Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910671	A. BUILDING: _____ B. WING _____	R 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT LAUDERDALE RETIREMENT HOME	401 SE 12TH COURT FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to the licensure complaint survey, #2019001239, was conducted on . . . . . and through at the Fort Lauderdale Retirement Home. The facility had uncorrected deficiencies identified at the time of the survey.	{A 000}		
{A 030} SS=G	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . . Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	{A 030}		

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{A 030}	Continued From page 1	{A 030}		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. [illegible] and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and [illegible];
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.
(g) In addition to the requirements of section

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{A 030}	Continued From page 2 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.	{A 030}		

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{A 030}	Continued From page 3 (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ., the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency	{A 030}		

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{A 030}	Continued From page 4	{A 030}		

termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone

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{A 030}	Continued From page 5 to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to honor resident rights by failing to document resident grievances and showing how the grievances would be resolved. Specifically, regarding numerous food complaints and complaints regarding the continued presence of bed bugs filed with the facility's management staff. The findings included:	{A 030}		

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{A 030}	Continued From page 6 During multiple confidential interviews with residents during . . . . . through . . . . . it was confirmed the facility's bed bug infestation is still active and that they have complained to the Administrator about the problem and being bitten by the bugs. It was further voiced that the facility has still not . . . . the food concerns voiced by the residents regarding being offered a variety of foods instead of pork and turkey repeatedly during the week. The residents also voiced concerns regarding the building being extremely hot at various times and the facility not properly fixing the units and/or installing appropriate units to ensure the air flow throughout the building and in common areas remained at comfortable temperatures. Review of the facility's Department of Health Inspection (DOH) report revealed, the facility has had an unsatisfactory inspection since . . . . regarding the presence of bed bugs. During an interview with the Administrator on . . . . . at 12:00 PM, she confirmed that the building has a bed bug infestation problem and that she has had a difficult time eradicating bed bugs from the building in spite of routine pest control implemented within the facility. She also confirmed that she was working directly with the DOH to resolve the problems, this was also confirmed with a DOH staff member on . . . . . at 11:00AM. Therefore, this deficiency remains uncorrected. Class II	{A 030}		
{A 152} SS=G	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other	{A 152}		

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{A 152}	Continued From page 7 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be .	{A 152}		

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{A 152}	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide a clean, safe, and decent living environment. As evidence of the facility's failure to remedy and eradicate the bed bugs infestation in the buildings (#401 and #415) and ensure all existing mechanical, electrical and structural systems and appurtenances were maintained in good working order (including cooling air flow systems located in the building). The findings included: a) During the observational tour on in bldg. 401 (#), a live bed bug was observed crawling on Resident #1. The resident was laying down fully dressed and the bed bug was crawling up her pants , the resident was unaware that a bed bug was on her. The resident stated sometimes she gets bit and other times she don't. She further stated she had not been bit in about a week. During an observational tour in building(bldg.) 415 (#) black smeared dots, similar to bed bug droppings were observed on the mattress. The resident in this room stated the bed bug issues is a cycle sometimes, it is a lot of them, and other times there is a few of them but it never stopped completely. During record review of the facility bed bug policy (not dated), it stated the facility would have biweekly treatment and inspection by a license pest control company. The policy and procedure for pest and rodent control stated the facility will contract with a pest control company that specializes in the treatment of bed bugs to monitor and inspect the facility on a biweekly basis and treat as needed. The policy further	{A 152}		

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{A 152}	Continued From page 9 stated a pest management professional should inspect the suspect room, adjacent rooms, the resident new room, all furniture and equipment, and lunge and public areas the resident may have been using. The facility policy failed to address the ongoing maintenance protocol for the bedbug treatment and a prevention resource for the bed bug reoccurrence. The facility failed to provide a system in place to monitor the effectiveness of the treatment plan and policy. Record review of the Department of Health (DOH) inspection that was conducted on revealed the following; An unsatisfactory report due to the findings of live bed bugs in building 415 (#) and observed live and bed bugs in building 401 (#). The facility was cited as having infestation/presence of bed bugs. An interview conducted with the DOH inspector on at 3:49 PM revealed the facility had live and bed bugs and bed bug fecal matter on the headboard, sides and corner of the mattress and inside the mattress covers in both buildings. DOH also furnish unsatisfactory reinspection reports from - due to the presence of bed bug infestation throughout the facilities, illustrating that the facility has had an ongoing problem with bed bugs. Record review of the last 3 invoice statements revealed the bed bug company visited the facility on and conducted general pest control inside of the kitchen area and common area, the rooms were inspected for bed bugs but no mention of routine spray for bed bugs. The pest control company conducted another routine visit on . It was noted on the receipt that general pest control treatment in kitchen and common areas were conducted. it also noted that	{A 152}		

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{A 152}	Continued From page 10	{A 152}		

a bed bug inspection for the main bldg. was conducted but no mention of routine treatment for bed bugs. The receipt further stated an original bed bug treatment completed in 2018 eradicated 98% of bedbugs. Before initial treatment, the bedbug infestation was extreme. After inspection, completed . . . , the previous infestation is now at a controllable level.

An interview conducted on at 9:01 AM with the Pest Control Manager, revealed they began treating this facility in , . At this time, they stated the facility had a huge bed bug infestation; the worst ever seen in all of the years as an Exterminator. It was further stated bed bugs were observed all over the walls, encrusted all over the doors and bedbugs encrusted on the window panels. The Manager stated they are . . . . . to go routinely to the facility on a monthly basis, treat the general areas (kitchen and all common areas), and spray the rooms that bed bugs were only observed in. The pest control company conducted another routine visit on . It was noted on the receipt that general pest control treatment in kitchen and common areas were conducted. The last treatment conducted at the facility by the Pest Control company was on in which the presence of bed bugs was confirmed throughout the facility.

Multiple resident interviews conducted on . . . . . between 9:15 AM and 11:00 AM revealed that the facility still currently has a bed bug infestation. The residents reported observing bed bugs up to last week, the residents stated they are used to it and have realized it is a problem that won't go away.

A confidential interview was conducted on

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{A 152}	Continued From page 11 . . . . . (confidential time) stating the facility does currently have a bed bug infestation. The confidant stated they are having a pest control company treat the facility but the facility still has a bed bug issue. It was further stated the bed bug issue will never be gone completely because the owners are will not invest needed resources into the building, this building needs more than a bed bug treatment unless you are going to get behind every wall and under every floor in this facility. An interview was conducted with the facility's designee on . . . . . at 10:01 AM regarding the bed bugs. The designee admitted the facility does have an ongoing bed bug issue. It was stated they have since hired a new pest control company that started services in . . . and the observation of bed bugs are decreasing but the presence of bed bugs are still present. It was further stated "a lot of the residents leave the facility and lay down in alleys, many of them don't bath and that is making the bed bug issue hard to get rid of; when we think got rid of them, we're starting all over again". The designee further stated the facility does have a bed bug policy in place but the policy does not seem to be effective due to the continuation of the bed bug findings between DOH, AHCA and the pest control company. The facility failure to properly assess the bed bug protocol, DOH inspection reports and pest control documentation resulted in an extended period of bed bug infestation. This also resulted in a number of residents being bitten and created a large presence of bed bugs. According to the pest company, once treatment is used they are unable to implement retreatment until 30 days, even with new presence of bed bugs. Further discussion with the designee and pest control company	{A 152}		

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{A 152}	Continued From page 12 revealed the facility has been unable to conduct an ongoing effective treatment plan due to the 30 day manufacture requirement in the bed bug spray used by the pest control company. b) During an onsite revisit conducted at the facility on thru , it was revealed the facility still had an infestation of bed bugs in various locations of the facility. During an interview with the Administrator on at 12:15 PM, she confirmed the presence of bed bugs and that she has routine and as needed pest control to treat the infestation. In addition, she confirmed that she was working under the guidance of Department of Health (DOH) to eradicate to problem. Record review of the facility's bed bug Contingency Plan Policy & Procedure dated , revealed the following: 1. Educate all staff about procedures and responsibilities to respond to a bed bug incident, including spraying bed linens and bed with during linen changes. 2. All staff should do routine inspections for bed bugs as part of their daily routine. 3. Caregivers should listen to reports of bites by residents and visitor's look for possible bed bug bites on residents. 4. Part of the bed bug prevention plan stated, clutter will be reduced, cracks and crevices will be seals and holes and peeling paint will be repaired. 5. If a resident reports a bed bug, the resident will be re-located to another room, and the room will be out of service. 6. Inspect all personal items for bed bugs before	{A 152}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 152}	Continued From page 13 re-locating the resident and wash and dry. 7. A pest management professional should inspect the suspected room, adjacent rooms, the resident's new room, all furniture; equipment, lounge and common areas the resident may have been using. 8. Daily resident roster should be initialed by their name confirming they sprayed their beds with . . . . daily. Further record review reveals a legal proceeding before the Broward County Sanitary Control Board dated . . . . . , the facility should correct the following outstanding violations. Thereby, effecting substantial compliance with the laws as evidenced by the following action items: The Respondent shall implement and maintain a bed bug mitigation plan documented in writing for inspection by the Department of Health inspectors upon request: 1) Residents shall not be in beds or rooms where bed bugs are observed; 2) . . . . . bug mattress covers (bed bug , . . proof) to be placed on client mattresses; 3) Heat treatment of affected areas as appropriate; 4) Seal and/or shut all cracks, crevices, and entry points to wall . . , using a high-quality -based sealant, especially within 20 of any spot where bedbug bites have been reported, or where bed bugs have been collected or observed. 5) (Section 3) The board recommends that the Respondent change any wooden base boards to commercial fully sealed material throughout the facility. (Documentation of evidence attached)	{A 152}		

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	AL11910671	A. BUILDING: _____ B. WING _____	R 09/19/2019

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{A 152}	Continued From page 14 Record review of the Termite and Pest control Bed Bug Customer Agreement dated . . . . . revealed the following: (Section 2) Services provided by the pest company will conduct a thorough visible inspection of the premises for evidence of infestation by Bed Bugs and will provide treatment for the control of the Bed Bugs as determined appropriate. The contract further stated for the purpose of this contract control is defined as the periodic eradication of existing Bed Bud infestations within practical limits. (Section 4) Customer agrees to maintain the premises subject to this contract in a condition, which does not promote infestations by Bed Bugs. Specifically, customer agrees to maintain the premises in a reasonable clean and sanitary condition and to keep the structure in such a state of repair so as to avoid providing easily accessible mean of access to Bed Bugs. A review of the Pest Control Company Services Report failed to identify in accordance to the Bed Bug Contingency Plan provided by the facility that the suspected room, adjacent rooms, the resident's new room, all furniture, equipment, lounge and common areas the resident may have been using were treated. The report identified rooms that bed bugs were reported to be observed and specifically stated only those rooms were treated. During a record review of the DOH (Department of Health) inspection report conducted on , revealed an unsatisfactory inspection report with violations of a consistent bed bug infestation, stained bed linens throughout the	{A 152}		

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{A 152}	Continued From page 15 facility, missing mattress cleanable covers; missing pillow cleanable covers; mattress disrepair; missing soap throughout the facility; and foul odor that exists in and throughout the facility. Further record review of the DOH history of the facility dated from - , all inspection reports were found to be unsatisfactory, including vermin bed beg infestation presence. During observations conducted at the facility during - , the following was noted. 1) The facility did not provide routine inspection reports for bed bug findings completed by staff as indicated in Section 1 of the facility's Policy and Procedure on Bed Bug Contingency Plan. 2) Clutter was observed in resident rooms in building #401, cracks and crevices were not sealed, and there was severe peeling paint in the bedrooms. (photographic evidence obtained) 3) During the inspection conducted by DOH on (in conjunction with Agency for Health Care Administration (AHCA), DOH confirmed active infestation in Room's #2, # 3, #6, #7, #8, #12 and #16. Bed Bugs were observed crawling on and around the residents bed. DOH's findings were documented and supported the findings of an unsatisfactory inspection report issued to the facility on the day of the inspection. 4) Building #401- revealed active bed bug and DOH advised the Administrative staff to re-locate the 2 (Resident #2 and #6) residents occupying the room until treatment is completed in the room and with resident belongings on . During an observation on at 11:55AM, AHCA surveyors found the 2 residents in # . One resident was sleeping and the other one was in the shower. During an interview	{A 152}		

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{A 152}	Continued From page 16	{A 152}		

with Resident #6 on .. at 11:55AM, he stated that no one told him not to return to the room and he occupied the room all day and night. There was no evidence of a sign on the door not to enter and the resident's belongings (deodorants and socks in the closet). The facility also failed to provide an invoice or a report to support the pest management professional should inspect the suspected adjacent room, the residents new room, all furniture, equipment, lounge and common areas as the contingency plan stated.

5) On . . . . . ., during the observational tour with the designated staff member in , Resident # 8's bed was observed with bed bugs crawling on top of his blanket and there was evidence of bed bug sheddings (shell). Also, bed bug droppings were found underneath the plastic mattress covers. (photographic evidence)

During multiple confidential resident interviews during the survey conducted on - between 9:00AM - 4:30 PM, they confirmed the facility currently has an active bed bug infestation. Residents confirmed that they have had bed bug bites and have visually seen bed bugs on their bed linen. Residents showed the surveyors their bed linen were soiled and spotted with red stains with dried . . . . Residents stated they have reported bed bug sightings to the Administrative Staff and even after the exterminator treatment, the facility remains to have bed bugs.

During an interview with Pest Control Manager (Pest Control Tech), on . . . . . at 11:15 AM, the following was revealed regarding services provided to the facility. He stated contractually he visits the facility on a bi-monthly basis and when they confirm a bed bug finding. When asked the status of how many rooms are currently active

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with bed bugs, he stated only one room in Building #401, and was unaware of the additional 4 rooms identified. The tech stated, when he started at the facility it was terrible, it looked like nothing was ever done to eradicate the Bed bugs. Bed bugs were everywhere and alive. He stated every time he comes to the facility he is doing what they call an extensive treatment where the entire room is heated, all of the resident belongings are included in the heat treatment and they cover the mattresses after the treatment to ensure protection. The tech further stated the problem with the bed bugs is that when they bite they hide whether in the walls, cracks and crevices in the building. The bed bug sighting would be referred to his company and then he came out to spray, he stated once they pass over the spray they will eventually die but they take some time to die and will still bite the residents. Additionally, the Tech stated the other issue is that these bed bugs are getting to the spray. If the bed bugs has already laid eggs and exposed the eggs to the chemical sprayed then they have babies, the babies are now to the chemicals to kill them and therefore the treatment won't be effective or as effective as it should be. The Tech stated, tenting would be an option because he doesn't doubt that the bed bugs are behind the walls and in any other unseen places within the facility but he cannot guarantee that it would completely get rid of the bed bud infestation. He also stated if tenting the building was an option the Administrator would have to vacate the property of all residents for at least three days for the tenting to be effective. When asked about the proper method for resident's clothing/laundry, he stated that all clothing should be removed and separately (no co-mingling) into the dryer for at least 45 minutes for the clothing to reach 130 degrees, then wash

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{A 152}	Continued From page 18 and dry. It was also stated, that if you put it into the wash first, the water temperature is not hot enough to kill the bed bugs. Therefore, the dryer is recommended first to be hot enough to kill any bed bugs on the clothing. During an interview conducted with the Administrator on . . . . . at 4:31 PM, she stated that she has been going to Legal Hearings with the DOH and have complied with everything they have ask her to do. At this time, the Administrator stated that she did not tent the building because she did not feel it would be cost effective. The Administrator further stated if she tented the building, she would want a guarantee from the pest control company, and she can't get a guarantee from the pest control company that it would rid the bed bug infestation to its entirety. During a review of the DOH legal documents regarding the hearings from , - revealed, the facility was actively working with DOH regarding implementing steps and procedures to rid the bed bug infestation. Although, the facility met all of the requirements of DOH, the facility had continued unsatisfactory DOH inspections. c) During the tour of the facility on - . . . . , the surveyors noted that the temperatures in the facility were extremely hot and uncomfortable, the residents and staff were seen profusely sweating . Surveyors observed throughout the tour, that the air conditioning (A/C) system (wall units and fans) were not funcitioning appropriately to ensure comfortable temperatures for the residents. Temperatures were taken at various times throughout the day during the survey, the readings at times were noted above	{A 152}		

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{A 152}	Continued From page 19 81 degrees Fahrenheit (F) in common areas, dining room and residents' rooms. The Administrator and office staff was observed inside of the front office which had cool temperatures. The office A/C unit was set to 67 degrees F and felt cool. It was also observed that the facility Administrator nor Staff had acknowledged the problem until the surveyors had identified the problem; even though residents were complaining of the temperatures and could be seen sweating. The Administrator and office staff was observed inside of a closed office in the front of the building for most of the survey which had cool temperatures. After surveyor intervention on and , a large fan was observed in the hallway as a cooling method and residents were seen sitting right in front of it to cool off. The forecast temperature for the area on - was registered at 88 degrees F outside. During the tour with the other rooms, each room felt extremely warm and residents complained about the hot air to the local Building Inspector, and other third-party agencies. On at 12:00pm, the temperature concerns were brought to the Administrator's attention in the Dining Room located in building #401. The Administrator stated, she will get an electrician to install a 220 electrical window unit; however, the window unit required a electrician to install a 220 watt socket to be installed. On , the 220-watt socket was installed without the proper permits. On at 12:45pm, the local Building Code Inspector shared his concerns regarding proper permits for the gas dryer; the generator transfer switch; and the A/C replacement in Building #415.	{A 152}		

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{A 152}	Continued From page 20 The following was noted per the Building Code Inspector's report : 1) Installation of a gas dryer with an exhaust vent without a permit. 2) Replacement of a Central AC unit without a permit and inspections. During further interview conducted with the local Building Inspector on at 10:10 AM by phone, he stated, he received several complaints from residents in building #415 during his initial tour about the hot air temperatures. This led him to check if permits were pulled for the a/c unit replacement in which he found that no permits were found for that replacement. He further stated, the buildings are very old and require insulation in the walls and attics. He also stated that the exterior envelope of the building might be maintaining heat which makes it harder for the building to keep cool. The importance of the permit is necessary to ensure the load capacity to cool the building is enough for the square footage. Therefore, this deficiency remains uncorrected. Class II	{A 152}		