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	255115	A. BUILDING _____ B. WING _____	09/22/2022

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MANHATTAN NURSING AND REHABILITATION CENTER LLC	4540 MANHATTAN RD JACKSON, MS 39206

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint investigation (CI) MS# 19524 at the facility from 9/19/22 to 9/22/22. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA did not substantiate CI MS # 19524 for Quality of Care related to positioning and leaving residents wet or Resident Rights related to visitation, with no citations related to the complaint. The SA cited F-567, F-576, F-640, F-644, F-812, and F-925 during the survey. The facility was licensed for 180 beds with a census of 131.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in	F 567		10/29/22

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

Electronically Signed | 10/12/2022

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F 567	Continued From page 1 an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure that residents have reasonable and ready access to their funds, as funds are not available on weekends. This deficient practice has the potential to affect 95 of 95 residents with funds held by the facility. Findings Include: Review of the facility's "Resident Bill of Rights", dated 11/17, revealed, "Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement of (his or her)	F 567	1. Resident funds were made available for Residents to access beginning the weekend of 09/24/22. A special Resident council was held on 09/28/22 to ensure that Residents were aware of funds being available on the weekends. A total of 16 Residents attended the council on 09/28/22. No Residents had any complaints or exhibited any negative outcomes regarding funds not being available on weekends. 2. All Residents who have personal funds available within the facility have the potential to be affected. 3. All cognitive Residents were interviewed on 10/04/22 by the Social Service department to ensure they were	

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F 567	Continued From page 2 quality of life, regardless of diagnosis, severity of condition or payment source and to exercise those rights as a citizen of the United States without interference, coercion, including those rights specified herein...22. Manage his or her financial affairs. The resident must authorize the facility in writing to manage any personal funds and the facility must ensure the resident has reasonable and ready access to those funds ..." On 09/20/22 at 02:07 PM, during a Resident Council meeting, the 17 residents present complained of not being able to get their funds on the weekends. The residents admitted that they have not requested money on the weekend because there is no one available that has access to the money. They said that if they forget to ask for money by Friday afternoon, they just wait until Monday. During an interview on 09/22/22 at 08:27 AM, the Business Office Manager (BOM) confirmed that resident funds have not been available to residents on Saturday and Sunday. In an interview on 09/22/22 at 01:48 PM, the Interim Administrator also confirmed that resident funds were unavailable on Saturday and Sunday because the Business Office Manager is off.	F 567	aware that personal funds were available on weekends. An in-service was initiated on 09/23/22 by the Executive Director for department heads in regards to Residents who have personal funds are able to receive money on the weekend. The department heads who are assigned to work as weekend managers (Saturday and Sunday) will be responsible for managing Residents' personal funds on weekends. 4. The Executive Director initiated weekly audits x 4 weeks beginning 09/26/22 of the weekend managers' reports to ensure that personal funds were available for the Residents on the weekend. Any concerns will be immediately addressed. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee beginning 09/30/22. The Quality Assurance Committee will determine on 10/28/22 the frequency or discontinuation of audits based upon results achieved.	
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own	F 576		10/29/22

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F 576	Continued From page 3 expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on facility policy review and resident and staff interviews, the facility failed to ensure that residents received their mail promptly, within 24 hours of delivery. This had the potential to affect 131 of 131 residents residing at the facility.	F 576	1. Personal mail was delivered beginning 09/24/22 for Residents who received mail. An emergency Resident council was held on 09/28/22 to ensure that Residents were made aware that delivered on	

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F 576	Continued From page 4 Findings include: Review of the facility's "Resident Bill of Rights", dated 11/17, revealed, "Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life, regardless of diagnosis, severity of condition or payment source and to exercise those rights as a citizen of the United States without interference, coercion, including those rights specified herein...27. To send and receive mail promptly and unopened ..." During an interview on 09/20/22 at 2:00 PM, during a Resident Council meeting, the residents complained that they do not receive their mail on weekends because the Activities Director is off on weekends. There were 17 residents in the meeting. During an interview on 09/21/22 at 9:30 AM, with the Activities Director, she confirmed the mail that is delivered to the facility on Saturdays is not delivered to the residents until Monday morning when she returns to work. She said there was "no weekend staff to deliver the mail." During an interview on 09/22/22 at 1:44 PM, with the Administrator, she confirmed the residents were not receiving their mail on Saturdays. The Administrator said she thought the Manager on duty was passing out the mail on weekends, but she was advised today that the mail was being held until Mondays when the Activities Director returned to work. The Administrator said the	F 576	weekends. A total of 16 Residents attended Resident council and voiced no complaints or had any ill effects from this deficient practice. 2. All Residents who receive personal mail have the potential to be affected. 3. All cognitive Residents were interviewed on 10/04/22 by the Social Services to ensure they were aware that personal mail would be delivered on weekends for any Residents who receive mail. An in-service was initiated on 09/23/22 by the Executive Director for Department Heads in regards to ensuring that Residents who receive mail on the weekend is delivered. The department heads who are assigned to work as weekend managers (Saturday and Sunday) will be responsible for delivering Residents' personal mail on weekends. 4. The Executive Director initiated weekly audits x 4 weeks beginning 09/26/22 of the weekend managers' report to ensure that personal mail was delivered on weekends. Any concerns will be immediately addressed. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee beginning 09/30/22. The Quality Assurance Committee will determine on 10/28/22 the frequency or discontinuation of audits based upon the results achieved.	

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F 576	Continued From page 5 Manager on duty will be designated to deliver the mail to residents on weekends.	F 576		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 640		10/29/22

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F 640	Continued From page 6 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility document review, the facility failed to complete and transmit the Minimum Data Set (MDS) within the required timeframe for three (3) of 31 sampled residents. Resident #1, Resident #11, and Resident #20. Findings Included: A record review of a facility's document presented to the State Agency (SA) by Registered Nurse (RN) #1/Case Mix Consultant, undated, revealed, "(Proper Name of Facility) uses the Resident Assessment Instrument (RAI) Manual to code all assessments." A record review of "Center for Medicare and Medicaid Services (CMS)'s Resident Assessment Instrument (RAI) Version 3.0 Manual" revealed " ... 5.2 Timeliness Criteria ... For all non-Admission OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) assessments, the MDS	F 640	1. An audit of open Minimum Data Set (MDS) was conducted on 09/29/22 by the Executive Director to determine required transmission dates. A total of 26 MDSs out of 89 MDSs were transmitted late. A discharge assessment for Resident # 11 was transmitted on 10/07/22. Resident # 1, #11 and # 20 had no negative outcome related to this deficient practice. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was initiated on 09/23/22 by the Regional Case Mix Consultant for MDS nurses on ensuring that data must be completed and transmitted within the required time frame. 4. The Director of Nurses and/or Executive Director will review the Assessment Summary Report weekly x 6 weeks beginning 09/29/22 to ensure that MDSs are transmitted timely. Any concerns will be immediately addressed. The Executive Director will forward the	

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F 640	Continued From page 7 Completion Date ... must be no later than 14 days after the Assessment Reference Date (ARD) ...For the Admission assessment, the MDS Completion Date ...must be no more than 13 days after the Entry Date ...The Submission Time Frame for MDS records ...Discharge Assessment ...Submit by Z0500 B (Event Date) + (plus) 14 (days) ..." Resident #1 A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 01/24/22, with a diagnosis of Hemiplegia, and she was discharged on 04/18/22. A record review of the 5 Day MDS with an ARD of 04/04/22 for Resident #1, revealed that Section Z0500 was signed as completed by the RN Assessment Coordinator on 04/25/22, which was a difference of 21 days between the ARD date and the Completion date. A record review of the MDS validation page for Resident #1 revealed, "Item Values: 04/25/2022, 04/04/2022 ...Message: Assessment Completed Date Z0500 B (assessment completion date) is more than 14 days after A2300 (assessment reference date)", which confirmed the assessment was not completed in the required 14-day timeframe. Resident #11 A record review of the "Face Sheet" revealed the facility admitted Resident #11 on 03/15/2022 with a diagnosis of Encounter for Orthopedic Aftercare and discharged her on 05/20/2022.	F 640	results of the audits to the monthly Quality Assurance Committee beginning 09/30/22. The Quality Assurance Committee will determine on 10/28/22 the frequency or discontinuation of audits based upon the results achieved.	

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F 640	Continued From page 8	F 640		

A record review of Resident #11's "Departmental Notes" revealed " ... 05/20/2022 8:43 AM ... order given to transfer to (Proper Name of Local Hospital) er (emergency room) ..."

A record review of "Physician's Telephone Order" with an order date of 05/20/2022 revealed " ... transfer to (Proper Name of Local Hospital) ER due to Decrease LOC's (Level of Consciousness) and O2 sat (oxygen saturation) ..."

A record review of the clinical record revealed there was no MDS Discharge Assessment completed or submitted for Resident #11 when she was discharged from the facility on 5/20/22.

Resident #20

A record review of the "Face Sheet" revealed the facility admitted Resident #20 to the facility on 11/19/21 with a diagnosis of Chronic Kidney Disease.

A record review of the 5 Day MDS with an ARD of 11/26/21 revealed A0310A equaled "1" which indicated the type of assessment as a "5-day scheduled assessment", which is an Admission assessment. Review of Section A1600 revealed the "Entry Date" as 11/19/21. Section Z0500 was signed as completed by the RN Assessment Coordinator on 12/10/21. This was a difference of 21 days from the date Resident #20 was admitted by the facility on 11/19/21, until the assessment completion date of 12/10/21.

A record review of the MDS validation page for Resident #20 revealed, "Item Values: 01, 12/10/2021, 11/19/2021 ...Message: Admission Assessment (A0310A equal 01), Z0500

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F 640	Continued From page 9 (Completion date) is more than 13 days after A1600 (Entry date). which confirmed the assessment was not completed in the required 13-day timeframe. On 09/21/2022 at 1:26 PM, during an interview with RN #1, Case Mix Consultant, she confirmed that Resident #11 did not have a Discharge assessment completed when she was discharged from the facility on 5/20/22. She reported the RN who completes the assessments is the person who is responsible for transmitting the assessment. RN #1 acknowledged that Resident #1 and Resident #20 MDS assessments were not completed or transmitted within the required times because the facility at that time had only one (1) MDS staff that could provide complete assessments. On 09/22/22 at 10:49 AM, during an interview with the Director of Nursing (DON), she explained she expected the MDS nurse to perform their job according to their job description and the assessments should be completed and transmitted on time.	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		10/29/22

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F 644	Continued From page 10 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation, and clinical record review, the facility failed to ensure one (1) out of four (4) residents reviewed for Pre-Admission Screening and Resident Review (PASARR) were referred for a Level II PASARR after development of a serious mental disorder. Resident #62. Findings Include: Record review of the Pre-Admission Screening (PAS) dated 2/12/21 for Resident #62 revealed the resident did not have a serious mental disorder upon admission. Record review of Resident #62's Face Sheet revealed an admission date of 2/11/21. Record review of services provided to Resident #62 on 2/24/22 by Behavioral Health Services LLC, revealed a new diagnosis of Bipolar Disorder. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/18/22, revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 644	1. An audit was conducted on 10/12/22 by the Executive Director for all Residents that develop a serious mental disorder to ensure the PASARR is reflective of the mental disorder and a LEVEL II referral was completed. A total of 28 PASARRs required submission for to the PASARR due to serious mental illness diagnosis. A Preadmission Screening and Resident Review (PASARR) was completed for Resident # 62 on 10/05/22 by the Admissions Director to reflect diagnosis of serious mental disorder. Resident # 62 had no negative outcome from this deficient practice. 2. All Residents who develop a serious mental disorder have the potential be affected. 3. An in-service was initiated on 09/23/22 by the Executive Director for the Director of Nurses, Medical Records and Admissions on ensuring a new PASARR was completed for Residents who develop serious mental disorder. 4. The Director of Nurses and/or Unit Managers will audit new orders 3 x week x 6 weeks beginning the week of 09/29/22 to ensure that a new PASARR any onset	

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F 644	Continued From page 11 Review of Section I included diagnosis of Bipolar Disorder and Section N revealed #62 had received Antipsychotic medication six (6) of the last seven (7) days. On 09/21/22 at 12:34 PM, in an interview with Licensed Practical Nurse #2 (LPN) she revealed she became responsible for overseeing PASARRs in August 2022. She stated before a resident enters the facility, she does the PAS, and requests a Level II if needed. She also stated that she requests a Level II PASARR when current residents are prescribed psychotropic medications. She admitted that Resident #62 should have had a Level II when diagnosed with Bipolar Disorder to ensure that the resident received appropriate treatment for her mental illness. On 09/22/22 at 2:04 PM, in an interview with the Director of Nursing (DON), she stated with a new diagnosis of Bipolar Disorder, Resident #62 should have had a Level II PASARR, to ensure that the resident was receiving appropriate care.	F 644	of a mental illness is completed. Any concerns will be immediately addressed. The Director of Nurses will forward the results of the audits to the monthly Quality Assurance Committee beginning 09/30/22. The Quality Assurance Committee will determine on 10/28/22 the frequency or discontinuation of audits based upon results achieved.	
F 812 SS=F	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	F 812		10/29/22

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	255115	A. BUILDING _____ B. WING _____	09/22/2022

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F 812	Continued From page 12 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, staff interviews, and facility policy review, the facility failed to appropriately label opened items in the freezer and walk-in refrigerator and properly store perishable items to maintain food quality and prevent contamination, for one (1) of three (3) dietary observations. This has a potential to affect all residents receiving meals prepared by the facility's dietary department. Findings include: The facility's "Labeling and Dating Foods Policy" (undated) states, "All foods stored will be properly labeled according to the following guidelines ... Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturer's expiration date... Once a package is opened, it will be re-dated with the date the item will be use by according to current safe food storage guidelines or by the manufacturer's expiration date ...". The facility's "Food storage (Dry, refrigerated, and Frozen) Policy" (undated) states, "Food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to	F 812	1. On 09/19/22 the Dietary Manager immediately discarded open items that were not dated in the freezer and walk-in refrigerator and discarded perishable items to maintain food quality and prevent contamination. No Residents were affected by this deficient practice. 2. All Residents who receive meals from the dietary department have the potential to be affected. 3. An in-service was initiated on 09/20/22 by the Dietary Manager for the dietary staff on ensuring that open items are labeled appropriately and discarded to maintain food quality and prevent contamination. 4. The Dietary Manager initiated audits beginning 09/26/22 3 x week x 4 weeks to ensure appropriate labeling of opened items and food quality and contamination is maintained for perishable items. Any concerns will be immediately addressed. The Dietary Manager will forward the results of the audits to the monthly Quality Assurance Committee beginning 09/30/22. The Quality Assurance Committee will determine on 10/28/22 the frequency or discontinuation of audits based upon the results achieved.	

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F 812	Continued From page 13	F 812		

ensure the highest level of food safety... General storage guidelines to be followed: ... Label food item held for longer than 24 hours. The label should include the name of the food if not in original packaging, the date by which it should be sold, consumed, or discarded ...".

On 09/19/22 at 11:01 AM, the State Agency (SA) conducted an initial tour of the dietary department with the Dietary Manager (DM) and the facility Dietitian and observed the following:

1. In the Dry Storage room, there was a 22.68 kilogram(kg) size bag of yellow cornmeal partially open without a use by date, a five (5) lb. bag of Pasta Labelle noodles open and wrapped in plastic wrap without a use by date, and a ten 10 oz. bag of Lays Classic Potato Chips opened and wrapped in plastic wrap without being secured and without a use by date.

2. In the Dry Storage room, there was also a box of bananas covered with gnats.

3. In the freezer and walk-in refrigerator there was a box of biscuits opened and exposed to air, five (5) heads of iceberg lettuce exposed to air and turning brown in a torn, unsealed bag, and chopped green peppers that were leaking and wrapped in plastic.

On 09/19/22 at 11:26 AM, the SA in an interview with the DM, she stated that everything is supposed to be labeled within three (3) days of opening foods. She stated that if the residents consumed expired foods, they could get sick and possibly contract salmonella.

On 09/23/22 at 01:38 PM, the SA conducted a

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F 812	Continued From page 14 post-exit interview the Interim Administrator, who stated she expects the kitchen to label and properly store all items daily. She stated that if a resident consumes expired foods, they could get sick.	F 812		
F 925 SS=F	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, staff interviews, facility protocol review, and facility document review, the facility failed to keep pests out of the food preparation and service areas. Roaches were observed in the dietary area on one (1) of three (3) dietary observations. This has a potential to affect all residents receiving meals prepared by the facility's dietary department. Findings Include: Review of the facility's "Pest Control Protocol" (undated) stated, "General Description: Maintain an effective pest control program so that the facility is free of pests and rodents. The Facility maintains an effective pest control program ..." A record review of facility pest control contracts revealed that the facility has pest control contracts with two (2) pest control vendors that according to invoices are providing monthly services. The contract with Vendor #1 was signed on 1/17/22, with the second pest control contract was signed on 6/3/22.	F 925	1. On 09/21/22, the storage cart that holds plates and the steam table were immediately eradicated of pests and cleaned by the Dietary Manager. The pest was also eradicated from under the stove by the Dietary Manager. Pest control was notified on 09/21/22 and provided treatment. Pest control performed an additional treatment on 09/22/22 in the dietary department. Pest control was increased to weekly x 2 weeks beginning the week of 10/4/22. No Residents had any ill effects from this deficient practice. 2. All Residents who receive meals from dietary have the potential to be affected. 3. An in-service was initiated by the Executive Director for the dietary staff on 09/23/22 in regards to ensuring that pests are not present in food preparation and service areas. 4. The Dietary manager initiated rounds 3 x week x 6 weeks beginning 09/26/22 to ensure that pests are not present in food preparation and service areas. Any	10/29/22

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F 925	Continued From page 15 On 09/20/22 at 11:05 AM, the State Agency (SA) observed four (4) roaches in the dietary area. Two (2) roaches were seen on the storage cart that holds plates, one (1) large roach was seen on the floor in front of the steam table, one (1) small roach was seen coming from under the stove. On 09/20/22 at 11:09 AM, in an interview with the Dietary Manager (DM), she stated that a pest control company came this past week and sprayed. She stated that they have been coming consistently and the pest situation has gotten better. On 09/20/22 at 11:13 AM, an interview with the Dietitian revealed things have been better since pest control has been coming. She stated that roaches have not been seen in the kitchen until today. On 9/20/22 at 1:40 PM, eight (8) roach traps were noted throughout the dietary area and a light (used to attract pests) was noted above the dietary door. On 09/20/22 at 1:46 PM, during an interview with the Head Cook, she confirmed that in the past she would see roaches off and on around the steam table. She stated that since they have been spraying the kitchen, it has been better. On 09/21/21 at 03:05 PM, during an interview, the Interim Administrator stated that she was unaware of pest control problems in the kitchen but would review the facility's pest control contract. On 09/23/22 at 1:14 PM, in a post-exit interview	F 925	concerns will be immediately addressed. The Dietary Manager will forward the results of the audits to the Executive Director. The Executive Director will forward the audit results to the monthly Quality Assurance Committee beginning 09/30/22. The Quality Assurance Committee will determine on 10/28/22 the frequency of or discontinuation of audits based upon the results achieved.	

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F 925	Continued From page 16 with Pest Control Vender #1, the vendor revealed that the facility has had a contract with their company to provide monthly services since February 2022. She stated that their services include spraying the facility for pests and providing a Vector Machine that has a purple light used to attract and kill flies, roaches, and ants.	F 925		