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F 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 24, 2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Preventions (CDC) recommended practices to prepare for COVID-19. The findings on this statement of deficiencies demonstrate non-compliance with 42 CFR part 483 requirements for Long Term Care facilities. Complaint #26118 (AR00025070) was unsubstantiated. Complaint #26152 (AR00025104) was unsubstantiated. Complaint #26153 (AR00025105) was unsubstantiated. Complaint #26129 (AR00025080) was unsubstantiated.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed

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.

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F 000	Continued From page 1 Complaint #26151 (AR00025103) was unsubstantiated. Complaint #26154 (AR00025106) was unsubstantiated.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

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interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, and record review, the facility failed to ensure an indwelling urinary catheter drainage bag was concealed in a privacy bag when in common areas and resident room to promote dignity and maintain privacy for 2 (Residents #20 and #29) of 9 sampled residents who had physician's orders for an indwelling urinary catheter. This failed practice had the potential to affect 9 residents who had physician's orders for an indwelling urinary catheter, as documented on the list provided by the Director of Nursing (DON) on 7/23/2020. The findings are:

1. Resident #20 had a diagnosis of Urinary Obstructive Retention Uropathy. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/8/2020 documented the resident scored 11 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status (BIMS); required supervision with one person assistance for personal hygiene; required supervision with set up assistance only for bed mobility; required limited one person assistance for transfers, dressing and toilet use; and did not have an indwelling urinary catheter.

a. On 7/20/2020 at 11:18 a.m., the resident was lying in the bed. She had a urinary catheter

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drainage bag which contained clear, yellow, urine. The urinary catheter drainage bag was visible to the doorway leading to the hallway. The catheter drainage bag was not in a privacy bag.

b. On 7/21/2020 at 9:16 a.m., the resident was sitting on the side of the bed. She had a urinary catheter drainage bag was draining clear, yellow urine and was visible through the door to the hallway. The urinary catheter drainage bag was not in a privacy bag.

c. On 7/22/2020 at 10:35 a.m., the resident was sitting on the side of the bed reading a newspaper. The resident's urinary catheter drainage bag was visible through the door to the hallway. The urinary catheter drainage bag was not in a privacy bag.

2. Resident #29 had a diagnosis of Urinary Retention due to Neurogenic Bladder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/17/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; was always continent of bowel; and had an indwelling urinary catheter.

a. On 7/20/2020 at 10:05 a.m., Resident #29 was sitting up in her recliner in her room watching television. She had an indwelling urinary catheter with the drainage bag on the right side of recliner, hanging on the footrest of the recliner. There was no privacy bag present, and the catheter drainage bag was visible from the hallway.

b. On 7/21/2020 at 10:35 a.m., the resident was sitting up in her recliner in her room watching television. She had an indwelling urinary catheter

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F 550	Continued From page 4 with the drainage bag on the right side of the recliner; hanging on the footrest. There was no privacy bag present, and the catheter drainage bag was visible from the hallway. c. On 7/22/2020 at 9:10 a.m., the resident was sitting up in her recliner in her room watching television. She had an indwelling urinary catheter with the drainage bag on the left side of the recliner on the footrest. There was no privacy bag present, and the catheter bag was visible from the hallway.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure a call light was in reach for 1 (Resident #94) of 21 (Residents #94, #34, #78, #8, #81, #19, #37, #39, #26, #85, #1, #35, #48, #5, #2, #57, #80, #24, #29, #20, and #66) sampled residents to ensure they were able to call for staff assistance when needed. This failed practice had the potential to affect 82 residents who resided in the facility, as documented on a list provided by the Administrator on 7/23/2020. The findings are: Resident #94 had a diagnosis of Left Hip Fracture. The Quarterly Minimum Data Set with an Assessment Reference Date of 12/13/2019	F 558		

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documented the resident was moderately impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; was independent with bed mobility, required limited assistance with toilet use, and personal hygiene; was occasionally incontinent of urine; and always continent of bowel.

a. The Care Plan dated 6/23/2020 documented, " ...Maintain functional use of sensor pad at all times for enhanced monitoring..."

b. On 7/22/2020 at 9:17 a.m., the resident was sitting up in a recliner. The resident's call light was on the floor behind the recliner, and not within reach.

c. On 7/22/2020 at 9:23 a.m., Certified Nursing Assistant (CNA) #1 was asked to show this surveyor where (Resident #94's) call light was located. She looked around the room, and stated, "Oh, her call light is on the floor." She picked up the soft touch (pneumatic) call light and placed it in Resident #94's lap.

d. On 7/23/2020 at 11:15 a.m., CNA #2 was asked, "Can [Resident #94] use her call light?" She stated, "Yes she can." She was asked, "Should the call light be in reach at all times?" She stated, "Yes."

F 636 SS=D Comprehensive Assessments & Timing F 636
CFR(s): 483.20(b)(1)(2)(i)(iii)

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

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§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this

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chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure comprehensive Minimum Data Set (MDS) assessments were completed when required to obtain the information necessary to develop a Plan of are to meet the residents' needs for 1 (Resident #2) of 2 (Residents #2 and #34) sampled residents. This failed practice had the potential to affect 6 residents who required comprehensive assessments in the past 30 days, according to a list provided by the Administrator on 7/24/2020 at 10:03 a.m. The findings are:

Resident #2 had a diagnosis of Chronic Obstructive Pulmonary Disease. The Annual Minimum Data Set with an Assessment Reference Date of 6/25/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; and required one-person assistance for medication administration.

a. A Physician's Order dated 6/21/19 documented, "...DuoNeb inhalation solution 1 vial

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updraft QID [four times a day] ..."

b. The Plan of Care with a revised date of 4/8 2020 documented, "...Administer / monitor effectiveness of medication / treatments ..."

c. On 7/21/2020 at 8:49 a.m., the resident was receiving oxygen at 3 liters per minute via nasal cannula. The resident was sitting in a recliner in her room and was administering a breathing treatment to herself. There was no staff in the resident's room. The oxygen tubing was not dated.

d. On 7/21/2020 at 9:17 a.m., Licensed Practical Nurse (LPN) #3 / Minimum Data Set (MDS) Coordinator was asked, "Does the resident have an assessment for self-administration of medication?" She stated, "I am not sure. I will have to look. I think she has an order though." She was asked, "If she has an order, would you have done an assessment?" She stated, "I'm not sure."

e. On 7/21/2020 at 10:00 a.m., the facility provided a Self-Administration Assessment dated 7/21/2020, today's date.

f. On 7/22/2020 at 9:05 a.m., the Director of Nursing was asked, "Should a resident be giving their own breathing treatment if they are not assessed to do so?" She stated, "The nurse went in and sit it up, and the resident didn't want it right then. She usually doesn't do that." She was asked, "Should the treatment have been left in there [the resident's room]?" She stated, "We did an assessment and she has an order for it." She was asked, "Was the order before I asked for the assessment?" She stated, "She has an order

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F 636	Continued From page 9 and the assessment."	F 636		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a hand splint was applied to prevent increased limitation in range of motion for 1 (Resident #57) of 2 (Residents #57 and #80) sampled residents who had functional limitation in range of motion. This failed practice had the potential to affect 3 residents who had functional limitation in range of motion, according to a list provided by the Administrator on 7/23/2020. The findings are: Resident #57 had a diagnosis of Left Hemiparesis following a Stroke. A Quarterly Minimum Data (MDS) with an Assessment	F 688		

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Reference Date (ARD) of 5/13/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; required extensive two-person physical assistance for toilet use; and had functional limitation in range of motion to the upper extremity on one side.

a. The Care Plan documented, " ...Left hand / wrist splint daily 8AM [8:00 a.m.] through 12N [12:00 noon] as tolerated ...)

b. On 7/21/2020 at 11:48 a.m., Resident #57 was sitting in a wheelchair in his room. His left hand was contracted and was resting on a tray which was attached to the wheelchair. He was asked if he could open his left hand. He stated, "No." There was no positioning / splint device in his left hand.

c. On 7/22/2020 at 10:13 a.m., Resident #57 was sitting in a wheelchair. There was no positioning / splint device in his left hand. He was asked if he had ever had a splint or any other device applied to his left arm. He stated, "I used to, but they took it away from me."

d. On 7/23/2020 at 10:15 a.m., Certified Nursing Assistant (CNA) #1 was asked if (Resident #57) used a brace or splint to his left hand. She stated, "Therapy puts it on him when they come around. I'm not sure if they still come or not."

e. On 7/23/2020 at 10:39 a.m., Physical Therapy Assistant #1 was asked if (Resident #57) was supposed to have a brace. She stated, "In-house range of motion. He used to wear a splint. He used to have a splint. He used to have a lot of pain and his arm bothered him from the stroke."

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f. On 7/23/2020 at 10:43 a.m., Restorative Certified Nursing Assistant (RCNA) #1 was asked if (Resident #57) wore a splint to his left hand. She looked at a form on her desk, then she stated, "He has a hand brace for 2 hours in the morning." She was asked, "Do you know why he hasn't been wearing the splint?" She stated, "No, but I'll go see if it's still in his room." RCNA #1 walked down to Resident #57's room. She looked around his room, and in his drawers, and did not locate the splint. She stated, "I'll have to investigate."

g. On 7/23/2020 at 10:48 a.m., Certified Nursing Assistant #1 was asked how long she had worked with (Resident #57). She stated, "Six weeks." She was asked if she had ever applied a splint to his left hand. She stated, "I've never put a brace on his left arm." She was asked, "When was the last time you saw him wearing a splint to his left arm?" She stated, "I am not sure." She was asked, "Why is it important that he wears the splint?" She stated, "Support for that arm."

h. On 7/23/2020 at 11:41 a.m., the Director of Nursing (DON) was asked, "Why is it important that a resident wears a splint / brace, or other assistive device?" She stated, "To prevent decline in contractures, prevent it from getting worse, and maintain where it's at."

i. On 7/23/2020 at 11:50 a.m., the DON was asked for the policy on range of motion or assistive devices. She stated, "We don't have one."

F 695 SS=E Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) F 695

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§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure oxygen was administered at the flow rate ordered by the physician to reduce the potential for respiratory complications for 3 (Resident #1, #8 and #26) who had physician's orders for oxygen administration. This failed practice had the potential to affect 75 residents who had physician's orders for oxygen therapy, as documented in the list provided by the Director of Nursing on 7/24/2020. The findings are:

1. Resident #1 had diagnoses of COVID-19, Respiratory Infection, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease. The 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/2020 documented the resident scored 1 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS); required extensive one-person assistance for transfers and dressing; required limited one-person assistance with bed mobility, toilet use, bathing, and personal hygiene; had shortness of breath with exertion and when lying flat; and required oxygen therapy.

a. A Physician's Order dated 3/26/2020

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documented, "...Oxygen 2 LPM [liters per minute] prn [as necessary]..."

b. On 7/20/2020 at 12:10 p.m., the resident was sitting in the recliner and was receiving oxygen via nasal cannula. The oxygen flow rate was set at 1.5 liters per minute.

c. On 7/21/2020 at 10:38 a.m., the resident was sitting in the recliner and was receiving oxygen at 1.5 liters per minute via nasal cannula.

d. On 7/22/2020 at 10:20 a.m., the resident was sitting in a wheelchair and was receiving oxygen at 1.5 liters per minute per nasal cannula.

e. On 7/23/2020 at 10:58 a.m., Licensed Practical Nurse (LPN) #4 was asked, "Can you tell me how many liters the oxygen is set on?" LPN #4 stated, "1.5 liters per minute."

2. Resident #8 had diagnoses of COVID-19, Right Lower Lobe Pneumonia, and Lymphocytic Leukemia. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); required limited assistance for bed mobility, transfers, dressing, toileting, personal hygiene; had shortness of breath with exertion, when sitting at rest, and when lying flat; and required oxygen therapy.

a. The Physician's Order Listing dated July 2020 documented, "...Oxygen 2LPM [liters per minute] prn [as needed] via nasal cannula..."

b. On 7/20/2020 at 12:10 p.m., the resident was

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receiving oxygen with the flow rate on the oxygen concentrator set on 3 liters per minute via nasal cannula.

c. On 7/21/2020 at 10:38 a.m., the resident was receiving oxygen with the flow rate on the oxygen concentrator set on 1.5 liters per minute via nasal cannula.

d. On 7/22/2020 at 10:20 a.m., the resident was receiving oxygen with the flow rate on the oxygen concentrator set on 1.5 liters per minute via nasal cannula.

e. On 7/23/2020 at 10:57 a.m., Licensed Practical Nurse (LPN) #4 was asked, "Can you tell me how many liters the oxygen is set on?" LPN #4 stated, "1.5 liters per minute."

3. Resident #26 had diagnoses of Non-insulin Dependent Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and COVID-19. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/2020 documented the resident scored 10 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status; required limited one-person assistance for personal hygiene; had no shortness of breath; and required oxygen therapy. The resident has had a decline since he has developed COVID-19 and a Significant Change Minimum Data Set assessment was due to be completed next week.

a. The Care Plan dated 4/24/2020 documented, " ...Resident has potential for difficulty breathing related to chronic condition ... COPD [Chronic Obstructive Pulmonary Disease... Approaches ...

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F 695	Continued From page 15 Monitor for changes in / development of signs and symptoms of breathing difficulty..." b. The Physician's Order Listing dated July 2020 documented, " ...Oxygen at 1.5 to 2 LPM [liters per minute] via nasal cannula prn [as needed] for shortness of breath related to COVID-19 ..." c. On 7/21/2020 at 9:02 a.m., the resident was lying in the bed. The oxygen concentrator was on and the oxygen flow rate was set at 1.5 liters per minute. The nasal cannula was attached to the oxygen concentrator, and the nasal cannula was lying across the half-bedrail. d. On 7/21/2020 at 10:30 a.m., the resident was lying in the bed. The oxygen concentrator was on and the oxygen flow rate was set at 1.5 liters per minute. The nasal cannula was attached to the oxygen concentrator and was lying on the floor under the resident's bed. e. On 7/21/2020 at 11:49 a.m., the resident was lying in the bed. The oxygen concentrator was on and the oxygen flow rate was set at 1.5 liters per minute (LPM) via nasal cannula. Licensed Practical Nurse (LPN) #1 was asked, "Can you tell me what his oxygen flow rate is set on?" She stated, "It looks like it is between the 1.5 and the 2.0 liters. I corrected it now." She stated, "I am going to check his oxygen saturation rate." She checked the resident's oxygen saturation, and stated, "It's 91 percent. I am going to have them re-position him." She was asked, "Have you changed his oxygen tubing?" She stated, "No. We change that every Sunday and it is dated."	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure food items stored in the refrigerator and freezer were sealed and dated; and dented cans were removed to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential affect 75 residents who received meals from the kitchen, according to the lists provided by the Dietary Manager on 7/21/2020. The findings are:

1. On 7/20/2020 at 10:51 a.m., the following observations were made during the initial tour of the dry storage area with Dietary Employee #1:

a. On 7/20/2020 at 10:52 a.m., one gallon can of fruit cocktail was stored on a shelf in the Dry

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Storage area. The can of fruit cocktail was dented in the seam of the can. Dietary Employee #1 stated, "I must have missed that one."

b. On 7/20/2020 at 10:55 a.m., one bag of salad mix was stored on a shelf in the refrigerator. The bag of salad mix was not sealed, labeled, or dated. Dietary Employee #1 was asked, "Do you see a date?" Dietary Employee #1 stated, "No." Dietary Employee #1 was asked, "Do you see a date on the bag?" She stated, "No, I do not."

c. On 7/20/2020 at 10:58 a.m., one bag of frozen biscuits was stored in a box on a shelf in the freezer. The bag of biscuits was not dated. Dietary Employee #1 was asked, "Do you see a date?" Dietary Employee #1 stated, "It must have been on that tape I just pulled off. No, it's not on that."

2. A facility policy titled "Sanitation Inspection" provided by the Administrator on 7/22/2020 at 12:15 p.m. documented, " ...It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance with applicable state and federal regulations... Policy Explanation and Compliance Guidelines ... 1. All food service areas shall be kept clean, sanitary, free from liter, rubbish, and protected from rodents, roaches, flies, and insects... 5. Inspections will be conducted but not limited to the following areas ... a. Dry storage ... b. Freezer ... c. Refrigerator..."

F 814 SS=E Dispose Garbage and Refuse Properly F 814
CFR(s): 483.60(i)(4)

§483.60(i)(4)- Dispose of garbage and refuse

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F 814	Continued From page 18 properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure trash was properly contained within 2 of 2 dumpsters, to minimize the presence of foul odors and decrease the potential for pest infestation. The failed practice had the potential to affect all 75 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents form dated 7/21/2020. The findings are: 1. On 7/20/2020 at 11:29 a.m., during the tour of the outside 2 dumpsters with Dietary Employee #2, there was trash on the ground around the dumpsters. There were 8 pieces of wet, soiled, paper and an empty paper towel holder on the ground. Dietary Employee #2 was asked, "Should that trash be on the ground?" She stated, "No, they just dumped the dumpsters and they probably dropped it." Dietary Employee #2 asked Dietary Employee #3 to "pick that trash up please." Dietary Employee #3 was asked, "Should that trash be on the ground?" He stated, "No." 2. A facility policy titled "Dumpster" provided by the Administrator on 7/22/2020 at 12:25 p.m. documented, "...It is the policy of [facility] to keep dumpster area free from refuse... Procedure ... Trash service runs every Monday and Thursday mid-day..."	F 814		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and	F 925		

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F 925	Continued From page 19 rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen was free of pests to prevent the potential for the spread of infectious disease, and to prevent bacteria growth for residents who received food from 1 of 1 kitchen. The findings are: 1. On 7/20/2020 at 12:15 p.m., Dietary Employee #4 checked the temperatures of the food items on the steam table. Two (2) flies landed above the steam table while Dietary Employee #4 was checking the temperature of the food. Three (3) flies were crawling on the vent-a-hood over the stove. 2. On 7/20/2020 at 12:44 p.m., Dietary Employee #5 was serving lunch meal trays on the serving line. There were two (2) flies on top of the foil covering the rolls. There were three (3) flies crawling above the steam table. One (1) fly was on a tray on the serving line. Dietary Employee #5 was about to reach for the tray that had the fly on it, and was asked, "What do you see on that tray?" She stated, "A fly." She placed the empty tray on top of the steam table.	F 925		