STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0563 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family, staff, and physician interview the facility failed to allow an immediate family member to visit for [MEDICATION NAME] care in accordance with CMS memo Covid-19 QSO ,[DATE]-NH and the facility Covid-19 Policy/Plan for one (Resident #1) of three residents reviewed for visitation rights. Findings included: The facility Covid-19 Policy/Plan last updated on [DATE], stated, At this time and until further notice, no visitors, volunteers, or other persons are permitted to enter the facility with the exception of end of life or other [MEDICATION NAME] circumstances Resident #1 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. An immediate family member was listed as the resident's responsible party and health care power of attorney in the resident's medical record. Documentation on the most recent MDS assessment dated [DATE] coded Resident #1 as cognitively impaired, dependent on staff for bed mobility, toilet use, and personal hygiene but requiring extensive assistance with eating. Documentation on the care plan dated as initiated on [DATE] revealed Resident #1 was at risk for alteration in psychosocial wellbeing related to restriction on visitation due to Covid-19. One of the interventions was to encourage alternative communication with visitors. Documentation in a social service progress note dated [DATE] stated, (Family member) came to facility yesterday evening and filled out the DNR (Do not Resuscitate) consent for (Resident #1). Record Review revealed a physician's orders [REDACTED].#1. Documentation on a Hospice visit note dated [DATE] revealed, [AGE] year-old female, (family member) not present at admission due to facility restrictions for Covid-19. Paper notes signed by (family member). Hospice philosophy explained, (family member) POA (power of attorney), she is seeking no further aggressive measures, she wants comfort for (Resident #1) that is rapidly declining with [MEDICAL CONDITION]. Pt (patient) has had a weight loss since March, from 110 (pounds) to 92, thin frail appearance. She frequently refuses meals or consumes less than 25 %. Observed Pt eating, mechanical soft diet, pocketing notes, two bites consumed and then refused. Documentation in the nursing notes for Resident #1 on dated [DATE] at 7:51 AM revealed, Nurse was called to resident room. Resident noted with no pulse or breath sounds. Skin was cool to touch. Community Hospice was called and notified. Documentation in the nursing notes on [DATE] at 1:01 PM revealed, Resident remains picked up by funeral home. An interview was conducted on [DATE] at 1:00 PM with the family member of Resident #1 who was the health care power of attorney and responsible party. The family member revealed that she visited Resident #1 weekly to view her through the window and called the facility daily for updates regarding the condition of Resident #1 since the facility went into lockdown for Covid-19 in [DATE]. The family member stated she could see through the window that Resident #1 was not doing well in [DATE] and the nursing staff were notifying her that Resident #1 was not eating very much. The family member stated that Resident #1 was put on Hospice and an order for [REDACTED].#1 and had to hand the paperwork for approval of Hospice services and the DNR (do not resuscitate) order through the door on [DATE]. The family member indicated she was very regretful she was unable to sit and be with Resident #1 during her last days. The family member stated, I could see the life going out of her, but they wouldn't let me go in (to the facility). An interview was conducted with the facility social worker on [DATE] at 1:30 PM. The social worker revealed she set up a video conference and gave weekly updates to the family member of Resident #1. The social worker stated that the facility did not offer, and the family member did not ask to come into the facility to see Resident #1 prior to her death. The social worker indicated that unless a resident was actively dying the family members of residents were not allowed into the facility at that time. Nurse #5 was interviewed on [DATE] at 2:40 PM. Nurse #5 stated that he did not see much of a change in Resident #1, but she was in a gradual decline. Nurse #5 confirmed that the family member for Resident #1 called him daily in the evening for updates on Resident #1. Nurse #5 remembered that the last two times before Resident #1 died , the family member stood in the pouring rain for hours looking at Resident #1 through the window. Nurse #5 reiterated that he did not see much of change in Resident #1 but within 48 hours of being put on Hospice services, Resident #1 passed away. Nurse #6 was interviewed on [DATE] at 10:54 PM. Nurse #6 stated that the family member called her at least two times a week on the morning shift for updates on Resident #1. Nurse #6 stated that the medical director was aware of the decline in health for Resident #1. Nurse #6 stated that Resident #1 was not eating and only drank liquid supplement. Nurse #6 confessed that she did not notify the medical director or the family member when she observed the weight of Resident #1 dropped to 89 pounds on [DATE]. Nurse #6 stated that the physician and the family member both knew that Resident #1 had a major decline and she was placed on Hospice. An interview was conducted with the facility Administrator on [DATE] at 10:40 AM. The Administrator explained that Resident #1 was not actively dying and therefore the family member was not invited into the facility. The Administrator acknowledged the family member was in constant communication with the facility, but family members were not allowed in the building at that time unless the resident was actively dying. The Administrator explained that she relied on the clinical judgement of the facility nurses, administrative nurses, and the medical director to make the determination if a resident was actively dying. The facility medical director was interviewed on [DATE] at 12:47 PM. The medical director acknowledged that Resident #1 was physically declining, and he agreed that Hospice services were warranted at the time he wrote the order on [DATE]. He stated that he did not know that the death of Resident #1 was imminent. The Medical Director stated that he was under the impression that the family member of Resident #1 was allowed into the building when she brought the signed paperwork for the resident to be put on Hospice. The Medical Director denied that he was the one that made any decision about when a family member could come into the building for comfort care at the end of life for a resident. The Medical Director stated, I don't make those policies.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews the facility failed to notify the resident's responsible party of a change of condition for 1 of 3 residents (Resident # 3) reviewed for notification. The findings included: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #3's admission minimum data (MDS) set assessment dated [DATE] revealed his cognition to be moderately impaired, required extensive assistance from staff for activities of daily living, and had no pressures sores. A review of a Physician follow up visit dated 1/21/20, revealed Resident #3 developed a left posterior thigh abscess, and was started on [MEDICATION NAME] (an antibiotic). A review of Resident #3's Medication Administration Record [REDACTED]. A review of Resident #3's MAR for February and March 2020 revealed Bactrim DS (an antibiotic) was administered two times per day (BID) from 2/27/20 through 3/7/20 for wound infection. On 7/14/20 at 9:06 AM, an interview was conducted with the MDS nurse. The MDS nurses stated she was the wound

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

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) nurse at the time of Resident #3's admission at the facility. The MDS nurse stated Resident #3 had an abscess on his left posterior gluteal fold and the Physician had seen it and referred him to general surgery to have it lanced. The nurse stated she was unable to remember if a culture had been done on the abscess and she was unable to find any record of culture results, but stated the resident was on contact precautions for the wound abscess while at the facility. The MDS nurse stated the infection control nurse was no longer working at the facility and she was unable to find records of a culture report. The MDS nurse stated if Resident #3 had an infection in his wound, and it looked like he did because he was on antibiotics a second time, the responsible party (RP) would have been notified by her, but she was unable to find a report of notification in the medical record. On 7/14/20 at 10:07 AM, an interview was conducted with the nurse (#3) who frequently cared for Resident #3. The nurse stated Resident #3 was on isolation for [MEDICAL CONDITION]-resistant Staphylococcus Aureus (MRSA) (a bacterium causing infection) from a sore on his back thigh. The nurse stated there was a sign on the resident's door along with the appropriate personal protective equipment (PPE). The nurse stated the (RP) would have seen the isolation sign and PPE but would've been called also. The nurse stated it was the nurse's responsibility to call the RP, but she could not remember if anyone had called her. On 7/14/20 at 11:36 AM, an interview was conducted with Resident #3's RP. The RP stated she visited the resident and saw a bag on the door with PPE but no one had called to tell her the resident was in isolation or that he [MEDICAL CONDITION] in his wound. On 7/14/20 at 1:06 PM, an interview was conducted with the Administrator, who stated she was not aware Resident #3's RP was not notified of his change of condition as she did not start working at the facility until after he had been cleared of isolation.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to keep a urinary catheter bag from coming into contact with the floor for 1 of 3 residents (Resident #6) reviewed for catheter care. The findings included: Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's most recent Minimum Data Set assessment dated [DATE] revealed her cognition to be severely impaired and she required total assistance from staff for activities of daily living. The resident was assessed to have an indwelling catheter. Review of Resident #6's care plan dated as revised on 4/16/2020 revealed the resident was care planned for an indwelling catheter with potential for complications associated with catheter use. The interventions included to check catheter tubing for kinks each shift, position the drainage bag below the level of bladder, provide catheter care every shift, and monitor and report to the Physician any signs and symptoms of infection. During an observation on 7/13/2020 at 6:53 AM, the catheter bag and tubing were attached to the bed rail and both were dragging on the floor. The bed appeared in the lowest position. During an observation on 7/13/2020 at 4:12 PM, the catheter bag was attached to the bottom rail of the bed and the lower half of the bag was lying flat on the floor, appeared empty. The bed was in the lowest position. On 7/13/20 at 4:13 PM, an interview was conducted with Nursing Assistant (NA) #8 who was in the room and caring for the roommate of Resident #6. The NA stated the catheter bag was on the floor because the bed was in the lowest position, but it should not be on the floor. The NA stated she did not realize it was on the floor and proceeded to raise the bed until the catheter bag was off the floor. On 7/13/20 at 4:28 PM, an interview was conducted with Nurse #7 who stated she had not noticed the catheter bag was on the floor when she made rounds. The nurse stated the bed needed to be raised a little, so the catheter bag was not on the floor as that was an infection control issue. An interview was conducted on 7/14/2020 at 1:06 PM, with the Administrator who stated she expected staff to keep resident's urinary catheter bags from contacting the floor.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on record review and staff interviews the facility failed to have Registered Nurse (RN) coverage for at least 8 consecutive hours per day for 3 out of 17 days reviewed for staffing (7/5/20, 7/9/20 and 7/11/20). The findings included: On 7/13/20 at 3:58 PM an interview was conducted with the interim Director of Nursing (DON) who stated she was working as the facility's interim DON until the facility could hire someone for the position. The DON stated around the 3rd week of June 2020 the DON, Staff Development Coordinator (SDC), unit manager, and another Registered Nurse (RN) quit working at the facility. The DON stated she was put in the position of interim DON because she was the only regular staff RN still working at the facility. On 7/14/20 at 12:18 PM, an interview was conducted with the facility's staff scheduler, who stated most of the time she tried to have an RN on duty for 8 hours a day. The scheduler stated last month when all the RN's left, she had to move the current DON to that position, but also still had to schedule her to work as a floor nurse. The scheduler stated she had 2 as needed (PRN) RN's to help, but the facility did not use agency staff. A review of the daily staff schedule with the scheduler revealed the facility had no RN coverage on 7/9/20 and 7/11/20 and only 4 hours of RN coverage on 7/5/20. The scheduler confirmed the interim DON did not work on the dates of 7/9/20 and 7/11/20 and a PRN RN was not working on those dates. The scheduler confirmed the interim DON worked only 4 hours on 7/5/20 and a PRN RN was not working on that day. On 7/14/2020 at 12:50 PM an interview was conducted with the Administrator, who stated she moved the interim DON to that position on 6/20/20. The Administrator stated she would have liked to have RN coverage every day of the week but knew there were some dates an RN was not available since 6/20/20. The Administrator stated she did not look into using an agency RN because she had another RN that she thought could help cover.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to do hand sanitation according to facility policy in one out of five hallways in the facility. A nurse aide (NA #6) and a housekeeper (HK #1) failed to perform hand hygiene in-between residents in the quarantine unit. This occurred during a Covid-19 pandemic. Findings included: The handwashing/hand hygiene policy for the facility, dated August 2015, stated that alcohol-based hand rub or, alternately, soap and water should be used before and after assisting a resident with meals and after contact with objects in the immediate vicinity of the resident. 1.Continuous observations were made in the quarantine unit/300 hall on 7/13/20 beginning at 9:30 AM. Nurse aide NA #6 was observed leaving room [ROOM NUMBER] at 9:30 AM with a breakfast tray from the resident in that room. The breakfast tray was put on a dining cart in the hallway by NA #6 who then went directly into room [ROOM NUMBER]. NA #6 came out of room [ROOM NUMBER] at 9:35 AM with the breakfast tray from the resident in that room, put the breakfast tray on the dining cart in the hallway, and went directly to answer a call light in room [ROOM NUMBER] without doing any hand sanitation. NA # 6 was observed to touch the tray table and reposition the resident in room [ROOM NUMBER] as she spoke to the resident. NA #6 was observed to grab a pair of gloves and enter the bathroom in room [ROOM NUMBER] to wash her hands. The door to room [ROOM NUMBER] was closed by NA #6 and NA #6 left room [ROOM NUMBER] at 9:42 AM. NA #6 went directly into room [ROOM NUMBER], picked up the breakfast tray of the resident in the room, and put on the dining cart in the hallway. NA #6 went into Rooms 314, 312, 309, and 306 repeating the process of picking up breakfast trays and putting them on the dining cart in the hallway without doing any hand sanitation in between rooms. NA #6 was not observed to wear a plastic gown at any time during the observations beginning at 9:30 AM. An interview was conducted with NA #6 on 7/13/20 at 9:51 AM. NA #6 confirmed that she did not do any hand sanitation except for washing her hands prior to assisting the resident in room [ROOM NUMBER] and prior to and after assisting the Resident in room [ROOM NUMBER], after she closed the door. NA #6 confirmed she did not put on a gown since she started picking up the breakfast trays. NA #6 stated that she was expected to wash her hands after picking up every third resident food tray or every third room. NA #6 said she wore a plastic gown, did hand sanitation, and put on gloves in the quarantine unit when she was providing care but not when she was picking up meal trays. NA #6 stated that the gowns were hanging on the back of the resident door in each room. Nurse #3 was interviewed on 7/13/20 at 10:20 AM. Nurse #3 stated that she had spoken with NA #6 regarding hand washing about a month ago. Nurse #3 added the information that NA #6 did not usually work in the quarantine unit. Nurse #3 explained that it was important to wear the gown as directed and do proper hand sanitation in the quarantine unit because although the residents were tested for Covid-19 multiple times, the [MEDICAL TREATMENT] patient was coming and going. Nurse #3 explained that the staff were expected to wear a gown while in each resident room. Nurse #3 further explained that the gown was not necessary in the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) hallway, but on the back of each resident's door was a gown to be used while in the room with a resident. An interview was conducted with the Director of Nursing (DON) on 7/14/20 at 10:45 AM. The DON denied that she was the person responsible for the infection control policies and procedures. She stated that she was unable to provide what the expectations were for infection control in the facility and she was not involved with any monitoring or tracking of infections within the facility. An interview was conducted with the facility Executive Director/Administrator on 7/14/20 at 11:36 AM. The Executive Director/Administrator stated that the DON was the person responsible for the infection control policies and procedures and the expectation was that the staff follow the infection control policies and procedures. 2. Continuous observations were made in the quarantine unit/300 hall on 7/13/20 of housekeeper (HK) #1 beginning at 10:43 AM. HK #1 was observed to be wearing gloves when she entered room [ROOM NUMBER]. HK #1 was observed to exit and reenter room [ROOM NUMBER] multiple times with garbage bags, toilet brush, cleaning spray, and cloth wipes. HK #1 was observed to enter room [ROOM NUMBER], with the same gloves on, repeating the same process of cleaning the room as she had for room [ROOM NUMBER]. At 10:53 AM nurse aide (NA) #7 stood in the doorway to room [ROOM NUMBER] and requested that HK #1 retrieve a towel from the clean linen cart. HK #1, with the same gloves on, took a towel off the clean linen cart and handed to NA #7, who reentered room [ROOM NUMBER]. NA #7 was interviewed on 7/13/20 at 11:00 AM. NA #7 stated that she needed HK #1 to retrieve a clean towel for her from the clean linen cart because there were no other staff members on the hallway, and she did not want to remove her gown to retrieve linen for the resident in room [ROOM NUMBER]. HK #1 was observed to grab a wet mop head, attach it to the mop, and clean the floor of room [ROOM NUMBER]. Upon completion of cleaning the floor of room [ROOM NUMBER], HK #1 disposed of the wet mop head and put another wet mop head on the mop, repeating the process of cleaning the floor in room [ROOM NUMBER]. HK #1 continued to keep the same gloves on. HK #1 then proceeded to clean the hand rails, wipe down the fire extinguisher, wipe down the hand sanitizer dispensers, and move dirty linen barrels out of the way without changing her gloves. HK #1 then, with the same gloves on, began to clean room [ROOM NUMBER], completing garbage removal, bathroom cleaning, and wiping down surfaces with cleaning spray in the room. HK #1 mopped the floor in room [ROOM NUMBER] by putting a wet mop head on a mop and wiping down the floors with the mop. At 11:23 AM Nurse #3 told HK #1 that she needed to change her plastic gown that she was wearing after she entered each room. HK #1 entered the room [ROOM NUMBER], designated as the nurse's station, and changed her plastic gown. HK #1 was not observed to change her gloves at that time. HK #1 was then observed to enter room [ROOM NUMBER], for the purposes of cleaning the room with a toilet brush and cloth towel in hand. HK #1 completed the cleaning process in room [ROOM NUMBER], removed her plastic gown, and hung it on the back of the door in room [ROOM NUMBER]. At 11:47 AM HK #1, with the same pair of gloves, resumed wiping down the hall way railings, resident chairs, nursing equipment, and doors. HK # 1 was interviewed on 7/13/20 at 11:58 AM. HK #1 confirmed that she had not changed her gloves or did any hand hygiene since she started cleaning the resident rooms. HK #1 confirmed that she had training on procedures for cleaning in the quarantine unit but that she had just forgotten to change her gloves. The housekeeping supervisor was interviewed on 7/14/20 at 8:47 AM. The housekeeping supervisor stated that the housekeeper on the quarantine unit was supposed to hand sanitize and change gloves in between cleaning rooms in addition to changing her plastic gown going from room to room. The housekeeping supervisor confirmed HK #1 had been trained in the infection control procedures for the quarantine unit but that she had probably forgot.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, and staff interviews, the facility failed to maintain an effective pest control program to keep the facility free of American cockroaches and spiders for 5 of 5 resident hallways (hallways 100, 200, 300, 400, and 500), and the central nurse's station. The findings included: Review of the facility's contracted pest control company records revealed service was performed on the following dates: - 4/6/2020, the rooms serviced were 105, 106, 202, 204, 206, 207, 208, 209, 210, 307, 311, 403, 500, and 501. Interior rodent service was performed. - 5/12/2020, insecticide for cockroaches was applied to the interior areas of kitchen, office and side door-introduction point. Mice were baited in the exterior area. - 6/9/2020, insecticide for cockroaches was applied to the interior kitchen area. Mice were baited in the exterior area An observation was made on 7/13/20 at 6:15 AM of a large American cockroach crawling on the floor in front of the 100/200 nursing desk near the medication cart. Nurse Aide (NA # 1) was observed to obtain a paper towel and dispose of the cockroach. NA # 1 was interviewed at the time of the observations and indicated that it was not unusual to see cockroaches in the building. NA # 1 further indicated that it was documented in the computer system when a cockroach was observed. An observation was made on 7/13/20 at 6:20 AM of a dead large American cockroach in the exit hallway between the 300 and 400 halls. Nurse # 1 was interviewed on 7/13/20 at 6:26 AM. Nurse #1 revealed that 3 hours prior to the interview the cockroaches were crawling around everywhere. Nurse #1 stated that last week she observed four cockroaches crawling up the wall of the resident in room [ROOM NUMBER] B and inside the feeding tube syringe bag attached to the wall. Nurse #1 stated she tied off the feeding tube syringe bag and threw the bag away. Nurse #1 also observed cockroaches crawling all over the bed side table for the resident in room [ROOM NUMBER] A. Nurse #1 stated that it did not do any good to notify anybody about the cockroaches. NA #3 was interviewed on 7/13/20 at 6:27 AM. NA #3 revealed that she went in room [ROOM NUMBER] B to provide care to the resident on the 11:00 PM to 7:00 AM shift on 7/13/20 and observed a large cockroach crawling up the sleeve and covers of the resident. NA #3 stated she removed her slip-on shoe, brushed the cockroach off the resident, and killed the cockroach with her shoe. An observation was made on 7/13/20 at 6:34 AM of a large wolf spider crawling on the floor near the back nurse's station. A resident in a wheel chair was observed at the time of the observation of the spider to be sitting at the nurse's station in the back of the building. An observation was made on 7/13/20 at 7:10 AM of the dead wolf spider and multiple baby spiders crawling all over at the entrance to the 400 hallway. Nurse #1 was interviewed at the time of the observation. Nurse #1 stated, They stomped on the spider and baby spiders are crawling everywhere. We are trying to stomp on them too. An observation was made on 7/13/20 at 9:15 AM of two dead cockroaches in the hallway outside rooms [ROOM NUMBERS]. Record review revealed Resident #13 was assessed as alert and oriented on his most recent minimum data set (MDS) assessment dated [DATE]. Resident #13 was interviewed on 7/13/20 at 8:28 AM. He stated in his room on the 400 hall he had seen cockroaches every evening and had seen them crawl across his bed. The Resident stated he had let the nurse know, and he stated maintenance and housekeeping had seen them also. Record review revealed Resident #9 was assessed as alert and oriented on his most recent MDS assessment dated [DATE]. Resident #9 was interviewed on 7/13/20 at 9:15 AM. He stated in the past 14 days, while he was in the quarantine unit on the 300 hall, he had seen cockroaches in his room. He revealed that he was getting assistance from a nurse aide in getting dressed when he saw a large cockroach crawling in his room. He indicated the nurse aide killed the cockroach and threw it in the trash can. He stated that he had told the nurses and the nurse aides about the cockroaches and he indicated the staff were aware of the presence of cockroaches. Resident #9 added the information that he had run over two cockroaches with his wheel chair 2 days ago. Record review revealed Resident #10 was assessed as alert and oriented on her most recent admission MDS assessment dated [DATE]. Resident #10 was interviewed on 7/13/20 at 10:15 AM. She stated she had been on the 300 hallway since her admission and she had seen a cockroach in her room crawling around on two different nights. She stated she woke up that morning and the cockroach was now squashed over by the trash can. The dead cockroach was observed on the floor next to her trash can at the time of the interview. An interview was conducted with housekeeper #1 in the quarantine unit on 7/13/20 at 10:30 AM. Housekeeper #1 stated she had seen cockroaches in the facility on the 300 hallway. She indicated she kills them, sweeps them up, and disposes of them. She stated that nobody had told her to tell anybody. On 7/13/2020 at 3:16 PM, an interview was conducted with the Maintenance Director who stated the facility had a computer TELS system in place for staff to notify him of sighting of bugs in the facility, and their location. The Director stated he and his assistants used a bug killer to spray inside the facility when bugs were reported to him. The Director reviewed the reported bug sightings in the facility with the surveyor and was as follows: 2 dates reported in April, 4 dates in May, 3 dates in June and 1 date in July. The Director stated of all the sightings of bugs noted on the morning of 7/13/20, he had not received one report in the TELS system to alert him for bug treatment needed. The Director stated the facility had a Pest Control Company contracted to come and treat the facility once per month, depending on what the issues were. The Director stated he thought the pest control company treated the exterior of the building in June for cockroaches. The Directed stated he and his staff had not made any rounds at night to observe for bugs, because no bug problems had been reported at night. The Director stated he expected the roach population be controlled to not come into the building. On 7/14/2020 at 1:06 PM, an

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