and 400 hallways for small cockroach activity.

March 22, 2024-Inspected interior and checked all pest signting logs which had requests for 300 and 400 hallways. Treated gaps in baseboards in hallways.

April 5, 2024 - Checked all logbooks and pest sighting logs which had a request for room [ROOM NUMBER]. Inspected room [ROOM NUMBER] and found activity in tv. Treated rooms again in 300 and 400 hallways. No activity found in 400. Only rooms with activity are in 300 hallway and are found in clutter in closets.

April 19, 2024-Inspected common crawling pests and roaches primarily. No signs of roaches alive or captured.

May 3, 2024 -Courtesy visit to assist cleanburn at account and training

May 22, 2024-treated commong areas, entry points, snack bars, kitchen area, laundry rooms, behind kitchen, back laundry warehouse and cleaning closets. Targeted large and small cockroaches

June 21, 2024- treated interior entry ways and common areas. Cockroaches reported in dining room, spot treated corners of dining room and a couple wall openings were dusted. Spot treated cracks and crevices of kitchen area. Treated and set monitors out in pantry/dry storage.

(continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	July 12, 2024 - serviced the bait stations along the back side before the rain kicked up. Spot treated some active wasp nests while inspecting. Two employees reported small roaches. 1. Very minor German roach activity in desk of the receptionist. 2. Moderate to heavy German roach activity observed in the activities room. Baited heavily and installed insect monitors. July 24, 2024 - Treated rooms 104,106,200,201,203,205-218,315,402,403. Treated drains on the different wings, piney point bistro, creek cafe, [NAME] hill lounge and spring bistro, treated back of kitchen and dishwashing area, front reception desk, treated main dining area. Maintenance did not report any roach activity. July 25, 2024 - In recreation center - small roach activity in the reception desk on the side facing the front door and wing four room [ROOM NUMBER]. Mainly in the mini fridge, base covers, trash can, restroom. Only around 20 live roaches running around. Majority were in an electric hole punch. We tossed the device out as it is infested with roaches. Dusted cracks and crevices and baited individual roaches. Captured 2 juvenile roaches at reception. Record Review of the [Active Pest Log] dated 1/16/2024 - 7/20/2024: January 16, 2024, roaches on nurses' station: January 17, 2024, roaches in room [ROOM NUMBER] January 17, 2024, roaches in room [ROOM NUMBER] January 18, 2024, roach infestation in room [ROOM NUMBER] February 6, 2024, Roaches in rooms 320; 326, 302B, 327, 304 and the nurse's station February 11, 2024 roaches in rooms 314 & 317 March 8, 2024, roaches seen in room by occupant April 2, 2024, Roaches seen in room [ROOM NUMBER] April 10, 2024, Roaches in med room & nurses station April 19 2024, Roaches in the med room and hallway July 29, 2024, med room bunch of dead roaches July 30, 2024, roaches in room [ROOM NUMBER] Observation on 7/31/24 at 9:50 pm, revealed a small roach was observed running across the notepad that was on the conference room table. In an interview on 7/31/2024 at 9:40 am, Resident #4 stated he saw a roach climb up the walls recently and had brought that to the attention of an unknown charge nurse a few days ago. (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/31/24 at 2:39 pm with MS who stated he was unaware of the facility's policy that indicated pest control will be monthly. He stated he was responsible for ensuring Pest Control is called and come to the facility. He stated he is the contact person for the Pest Control company. He stated there has been a roach infestation problem in the facility for over a year. He stated residents have reported this problem to nursing staff who placed the information in the Versacor Log (maintenance sighting log used to identify any issues in the facility regarding roaches or bugs anywhere in the facility for the maintenance supervisor to review). He stated staff are to report roaches as they see them, then he will call Pest Control to come out. He initially stated he had not seen any roaches since pest control last month. He then stated he seen a roach run in the 400 hallway on or about July 15, 2024, or July 16, 2024. He stated he killed it by stepping on it, then cleaned the area where he stepped on it. Afterwards, MS stated he called and was told the hurricane had thrown the schedule off and was told they would be out on July 24, 2024. He could not offer any reason why no pest control was administered in January 2024. He could not offer a reason why there was only one application in June 2024. In an interview on 7/31/24 at 3:49 pm, AA stated, she saw multiple roaches that past Sunday Morning, 7/28/24 in the activities room when she turned the lights on. The roaches scattered, but she didn't stay in there long enough to investigate where they scattered to. She stated informed her supervisor without making any notation in the folder located at the nurse's station. She said she was informed by her supervisor that the pest control guy would be coming out soon. In an interview on 7/31/2024 at 8:45 pm, the LVN stated, there were a lot of roaches throughout the facility. She stated she typically stand or sit on a stool while working. She states when passing medications, she will not lean on the med cart because she has seen roaches on the medication cart. In an interview on 7/31/24 at 9:15 pm, the DON stated she was aware of continued issues regarding roaches. She said Pest Control has been coming twice per month to address and spray for the roach issues throughout the facility. When informed the roach problem is concerning because it's been more than a year and the roach issue still exist, the DON stated she will call the pest control company to see if there is anything else they can do. She stated another option she will use is get another pest control company. Record Review of the facility's Pest Control Policy dated 4/1/2017 revealed, every month service specialists will service each area throughout the facility. However, should the need arise, calls from the facility requesting assistance to a pest issue will be responded to within 30 minutes of the call being received, and an on-site visit will be conducted within 24 hours.