STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00369814. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00369814 - Substantiated. Federal/State deficiencies related to the allegations are cited at F842 and F880. Unrelated deficiency cited. Survey dates: January 11 and 12, 2022. Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 6 Medicaid: 47 Other: 6 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 21, 2022.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during survey event ID YB311. Please accept this plan of correction as the provider's credible allegation of compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.			

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard			

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	medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure accurate and timely charting was completed for 1 or 3 residents reviewed for falls (Resident B) Findings include: On 1/11/21 at 11:09 a.m., Resident B's record was reviewed. He was admitted to the facility on 12/2/22. His diagnoses included, but were not limited to	F 0842	It is the practice of the facility to maintain medical records on each record that are complete, accurately documented, readily accessible and systematically organized. Resident B no longer resides in the facility. A 60 day “look back” audit was completed by the DON/ADON/MDS Coordinator at which time Falls and/or Changes of Condition-- were reviewed to	02/01/2022

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	chronic kidney disease, anemia, vascular dementia with behavioral disturbance, and essential hypertension (high blood pressure). On 12/3/21 at 6:31 a.m., Resident B had an unwitnessed fall. He was assessed and found to have no injuries. He was placed in a wheelchair and put at the nurse's station. The Director of Nursing (DON) and the physician were notified. On 12/4/21 at 2:12 p.m., a nursing note indicated Resident B was dependent upon staff for activities of daily living (ADLs), grooming, and was assisted with eating. He only ate a few bites of food and refused his medications. On 12/5/21 at 16:55 (4:55 p.m.), a nursing note indicated he was complaining of left leg pain. Since he had a fall two days prior, an x-ray was ordered. On 12/5/21 at 19:03 (7:03 p.m.), the x-ray was completed with no fractures. On 12/6/21 at 11:23 a.m., a nursing note indicated Resident B was unresponsive and had an oxygen saturation of 71% on room air. He responded to painful stimuli and opened his eyes and made sounds. On 12/6/21 at 11:46 p.m., a nursing note indicated Nurse Practitioner (NP) 20 face timed (video visit) with the nurse and resident. She ordered him sent out to the emergency room (ER) via 911 to be evaluated for unresponsiveness. On 12/6/21 at 11:54 a.m., NP 20 notes indicated the patient fell over the weekend and was lethargic and had a change in consciousness and		ensure that related documentation was accurate and timely. Any concerns will be addressed in QAPI. Residents who reside in the facility have the potential to be affected by this finding; however, no resident were affected. On 01/29/22 DON/ADON reviewed the neuro check policy & procedure with all nurses and Educated them on timely and accurate documentation in the medical record and neuro check sheets. Documentation of incidents and neuro checks will be audited during morning meeting with the IDT team. Falls and/or Changes of Condition will continue to be monitored by the IDT (Interdisciplinary Team), at the daily morning CQI meetings as part of the agenda. Additionally, the DON/ADON/Designee will audit Falls and or Changes of Condition which have occurred over the past 24 hours 4 days a week for 4 weeks, then 3 days a week for 4 weeks, then 2 days a week for 4 weeks, then weekly for 4 weeks then monthly for 3 months. Any concerns will be addressed if found. The results of the audits will be submitted to the QAPI committee weekly and then monthly as indicated. Any patterns will be identified. If needed, the QAPI committee will write an Action Plan. Any Action	

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	mental status. He oxygen saturation was 71%. He was sent to the ER to be evaluated. On 12/6/21 at 12:00 p.m., 911 arrived to pick-up Resident B. The DON notified the resident's wife. On 12/6/21 at 11:16 a.m., while the resident was still in the building, LPN 5 added a late entry nurse's note. It was dated 12/4/21 at 2:30 p.m. The note indicated the resident was lethargic and did not follow commands. On 12/6/21 at 2:02 p.m., after the resident had left the facility, the ADON added a late entry nurse's note. It was dated 12/3/21 at 6:18 a.m., which was prior to the resident's fall on 12/3/21 at 6:31 a.m., but it referred to the fall that had not occurred yet. It was an SBAR (acronym for talking to physicians: situation, background, assessment, recommendation) note indicating Resident B had a change in condition because of the fall. The vital signs were recorded as within normal limits, except for the 71% oxygen saturation, dated 12/6/21 at 11:00 a.m. His mental status was listed as increased confusion since admission. On 12/14/21 at 11:25 a.m., 8 days after the resident had left the facility, the ADON added a late entry nurse's note. It was dated 12/6/21 at 11:21 a.m. The note indicated the Interdisciplinary Team (IDT) reviewed the fall on 12/4/21: zoomed meeting/face time (video visit) with resident and telehealth nurse. NP 20 indicated to send him to the ER to be evaluated. Resident B had care plans indicating he had a potential for falls and late loss ADLs. Resident required staff to assist with ADL's.		Plan will be monitored by the Administrator or designee weekly until resolved.	

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	On 1/12/22 at 12:35 p.m., the Administrator provided Resident B's neuro check sheets. Under lethargic, on 1/4/22 at 2:15 p.m. and 6:15 p.m., no assessment was completed. The area was left blank. During an interview, on 1/13/22 at 12:40 p.m., LPN 5 indicated the first time she provided care for Resident B, 1/4/22, she charted lethargic as his baseline. To her, lethargic meant drowsy or sleepy, it was not a change in condition. Some nights, he was up all night. Regarding his oxygen (O2) assessment, on 1/6/22 at 11:00 a.m., of 71% on room air, she indicated she had put him on 2 liters of oxygen per nasal cannula but did not chart it. During an interview, on 1/12/22 at 3:52 a.m., the DON indicated sometimes it was hard to chart immediately but everything should have been charted before the end of a shift. The neuro checks sheets should have reflected the actual condition of the resident since lethargy and pain are assessed and Interdisciplinary Team (IDT) notes should have been charted the day after his fall. During an interview, on 1/12/22 at 3:57 a.m., the DON indicated when Resident B's oxygen saturation was assessed at 71%, the nurse should have added oxygen per nasal cannula, called the physician, and charted both. On 1/12/22 at 4:07 p.m., the DON indicated Resident B was breathing but not responding to verbal and tactile stimuli, the staff were working fast and did not chart everything. A current policy, titled, "Standard Supervision			

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	and Monitoring," with no date, was provided by the Administrator, on 1/12/22 at 4:55 p.m. A review of the policy indicated, " ...This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs ...." This Federal tag relates to Complaint IN00369814. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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 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			

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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 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.			

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	§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. Based on observations, interviews and record reviews, the facility failed prevent the potential spread of COVID-19 during a global pandemic when staff failed to wear face masks appropriately, failed to don (put on)/doff (take off) Personal Protective Equipment (PPE) before entering transmission-based precautions (TBP) isolation rooms and performed hand hygiene at appropriate times for 2 of 2 days of observation and with the potential to effect 59 of 59 residents residing in the facility. Findings include: 1. Upon entrance to the facility on 1/11/22 at 9:15 a.m., both the Administrator and Director of Nursing (DON) were observed to be wearing an N95 face mask with a second unidentified black object underneath their masks. The object stuck out from either sides and bottom of the N95 so that a proper seal was not obtained. During an initial infection control observational tour of the building on 1/11/22 from 9:18 a.m. until 9:30 a.m., the following was observed: a. At 9:18 a.m., LPN 6 was observed at the central nurses' station. She wore a KN95 face mask. At this time, she indicated she was aware that there was a COVID outbreak in the facility but did not think there was a difference between a	F 0880	**F 880 Infection Control** It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease. All residents residing in the facility have the potential to be affected; however, no resident was affected. An all staff in-service was conducted by DON/Designee, the following was reviewed: A.) Proper PPE for zone B.) Hand Hygiene C.) Demonstration of the correct way to wear a N95 D.) Return demonstration of donning a N95 Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Newly hired staff will receive the in-servicing prior to working. This will be tracked and documented by the Administrator/D.O.N/Designee.	02/01/2022

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	KN95 mask or an N95 mask. b. At 9:20 a.m., the Assistant Director of Nursing, (ADON) was observed at the nurses' station. She also wore an N95 face mask, but an unidentified black object stuck out on all side from the mask so that a proper seal was not obtained. The adjustable nose piece of the N95 was not pinched at the bridge of her nose, so that it did not fit the form of her face. At this time, the ADON indicated there was a COVID outbreak in the building, but she felt there was no way to prevent the spread of the virus or contain the virus. c. At 9:23 a.m., Certified Nursing Assistant (CNA) 16 was observed on the 300 hall. He wore a surgical mask underneath an N95 and the N95 straps were both below his ears around the back of his neck so that the N95 continued to slip, pulled down by the elastic straps. He indicated he was working on the 300 hall with one other CNA. He continued to adjust his N95 as it would not stay in place. A proper seal was not obtained. d. At 9:24 a.m., Qualified Medication Aid (QMA) 7 was observed at a medication cart on the 300 hall. She wore a KN95 face mask. e. At 9:25 a.m., the Activity Director (AD) was observed on the 300 hall going in and out of resident rooms. She was observed to wear an N95 face mask, with the same unidentified black object that stuck out from underneath. A proper seal was not obtained. At this time the AD indicated she had just returned from work after she tested positive for COVID last week. The object she used under her mask had been provided by the DON. It was a "spacer" used under the masks to help create more "breathing room" and made the N95 more comfortable to wear. She indicated the DON had not provided any material with the "spacer" on how it was intended to be used and its proper placement. She		A Root Cause Analysis was conducted by the Infection Preventionist, Administrator, Nurse Consultant, and the Medical Director to determine the Root Cause of the facility's Infection Control Citation. The facility has an opportunity to improve its education, and to ensure that all staff has adequate knowledge of the facility's infection control practices, proper donning and doffing, hand hygiene, and proper way to wear a N95. Reviewed and updated the LTC infection control assessment was completed on 01/28/2022. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure that proper PPE for zone, hand hygiene being performed when needed and N95 mask are being worn properly. DON/Designee will audit 3 random staff by skills validation for performing hand hygiene when required, proper PPE for zone and proper wearing of the N95 5 days a week for 12 weeks, 3 days a week for 8 weeks, and weekly for 4 weeks. Auditing will be done on various shifts and some weekend days/shifts. Staff in non-compliance will be re-educated or up to progressively disciplined. Any concerns will be addressed if found. Results of the monitoring will be presented to the QAPI committee weekly until	

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	just followed what the DON did. f. At 9:28 a.m., CNA 12 was observed as she walked off the 100 hall and onto the 300 hall. She wore a surgical mask under an N95, and the bottom strap of the N95 was not secured behind her neck. It was left lose in the front and tucked under the bottom of the N95 so that a proper seal was not obtained. She indicated she was working a split assignment on both 100 and 300 halls. During an interview on 1/11/22 at 9:30 a.m., the Administrator and DON indicated the building was in the middle of an outbreak that was contained on the locked 200 Memory Care unit. Because of the outbreak and county positivity rate the Administrator and DON required all staff to wear an N95 face mask and face shield when on the floor in any resident common area, and when they provided resident care. 2. On 1/11/22 at 9:44 a.m., upon entrance to the secured memory care unit, the Red Zone (a designated, quarantine area for COVID positive residents) was observed sealed off with a white plastic barrier, just past the nurses' station. The Red Zone was marked with Red Stop Signs which indicated: "Contact Droplet Precautions." At this time, a Tele-Health Assistant was observed at the nurses' medication cart outside of the Red Zone. She indicated she did not want to enter the Red Zone, so the nurse had taken her assessment tablet with a live-feed connection to the doctor into the Red Zone to assess and resident. On 1/11/22 at 9:47 a.m., QMA 14 was observed as she exited the Red Zone. She stepped through the plastic barrier and returned to the nurses' cart and handed the Tele-Health assistant a tablet. At this time, QMA did not perform hand hygiene upon her exit from the Red Zone, and she was		compliance is achieved. Any patterns identified will be addressed immediately. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any written Action Plan will be monitored by the Administrator or designee until resolved.	

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	observed wearing a surgical mask underneath an N95. The N95 did not cover her nose. A proper seal was not obtained. She began to prepare a medication cup. On 1/11/22 at 9:52 a.m., QMA 14 knocked on the closed door of room 201. The door was marked with a Yellow Stop Sign which indicated, "Contact Droplet Precautions, required PPE to enter this room: N95 Mask, Faceshield or goggles must cover top, bottom and sides of eyes with no gaps (*For all HCP regardless of vaccination status), Single gown - with each encounter, gloves (hand hygiene donning/doffing) ...." QMA 14 did not don an isolation gown, or gloves, or perform hand hygiene before she entered the room, and her N95 was still misplaced on top of a surgical mask. On 1/11/22 at 9:55 a.m., QMA 14 exited room 201. She did not perform hand hygiene upon exit. On 1/11/22 at 10:03 a.m., CNA 17 was observed as he squatted down and stuck his head and shoulders through the plastic Red Zone barrier. He was observed to have a surgical mask on underneath his N95, and his N95 straps were both below his ears so that the mask was tugged down off his nose. A proper seal was not obtained. He indicated he wore the surgical mask with his N95 to make it more comfortable. On 1/11/22 at 10:06 a.m., Physical Therapy Assistant (PTA) 15 was observed as she entered room 207. She wore a surgical mask underneath her N95 so that a proper seal was not obtained. On 1/11/22 at 10:11 a.m., QMA 14 entered room 202 (Marked with a Yellow Stop Sign). She			

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	155717	A. BUILDING 00 B. WING	01/12/2022

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	did not don an isolation gown, or gloves, she did not perform hand hygiene, and her mask was still misplaced on top of a surgical mask. On 1/12/22 at 3:03 p.m., Laundry Aid (LA) 18 was observed at the nurses' station. She wore only a surgical mask as she manipulated an N95 mask in her hands. She altered the N95 mask by adjusting the straps so that they did not secure around the back of her head and neck but hooked behind her ears. During an interview on 1/11/22 at 11:00 a.m., the Administrator indicated unvaccinated, newly admitted residents would be put on isolation for 14 days as a precaution to monitor for the development of COVID symptoms. If a resident was fully vaccinated and post two weeks from their second shot, they did not have to go into isolation upon their admission. At that time, the "true Yellow" isolation/precaution rooms were on the 200 hall since those residents were directly exposed to covid positive resident's during the outbreak. Staff should treat those rooms with full PPE precautions before they entered. During an interview on 1/11/22 at 2:15 p.m., the DON indicated the "brace" she wore under her N95 was something she ordered to help herself and the staff breath while wearing the N95. She ordered the mask brace off of the internet, it was called: "Large Mask Bracket 3d Silicone Smooth Breathing Natural Silicone Mask Support Frame." During an interview on 1/12/22 at 11:21 a.m., the DON indicated the mask insert brackets were given to any staff to wear if they wanted. The most important thing about an N95 was that it seals around mouth and nose and because the			

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	bracket was "stretchable" she believed it created a proper seal even though parts of the bracket stuck out from under the mask. On 1/12/22 at 12:40 a.m., the Centers for Disease Control and Prevention (CDC) website article titled, "Improve How Your Mask Protects You," dated 4/6/2021 was reviewed. The article indicated the use of a mask fitter or brace was acceptable over a disposable or cloth mask in order to help prevent air from leaking around the edges of the mask. However, a mask brace or bracket should not be used with an N95. " ...DO NOT: Combine a KN95 mask with any other mask ...." On 1/12/22 at 3:40 p.m., the Administrator provided a copy of current, but undated, facility policy titled, "PPE and Universal Precautions Guidelines." The policy indicated, " ...PPE is provided to prevent blood and other potentially infectious materials from contacting employees clothing, skin, eyes, mouth, and other mucous membranes...." This Federal tag relates to Complaint IN00369814. 3.1-18(b)(2)			
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure a resident room was free of flying insects subsequently to open food and drinks in the resident's room for 1 of 1 random observation of a resident's room	F 0925	**F 925 Maintains Effective Pest Control Program** It is the practice of this facility to maintain effective pest control program so that the facility is free	02/01/2022

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	(Resident D). Findings include: On 1/12/22 at 3:20 p.m., several flying insects were observed in Resident D's room. She had 5 drink cups on her dresser, three with rings of evaporation lines inside the cups. The cups still contained liquids. About 25 flying insects were observed on the 5 cups and several other insects were still flying above the dresser. An open canister of popcorn was observed, with an unsealed container of cookies on top of it, there were several more flying insects on those containers. An overflowing laundry basket with soiled clothing was observed with several flying insects on the soiled clothes. To the immediate left of the dresser, was a free-standing closet for clothes. On the side of this closet another 16 flying insects were observed. A record review was completed for Resident D. Her diagnoses included, but were not limited to, Huntington's disease (hereditary disease marked by degeneration of the brain cells), muscle wasting, generalized muscle weakness, lack of coordination, Alzheimer's disease (progressive mental deterioration due to degeneration of the brain), dysphagia (difficulty swallowing), schizoaffective disorder (breakdown in the relation between thought, emotion, and behavior), abnormal involuntary movements (jerky movements of the hips, shoulders, and face), and cognitive communication disorder. Her care plans included, " ...Resident requires extensive staff assist with ADLs due to impaired balance secondary to Huntington's disease and involuntary movements, and sometimes it is difficult to understand her, she does not have		of pest and rodents. Resident D has been educated as to the need to keep food/drink covered and how food safety can be compromised. All residents rooms were checked pest with no other concerns being noted. Resident D has been has been encouraged to use lidded containers for her liquids in an effort to keep her living space sanitary. All residents residing in the facility have the potential to be affected; however, no resident was affected. Residents care plan was reviewed and updated as indicated. DON/ADON/Designee educated staff on the Pest Control policy and of removal of open food and drinks when residents are done. Administrator or designee will audit 2 rooms 4 times a week for 4 weeks; then 2 rooms 3 times a week for 4 weeks; then 2 rooms a 2 times a week for 4 weeks; then weekly for 4 weeks; then monthly for 3 months. Any concerns will be addressed immediately. Results of the monitoring will be presented to the QAPI committee monthly. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any written Action Plan will be monitored by the Administrator or designee until resolved.	

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	good control of her arms...." During an interview, on 1/12/22 at 4:20 p.m., the Director of Nursing (DON) indicated staff should have cleaned up the food and drinks, so the resident was not living with insects in her room. During an interview, on 1/12/22 at 5:01 p.m., the Administrator indicated the facility should have care planned Resident D for hanging on to too many things in her room. She got upset when things were taken out of her room. During an interview, on 1/12/22 at 5:02 p.m., the DON indicated Resident should have had a care plan because the resident tended to hoard food and drinks, and we would have assisted and educated the resident to remove items from her room because it causes gnats to accumulate. A current policy, titled, "Pest Policy," with no date, was provided by the Administrator on 1/12/22 at 4:55 p.m. A review of the policy indicated, " ...The maintenance staff and all other staff will be cognizant of the necessity to maintain a clean, safe and comfortable, homelike environment that is free of pests ...Upon a sighting of any pest or rodent or any evidence of a pest or rodent by any person in the facility, the Administrator will be notified. The problem will be addressed ...Residents will be encouraged and assisted in the storage of food stuff in their rooms by use of proper containers in an effort to deter vermin that might be attracted to unprotected food ...." 3.1-19(f)(4)		DON/ADON/Designee educated staff that if a resident's family wants to do their laundry, soiled laundry must be placed in a container with an attached lid. Administrator or designee will audit residents laundry containers of residents who have their laundry done by family to ensure they have an attached lid 4 times a week for 4 weeks; then 3 times a week for 4 weeks; then 2 times a week for 4 weeks; then weekly for 4 weeks; than monthly for 3 months. Any concerns will be addressed immediately. Results of the monitoring will be presented to the QAPI committee monthly. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any written Action Plan will be monitored by the Administrator until resolved.	