STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205105	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTGATE CENTER FOR REHAB & ALZHEIMERS CARE	750 UNION ST BANGOR, ME 04401

(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) COMPLETION DATE
F 000	INITIAL COMMENTS From 3/24/25 through 3/26/25, on-site visits were conducted at Westgate Center For Rehab & Alzheimers Care for the purpose of completing the annual Survey Process for Federal Recertification and to investgate complaints #ME00051002, #ME00051039, #ME00050848 and Facility Reported Incident #ME00047522. It was determined that Westgate Center For Rehab & Alzheimers Care was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000	F550: 1. R10 has a diagnosis of vascular dementia with behavioral disturbances, altered mental status, cognitive communication deficits, anxiety disorder and a Brief Interview for Mental Status (BIMS) score of 0 = Severely Impaired Cognition and a St. Louis University Mental Status exam (SLUMS) of 3 = Dementia. R10 has trouble recalling information.	4/30/25
F 550 SS=D	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.	F 550	Reviewed with CNA4 the resident's right to self-determination in reference to the visitor (surveyor). CNA4 indicated an attempt to provide privacy and dignity during morning care was the intention. CNA4 was completing care tasks prior to the visitor (surveyor) entering to avoid potential disturbances and anxiety. Measures put in place include: Nursing and CNA staff will be educated on a resident's right to choose if/when they have a visitor to protect their right to a dignified existence and the right of self determination and weekly observations of staff interactions with residents will be done to monitor for compliance. Continued on page 2.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Pierce	Administrator	4/18/2025

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 550	Continued From page 1 §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 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 observations and interviews, the facility failed to protect a resident's right to a dignified existence and right of self-determination for a visitor for 1 of 1 resident's reviewed for Dignity (Resident # 10 [R10]). Finding: 1. On 3/25/25 at 9:10 a.m., a surveyor observed R10 lying in bed while talking with a Certified Nursing Assistant (CNA4). After the surveyor knocked on the open door and introduced self, the CNA4 made 2 attempts to close the door and prevent communication with the resident. The resident provided consent for the surveyor to enter and observe care. On 3/26/25 at 12:00 p.m., during an interview with the Director of Nursing, the surveyor confirmed that R10's right to self-determination for a visitor was not protected.	F 550	F550 continued. The results of the observations for monitoring will be reported to the QAA Committee monthly for three months. The Director of Nursing or designee is responsible for ongoing compliance. 2. For R10 and all other residents the Nursing and CNA staff will speak to each resident directly. CNA5 intended to speak to both R10 and the surveyor who were seated within close proximity of each other, less than 6-8 inches in appearance. Measures put in place include: Nursing and CNA staff will be educated on maintaining resident rights to a dignified existence by speaking directly to the resident. Random weekly observations between staff and residents will be observed for compliance. The results of the observations will be submitted to the QAA Committee monthly for three months. The Director of Nursing or designee is responsible for ongoing compliance.	

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F 550	Continued From page 2 2. On 3/25/25 at 9:18 a.m., during an interview with a surveyor and R10, CNA4 and CNA5 entered R10's room and explained to the surveyor that R10's family took the shoes home, that R10 cannot wear them until the wound on his/her heel resolves. At this time the surveyor requested this to be explained to the resident not the surveyor. CNA5 repeated the explanation to R10. R10 stated, "I wish people would tell me instead of taking them without talking to me." On 3/26/25 at 12:00 p.m., during an interview with the Director of Nursing, a surveyor confirmed that the R10 was not treated with dignity when staff talked about him/her instead of to R10 directly regarding the missing shoes.	F 550	F656: For R10 the restorative walking program was reviewed by the Physical Therapist (PT) and the Director of Nursing. Orders were received for an evaluation. R10 was evaluated by the PT on 3/26/2025 and recommendations were made for ambulation, balance and strengthening with the PT for 6-8 weeks from the start of treatment. The restorative walking plan was discontinued. The care plan was revised. For all other residents on a restorative walking program the PT and Director of Nursing reviewed the orders and care plan and revised if indicated. Nursing and CNA staff will be educated on completion and documenting completion of assigned restorative walking programs. Measures put in place include: Staff education has been provided for following the restorative walking program beginning 4/10/2025. Also, random weekly audits of the restorative walking program documentation until 100% compliance is met.	4/30/25
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656	The results of the audits will be submitted monthly to the QAA Committee for three months. The Director of Nursing or designee is responsible for ongoing monitoring.	

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F 656	Continued From page 3 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to implement a resident's care plan in the area a restorative walking program for 1 of 1 residents reviewed for activities of daily living (Resident #10 [R10]). Finding: On 3/25/25 at 9:35 a.m., during an interview with a surveyor, R10 stated he/she is losing his/her ability to walk. R10 stated, "I don't think anyone	F 656		

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F 656	Continued From page 4 walked with me after therapy [ended]. I think I am a blind spot." On 3/26/25 at 10:40 a.m., a surveyor observed R10 ambulating in the hallway with Physical Therapy (PT) staff. PT stated nursing notified her of a decline in function and R10 has had several falls prompting her to conduct today's evaluation. On 3/26/25, R10's clinical record was reviewed. The care plan identified R10 as having a functional mobility deficit, for which the intervention "AMBULATION: [R10] will ambulate 50-75 feet with 2 wheel walker and extensive assist, as patient is able", last revised on 3/12/25. On 3/26/25 at 12:19 p.m., during an interview with a surveyor and the Director of Nursing (DON), R10's clinical records was reviewed. The DON stated R10 should ambulate with staff on day and evening shift. At this time the surveyor confirmed that the medical record lacked evidence that R10 was ambulated 50-75 feet twice daily as directed by the care plan.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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F 684	Continued From page 5 by: Based on record reviews and interviews, the facility failed to complete neurological assessments for a resident who had a fall and hit their head, failed to follow their Bowel Regimen, and failed to follow physician orders for 3 of 18 residents reviewed (Resident #3 [R3], R48, and R6). Findings: 1. On 3/25/25 at 8:47 a.m., R3's clinical record was reviewed. On 3/20/25 at 12:37 p.m., a health status note from Third eye Health with a date of service of 6:04 a.m. it was documented that R3 being seen for an unwitnessed fall that occurred at 5:30 a.m. he/she was found on the floor in their room. R3 has a hematoma to the back of head to left side and reports head pain. Clinical record review shows documentation for Neuro checks that were initiated on 3/21/25 at 1:00 p.m. and lacked evidence that Neuro checks were completed as outlined in their Neurological Evaluation Policy. The facility's Neurological Evaluation Policy dated 4/23 and their neurological (neuro)/vital sign check sheet instructs staff that the licensed nurse performs neurological evaluations whenever there is the possibility of a head injury. On page 2 under number 3 the instructions for the timeframe for the neuro checks to be completed are: After the initial evaluation, the neuro checks are repeated every 15 minutes x 4 (1 hour, (hr.), every 30 minutes x 4 (2hrs), every 2 hours x 4 (8hrs), then every shift x 8 (64hrs)	F 684	F684: 1. R3 was seen and assessed via telehealth by an on-call provider and an order was obtained to apply ice packs as needed and to treat pain as needed per orders on the medication administration record. R3 was assessed by nursing staff and found to have no negative effect from the fall on 3/20/2025. For all other residents who fell in the month of March 2025, records were reviewed and no negative finding were identified. Measures taken include: A review and revision to the neurological assessment policy. Education for the nursing and CNA staff, Random weekly audits of falls will be done to monitor and ensure the neurological assessment policy is followed when indiated. Results of the random weekly audit of falls requiring a neurological assessment will be reported to the QAA Committee monthly for three months. The Director of Nursing or designee is responsible for ongoing compliance.	4/30/25

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F 684	Continued From page 6 The columns on the form to be completed included nurse's initials, date, time, vital signs (temperature, pulse, respirations, blood pressure) and neurological check (pupils, level of consciousness, motor function, speech, and facial symmetry). On 3/26/25 at 11:47 a.m., during a clinical record review with the Regional Director of Clinical operations the surveyor confirmed that the clinical record lacked evidence that the facility followed their Neurological Evaluation Policy after R3 had a fall with a head injury. 2. The facility's Bowel Regimen dated 4/27/23 under the heading procedure number 2. instructs that the charge nurse will review the Bowel Movement (BM) Record for residents in need of the bowel regime and list residents who have not had sufficient BM'S within the last three days, prune Juice (warm/cold upon preference) 4 ounce (oz) and senna-s 8.6/50 milligram (mg) tab, give 2 tabs by mouth x 1 now (at the beginning of the 10th shift) 3. If insufficient BM after the prune juice the charge nurse will administer Dulcolax tablet 10 mg by mouth the following shift. On 3/24/25 at 11:43 a.m. during a clinical record review a health status note for an acute visit with date of service for 3/19/25 at 8:45 a.m. documented that R46 is being seen today for loose stools. Staff reported R46 was having large loose stools. R46 was also seen on 3/12/2025 for diarrhea. Bowel medications were adjusted and held due to loose stools. During this record review it is documented that on	F 684	F684 continued. 2. For R46 the Bowel Protocol will be administered according to the policy. The Primary Care Provider reviewed the scheduled bowel medications and bowel history. Updated orders were received. For all other residents a records review indicated no other residents received medications for bowel care unnecessarily. Measures taken include: Monitoring the bowel movements as part of the morning clinical meeting report for intervention if needed. Weekly random audits of the bowel protocol will be done until 100% compliance is achieved. Education will be provided for nursing and CNA staff on the bowel protool. The results of the audit will be reported to the QAA Committee monthly for three months. The Director of Nursing or designee is responsible for ongoing compliance.	

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F 684	Continued From page 7 3/19/25 at 7:46 a.m. R46 received the Dulcolax 5 mg, 2 tablets to equal 10mg for constipation and resulted in R46 having a large loose stool prior to being seen by the Provider. The Bowel elimination record review showed that R46 had 2 large bowel movements on 3/18/25, a large bowel movement on 3/17/25 and a large bowel movement and a medium bowel movement on 3/16/25 showing R46 was not constipated and did not need a laxative per their bowel regimen policy. R46 did not go for 3 days without a bowel movement and was seen by the Provider for diarrhea on 3/12/25. On 3/26/25 at 2:06 p.m. during the review of R46's bowel elimination record and during an interview with the charge Nurse RN#1, the surveyor confirmed that R46 should not have received the Dulcolax laxative as he/she had 2 large bowel movements on 3/18/25 and did not meet the criteria for using the bowel regimen. 3. On 3/26/25, R6's clinical record was reviewed and included orders for Humalog (insulin) sliding scale to be administered at 5 units if blood sugar was 350 or greater (hold insulin if resident refuses meal) and for Hydralazine 10 milligram tablet to be administered if systolic blood pressure (SBP) was 160 or above. A review of R6's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for February 2025 was completed. On 2/19/25 at 1:00 p.m., R6's blood sugar was 406 but the documentation on the TAR indicated that the Humalog sliding scale insulin was not administered. On 2/2/25, R6's SBP was 121 but documentation on the MAR indicated Hydralazine was administered.	F 684	F684 continued. 3. R6's hydralazine was discontinued on 3/19/2025. R6's Humalog order was reviewed and updated on 3/21/2025. For all other residents that require medications with parameters the medications were reviewed with the Primary Care Physician (PCP) and adjustments were made as indicated. Measures put in place include: Education of staff and audits for monitoring. Nursing and CNA-Med tech staff will be educated on following provider orders for medications requiring parameters. Random weekly audits will be conducted for provider orders that include medications with a paramater until 100% compliance is met. The audit results will be submitted to the QAA Committee monthly for three months. The Director of Nursing or designee is responsible for ongoing compliance.	

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F 684	Continued From page 8 A review of R6's TAR and MAR for March 2025 was completed. On 3/11/25 at 6:00 p.m., R6's blood sugar was 355 but the documentation on the TAR indicated that the Humalog sliding scale insulin was not administered. The medication Hydralazine was documented as administered when SBP was less than 160 as follows: 3/8/25 at 5:00 p.m. when SBP was 132, 3/9/25 at 8:00 a.m. when SBP was 133, 3/10/25 at 5:00 p.m. when SBP was 142, and 3/17/25 at 5:00 p.m. when SBP was 129. On 3/26/25 at 2:03 p.m., during an interview with the Director of Nursing, a surveyor confirmed these findings. The DON stated that the insulin should have been administered because documentation also indicated that R6 ate greater than 50% of his/her meal and the Hydralazine should not have been administered.	F 684	F689: Mechanical Services was notified of the temperatures and adjustments were made on 3/25/2025. There have been no temperatures above 120 degrees F following the inital findings of temperatures above 120 - degrees F. The hot water temperature in resident rooms 109, 107, 101, 103, Cascade shower/restroom, 301, 302, 308 and for all other resident rooms and shower room temperatures were tested as a baseline. There were no temperatures above 120 degrees F.	4/30/25
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that hot water temperatures in resident rooms and restroom did not exceed 120 degrees Fahrenheit (F) on 2 of 3 days of survey (3/24/25 and 3/25/25).	F 689	Measures put in place include: A new Heat-Timer mixing valvethat was installed in a new location by Mechanical Services 4/15/2025. Random temperatures are taken daily and will be submitted to the QAA Committee monthly for three months. The Director of Maintenance or designee is responsible for ongoing complicance.	

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F 689	Continued From page 9 Findings: 1. On 3/24/25 between 11:47 a.m. thru 12:36 p.m., surveyors observed the following hot water temperatures: In Room 109 at 11:49 a.m., the hot water temperature was 121.7 degrees F and at 11:57 a.m. was 120.9 degrees F; In Room 107 at 11:59 a.m., the hot water temperature was 121.1 F; In Room 101 at 12:07 p.m., the hot water temperature was 124.1 F; In Room 103 at 12:10 p.m., the hot water temperature was 125.0 F; In Cascade Unit Shower/Restroom at 12:25 p.m., the hot water temperature was 125.4 F; In Room 301 at 12:27 p.m., the hot water temperature was 122.3 F; In Room 302 at 12:28 p.m., the hot water temperature was 122.3 F; and In Room 308 at 12:30 p.m., the hot water temperature was 120.5 F. On 3/24/25 at 12:50 p.m., the surveyor informed the Administrator that there was hot water greater than 120 degrees F. At 12:57 p.m., the surveyor notified the Maintenance Director of the surveyors findings of hot water. 2. On 3/25/25, in Room 103 at 12:07 p.m., the hot water temperature was 120.7 F. On 3/26/25 at 7:30 a.m., the Administrator stated that additional water temperature adjustments were completed last night when Mechanical Services lowered the temperature less than 120 degrees.	F 689		

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F 689	Continued From page 10 Documentation indicated the facility was monitoring hot water temperatures in resident rooms daily and the temperature log did not reflect temperatures above 120 degrees.	F 689	F812: The frozen Jennie-O Turkey Breast and Thigh Roast on the shelf in the walk in freezer during the inital tour was discarded when identified. Cook #1 and Cook #2 and all other kitchen staff have been educated beginning 3/27/2025 to wear a glove on each hand and dispose of the gloves, wash hands and put a new pair of gloves when in contact with the trash. The education included testing the sanitizer bucket to ensure 200 ppm before use and checking the outside package of frozen items for items that may have frozen to the package to be discarded. Measures put in place include: Random monitoring weekly of items in the walk in freezer to make sure nothing is stuck to the outside of the packaging, random observations of staff wearing gloves, washing hands and regloving if in contact with the trash and checking the sanitizer bucket before use for 200 ppm. The random weekly monitoring results will be provided to the QAA Committee monthly for three months. The Food Services Supervisor or designee is responsible for ongoing compliance.	4/30/25
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for 2 of 3 days of survey (3/24/25, and 3/25/25). Findings: On 3/24/25 at 10:20 a.m., during the initial tour of	F 812		

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	205105	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 11 the kitchen with the Food Service Supervisor (FSS), a surveyor observed in the walk in freezer, a package of "Jennie-O Turkey Breast and Thigh Roast" on the shelf. Package observed to have frozen raw meat / juices attached to the side of the package and exposed to the environment. A surveyor confirmed this finding with the FSS at the time of the observation. On 3/25/25 at 11:51 a.m., during a kitchen observation, a surveyor observed Cook #1 serving plates and wearing a glove on the right hand only. The gloved hand handled serving spoons and bread to serve food onto dishes. Cook #1's bare left hand was observed to be in contact with the surface of the dishes while plating food. Cook #1 opened a new bag of bread, walked to the trash, lifted the trash with one hand while reaching the other hand in to throw away the bread bag. Cook #1 then donned a new glove and returned to the steam table to serve food. At this time the surveyor confirmed with Cook #1 that she had been in contact with the trash and returned to serve food without washing her hands. On 3/25/25 at 11:54 a.m., a surveyor observed Cook #2 remove his soiled gloves and throw them in the trash. Cook #2's bare hands were observed to be in contact with the trash at that time. Cook #2 picked up the thermometer and attempted to place it in the mashed potatoes. At this time the surveyor intervened and confirmed with Cook #2 he had been in contact with the trash, then the thermometer, without washing his hands. On 3/25/25 at 12:00 p.m., during an interview with a surveyor, Cook #2 stated they use the sanitizer	F 812		

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F 812	Continued From page 12 bucket to clean the thermometer. The surveyor observed Cook #2 test the sanitizer bucket. The test strip result was 150 parts per million (ppm). Cook #2 stated the sanitizer bucket should contain a concentration of 200 ppm. A surveyor confirmed this finding with Cook #2 at the time of the observation.	F 812	F925: Westgate Center has a pest control contract with Modern Pest for services every month and as needed. Visit dates for the 1st quarter of 2025 are 1/23/2025, 2/17/2025, 3/13/2025, 3/27/2025, and 3/31/2025. Modern Pest was notified of the small flies. They have inspected the identified areas: Cascade unit rooms 308, 310, 311, 312, the shower room, kitchen and all other resident rooms, shower rooms and corridors were inspected. Maintenance continues to inspect with a room of the day and random checks. Measures put in place include: Weekly visits from Modern Pest for 4 weeks, having the old plumbing PVC pipe under the dishwahser capped by a plumber on 3/26/2025. The kitchen was deep cleaned including the area under the dish machine and mat. A new cleaning schedule was inplemented. Staff were educated to notify maintenance of any findings for the small flies 4/15/2025. Findings will be called to Modern Pest. All the window screens were inspected for tears/holes and one was identified for repair. The weekly results from Modern Pest and monthly visits and kitchen cleaning adherence will be reported to the QAA Committee monthly for three months. The Director of Maintenance or designee is responsible for ongoing compliance.	4/30/25
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 rodents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 3 units observed for pests (Cascade Unit). Finding: On 3/24/25 a surveyor observed small flies in the following locations: -At 10:20 a.m., a small fly was observed circling over the full recyclable containers bin in the kitchen. -At 10:59 a.m., a small fly was observed in the hall outside resident Room 308. -At 11:20 a.m., a small fly was observed on a resident's bedding in Room 310 and another small fly was observed in the bathroom of Room 310. -At 11:35 a.m., a small fly was observed flying in resident Room 312. On 3/25/25 a surveyor observed small flies in the following locations:	F 925		

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F 925	Continued From page 13 -At 9:28 a.m., a small fly was observed flying in resident Room 311. -At 11:30 a.m., a small fly was observed circling the trash in the dining room during the lunch service. -At 2:30 p.m., during an interview with the Food Services Supervisor (FSS), a swarm of small flies was observed in the kitchen by the dishwasher, flying around and landing on stacked ware-washer dish racks. The FSS stated this has been an ongoing problem. On 3/26/25 at 10:49 a.m., during an interview with the Maintenance Director and a surveyor, a swarm of small flies was observed by the dishwasher, flying around and landing on stacked ware-washer dish racks. The Maintenance Director stated Pest Control comes monthly. At this time the surveyor confirmed that the facility does not have an effective Pest Control Program.	F 925		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as	F 947		

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F 947	Continued From page 14 determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee personnel files/in-service training reviews and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on resident rights by failing to ensure that 2 of 5 Certified Nurse Assistants (Certified Nurse Assistant #1 [CNA1] and CNA2) completed the required annual training. Findings: On 3/25/25, during a review of employee personnel files, the following was noted: 1. CNA1 was hired on 8/19/2020. CNA1's employee personnel file lacked evidence of mandatory resident rights education within the last twelve months. 2. CNA2 was hired on 5/27/2021. CNA2's employee personnel file lacked evidence of mandatory resident rights education within the last twelve months. On 3/26/25 at 8:00 a.m., in an interview with the surveyor, the Assistant Director of Nursing, confirmed that there was no evidence that CNA1 and CNA2, had received resident rights training.	F 947	F947: The facility will implement and maintain an effective training program which includes training on resident rights. CNA1 and CNA2 have received education on resident rights. An audit was done for other CNA's to ensure they received education on the annual requirement for inservice training on resident rights. Measures taken include: A new education scheudule to ensure resident right training is provided minimally on an annual basis. A monthly random audit will be done for monitoring. The results will be provided to the QAA Committee monthly for three months. The Diector of Nursing, Assistant Director of Nursing/Staff Development Coordinator or designee is responsible for ongoing compliance.	4/30/25