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	255163	A. BUILDING _____ B. WING _____	06/26/2025

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MEMORIAL WOODLAND VILLAGE NURSING CENTER	5427 GEX ROAD DIAMONDHEAD, MS 39525

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 06/23/2025 through 06/26/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F583, F641, F806, F812, F867, F880, and F925. The facility had a census of 111 and was licensed for 132 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		

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

Electronically Signed

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F 583	Continued From page 1	F 583		

(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a resident's right to privacy and confidentiality by posting personal health information on the resident's wall for one (1) of twenty-three (23) sampled residents, Resident #82.

Findings included:

A review of the facility's policy titled, "Promoting/Maintaining Resident Dignity," dated 2/10/25, revealed, " ...It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality ... Compliance Guidelines ...11 ...No signage shall be posted in the room with personal information ..."

On 6/23/25 at 8:48 AM, during an observation, signage was observed posted on the wall above the bed for Resident #82 which indicated "205 A-Nectar thick liquids with no straws."

On 6/24/25 at 11:45 AM, during an observation

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and interview while Resident #82 was assisted with lunch, Certified Nurse Aide (CNA) #1 explained that Resident #82 was on nectar thickened liquids and was assisted with each meal. CNA #1 confirmed the signage on the wall above the bed, which read "Nectar thick liquids no straws." She stated this information was already included in the resident's plan of care and meal ticket and expressed uncertainty as to why it was also posted on the wall.

On 6/25/25 at 10:45 AM, during an observation and interview with the Director of Nursing (DON), she confirmed that signage in resident rooms disclosing personal care or health information was not permitted and constituted a violation of resident dignity. She verified the presence of the sign referencing "nectar thick liquids" and "no straws" in Resident #82's room. The DON stated she did not know who had posted the sign or how long it had been there but affirmed that she would have it removed and conduct a facility-wide audit to ensure compliance.

On 6/26/25 at 12:21 PM, during an interview with the Administrator, she acknowledged being informed of the signage and affirmed that resident health information should not be posted in resident rooms. She stated that her expectation was for all staff to honor residents' dignity and privacy and to avoid posting any health-related care information on the walls.

A record review of the "Admission Record" revealed the facility admitted Resident #82 on 7/6/23 with diagnoses including Nontraumatic Intracranial Hemorrhage.

A record review of the "Order Listing Report" with

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F 583	Continued From page 3 active orders revealed Resident #82 had a Physician's Dietary Order, dated 4/10/25, for Nectar/mildly thick consistency and no straws.	F 583		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed	F 641		

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F 641	Continued From page 4	F 641		

to accurately code the Minimum Data Set (MDS) assessment related to a resident having a restraint, when no restraint had been ordered or used, for one (1) of twenty-three (23) residents reviewed. Resident #99.

Findings included:

A review of the facility's policy titled "Conducting an Accurate Resident Assessment," dated 2/10/25, revealed, "... The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment ..."

A record review of the "Admission Record" revealed the facility admitted Resident #99 on 6/14/24 with diagnoses including Unspecified Dementia.

A record review of the "Annual Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 5/21/25 revealed Resident #99 had a limb restraint.

A record review of the medical record revealed there was no documentation indicating Resident #99 had a limb restraint.

On 6/23/25 at 7:34 AM, during an observation and interview, Resident #99 was lying in bed on her left side. Certified Nurse Aide (CNA) #1 explained that Resident #99 did not have any restraints.

On 6/24/25 at 12:20 PM, during an interview, Licensed Practical Nurse (LPN) #1 explained the facility does not use restraints, and Resident #99 has not had any restraints since being admitted.

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F 641	Continued From page 5 On 6/24/25 at 2:30 PM, during an interview, the Director of Nursing (DON) reported the facility is a restraint-free building. During a review of Resident #99's Annual MDS with an ARD of 5/21/25, Section P0100 indicated the use of a limb restraint less than daily. The DON explained this was coded in error and confirmed that Resident #99 does not have a restraint. She stated that all assessments are expected to be coded accurately to reflect the resident's status. On 6/24/25 at 3:10 PM, during an interview, LPN #2 explained that she had coded the restraint in error on the MDS and confirmed that Resident #99 did not and had never had a restraint. On 6/26/25 at 12:10 PM, during an interview, the Administrator explained that she expected all residents' MDS assessments to be coded accurately to reflect their current assessments.	F 641		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to acknowledge and	F 806		

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F 806	Continued From page 6	F 806		

honor the documented food preferences of one (1) of twenty-three (23) sampled residents, Resident #88.

Findings included:

A review of the facility's policy titled "Resident Meal Service," revised 1/2025, revealed, " ...Residents will be offered menu choices for all meals, beverages, and snacks, and are based on their ...food preferences ..."

A record review of the "Clinical" record revealed the facility admitted Resident #88 on 7/5/23 with diagnoses that included Hemiplegia and Hemiparesis.

A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/25 revealed Resident #88 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated his cognition was intact.

A record review of the meal ticket, dated 6/23/25, revealed Resident #88 had "Food Dislikes" listing of multiple vegetables including broccoli, carrots, and cauliflower.

A record review of the facility's " MenuWorks Weekly Menu" revealed the meal for Monday (06/23/2025) included "California Vegetables."

On 6/23/25 at 11:58 AM, during an observation and interview in the main dining hall, Resident #88 was removing vegetables from his plate. The meal on his tray included a California blend of vegetables consisting of broccoli, cauliflower, and carrots. Resident #88 stated he disliked vegetables and explained that this issue occurred

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F 806	Continued From page 7 frequently, despite his documented food preferences excluding such items. On 6/24/25 at 12:05 PM, during an interview with the Dietary Manager, he stated that kitchen staff do not currently review or acknowledge the food preferences listed on the residents' meal tickets. He explained that he had been in his role for less than ninety (90) days and had not yet had adequate time to address staff training or resolve deficiencies related to honoring resident meal preferences. He confirmed that dietary staff do not consistently review or implement resident preferences during meal service. On 6/26/25 at 1:14 PM, during an interview with the Administrator, she stated her expectation was for kitchen staff to ensure meals are prepared properly and meet residents' expectations. She acknowledged that the dietary department was newly staffed and that the Dietary Manager was still learning his role and responsibilities.	F 806		
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.	F 812		

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F 812	Continued From page 8 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to follow safe food storage and handling practices on one (1) of four (4) survey days. Specifically, the facility failed to properly store, label, and date frozen food items that were opened, discard expired bakery rolls and refrigerate lemon juice in accordance with manufacturer instructions. Findings included: A record review of the facility's policy titled, "Food and Supply Storage" dated 01/2025, revealed, " ...All food ...used in food preparation shall be stored in such a manner as to prevent contamination ...Procedures ...Foods past the "use by", "sell by", "best-by" or "enjoy by" date should be discarded. Cover, label and date unused portions and open packages ...Frozen Storage ...Label both the bind and the lid. Use food grade plastic bags for food storage ...Wrap food tightly to prevent cross contamination ..." On 6/23/25 at 8:23 AM, during an observation and interview with the Dietary Manager, there was one (1) tray of Sara Lee Artesano Bakery Sausage Rolls in the dry goods storage room with an expiration date of 6/20/25. The Dietary Manager stated he was unaware when the expired rolls had last been served. In the freezer, there was a package of breaded okra that was	F 812		

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F 812	Continued From page 9 open, not repackaged, and not labeled. A bag of frozen biscuits was open without proper repackaging or dating. A bag of frozen chicken tenders was stored in a torn clear plastic bag that had been rolled down and was neither repackaged, labeled, nor dated. The Dietary Manager acknowledged that dietary aides routinely open large food packages, use a portion of the contents, and return the rest to storage without labeling or dating. There was a one-gallon container of opened ReaLemon juice stored on a shelf, despite manufacturer instructions requiring refrigeration after opening. The Dietary Manager confirmed the juice was not stored according to manufacturer guidelines. On 6/26/25 at 1:14 PM, during an interview with the Administrator, she stated that her expectation is for kitchen staff to ensure residents receive food that is properly prepared and tastes good. She acknowledged that the Dietary department was newly staffed, including the Dietary Manager, who was still learning the position and job responsibilities.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		

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systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and

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implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project

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that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to properly store, label, and date food items and discard expired food on an annual recertification survey on 2/29/24 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of seven (7) deficiencies cited. F812.

Findings Include:

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F 867	Continued From page 13 Record review of the facility's policy, "Quality Assurance and Performance Improvement", dated 2/1/2025, revealed, " ...It is the policy of this facility to ...maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life ...Policy Explanation and Compliance Guidelines ...2. The QAA Committee shall ...c. Develop and implement appropriate plans of action to correct identified quality deficiencies ..." Record review of the "Provider History Profile" revealed the facility received a citation for F812-Food Procurement, Store/Prepare/Serve Sanitary on the survey conducted on 2/29/24. Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 2/29/2024, revealed the facility received a citation for F812, " ...Based on observation, staff interview, record review, and facility policy review, the facility failed to store food ...in accordance with professional standards for food service safety related to food items not dated with a use-by-date, no identifying label, expired foods, improperly stored and exposed food for one (1) of three (3) kitchen observations ..." During the current recertification survey, the facility failed to follow safe food storage and handling practices on one (1) of four (4) survey days. Specifically, the facility failed to properly store, label, and date frozen food items that were opened. discard expired bakery rolls and refrigerate lemon juice in accordance with manufacturer instructions	F 867		

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F 867	Continued From page 14 On 6/26/25 at 2:31 PM, during an interview with the Administrator, she confirmed that during the facility's last recertification survey, they were cited under F812 for failing to date and label food items, specifically applesauce, orange juice, and apple juice. She acknowledged that the same concern was identified again during the current survey. She explained that, following the previous citation, the facility's Quality Assurance and Performance Improvement (QAPI) Committee implemented a corrective plan, which included weekly audits conducted by the dietitian or kitchen manager for four (4) weeks, followed by monthly audits for three (3) months, beginning on 3/4/24. She confirmed that the QAPI Committee meets monthly, although the facility policy only requires quarterly meetings, and those meetings include the full interdisciplinary team and medical staff, including the Medical Director. The Administrator stated that additional in-service training could be provided to reinforce expectations, and that the Quality Assurance(QA) nurse could conduct follow-up with dietary staff. She also noted that the dietary team currently in place is new and many were not employed during the time of the last survey, emphasizing the need for education on proper procedures and regulatory requirements.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, facility policy review, and record review, the facility failed to follow appropriate infection control practices when a Certified Nurse Aide (CNA) placed soiled linens on the floor of a resident's room after incontinent care for one (1) of twenty-three (23) sampled residents, Resident #97.

Findings included:

A review of the facility's policy titled "Infection Prevention and Control Program, dated 2/1/25, revealed, " ... This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections ...Policy Explanation and

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Compliance Guidelines ...12. A. Linens and direct care staff shall handle, store, process, and transport linens to prevent spread of infection ... e. Soiled linen shall be collected at the bedside and placed in a linen bag... When the task is complete, the bag shall be closed securely and placed in the soiled utility room ..."

A record review of Resident #97's "Admission Record" revealed the facility admitted the resident on 7/31/24 with diagnoses including Cerebral Infarction.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/17/25 revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.

On 6/23/25 at 12:15 PM, during an observation and interview in Resident #97's room, CNA #2 was returning to complete perineal care. Soiled linens were observed resting directly on the floor without a barrier or a bag. When asked whether the soiled linens should be in direct contact with the floor, CNA #2 responded, "No," and stated that infection could be spread and cross-contamination could occur. CNA #2 then placed the soiled linens in a soiled utility bag.

On 6/26/25 at 10:31 AM, during an interview with the facility's Infection Preventionist (IP) Nurse, she stated that proper infection control guidelines require placing soiled linens directly into a linen bag to prevent contact with the floor. Allowing linens to touch the floor increases the risk of cross-contamination and infection for staff and residents.

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F 880	Continued From page 18 On 6/26/25 at 11:39 AM, during an interview with the Director of Nursing (DON), she stated that CNA #2 should have placed the soiled linens in a bag immediately and avoided letting them touch the floor to prevent contamination and the spread of infection throughout the building. She confirmed it was her expectation for staff to follow infection prevention guidelines when providing care.	F 880		
F 925 SS=D	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 observation, interview, record review, and facility policy review, the facility failed to maintain an effective pest control program related to ants for one (1) of twenty-three (23) sampled residents, Resident #49. Findings included: A review of the facility's policy titled " ...Pest Control Program," dated 2/1/25, revealed: " ...It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Definition: 'Effective pest control program' is defined as measures to eradicate and contain common household pests (e.g ...ants ...) ..." A record review of the "Transfer/Discharge Report" revealed the admitted Resident #49 on 8/5/21 and he had diagnoses including Acute Respiratory Failure with Hypoxia.	F 925		

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A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/25, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

On 6/24/25 at 10:44 AM, during an interview, Resident #49 stated that his room had ants and he had been bitten on his knees while lying in bed earlier that morning. He explained that this was not the first occurrence, stating it also happened on the prior Saturday (6/21/25).

On 6/24/25 at 11:45 AM, during an interview with the Administrator, she explained that the open cookies above the resident's bed and the proximity of his bed to the window likely contributed to the presence of ants. She confirmed that pest control services were provided monthly and that records showed visits dating back to January 2025, with the last visit in May. She added that the resident declined an offer to move to another room.

On 6/24/25 at 12:30 PM, an observation of Resident #49 revealed two older-appearing insect bites with individual pustules, one on each mid-thigh, and approximately five (5) newer red pustules located on the back of both knees.

On 6/24/25 at 12:41 PM, during an interview with the Director of Nursing (DON), she confirmed that visible bites were present on both legs. The DON explained that an unopened container of cookies found on the resident's above-bed shelf likely attracted the ants. She stated an investigation was conducted on Saturday (6/21/25) following the initial report, but no ants or bites were

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observed during the body audit. She confirmed that ants were later seen by Certified Nurse Aide (CNA) #3, who attempted to remove them from the resident's legs, but the resident declined, requesting the DON view them. The DON verified that pest control last visited the facility on 5/9/25 and was scheduled to return that day (6/24/25).

On 6/24/25 at 3:37 PM, during an interview with the Ombudsman, he stated that residents in the past year had complained to him about ants getting into their rooms at the facility.

On 6/26/25 at 11:46 AM, during a follow-up interview with the DON, she confirmed that Resident #49 had five (5) ant bites on the backs of his knees and two (2) older bites on the mid-thighs. She explained that the initial complaint was reported on 6/21/25 and a body audit conducted at that time did not reveal any bites or ants. However, the room was cleaned and treated. The DON stated the resident reported new ant bites again on 6/24/25. She acknowledged the risk of anaphylaxis from insect bites and emphasized the importance of staff reporting pest activity promptly. She reiterated that a pest control vendor conducts monthly visits and is expected to survey for infestations during each visit. Her expectation was that residents remain free from insect bites while residing in the facility.

On 6/26/25 at 2:20 PM, during an interview with the Maintenance Director, he stated that a pest control vendor provides monthly services and responds to any pest-related concerns as needed. He explained that staff typically report any sightings and he remains vigilant during his daily rounds to monitor for pests.

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