STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165082	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Lake City LLC	1409 West Main Street Lake City, IA 51449

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to provide adequate supervision to ensure timely intervention during a choking incident for 1 resident (Resident #1) and failed to ensure appropriately trained staff supervised and fed residents at risk for choking for 2 of 2 residents (Resident #1 and #3). On [DATE], while at supper in the assisted area, Staff A, Noncertified Nurse Aide (NCNA), assisted Resident #3 eat and observed Resident #1. Resident #1 choked. At the time, the only people in the assisted dining room were Staff A and the 2 residents. Staff A couldn't do the Heimlich and the walkie talkie failed to work to summon help timely. Staff A yelled for help. After hearing Staff A, Staff D Dietary Aide responded and learned they needed assistance. Staff D left the dining room to find additional staff to assist Resident #1. Staff A provided back thrusts without success. Once the nurse arrived, they managed to dislodge a piece of bread which allowed the resident to resume breathing. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 46 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began on [DATE] on [DATE] at 4:30 p.m. The Facility Staff removed the Immediate Jeopardy on [DATE] through the following actions: On [DATE], the Administrator initiated staff education to ensure all nursing staff are carrying a functioning walkie talkie during their shift. All nursing staff will be educated on [DATE] or prior to the start of their next shift. On [DATE], the Administrator and DON were educated by the VP of Operations on the requirement to ensure licensed nurses or certified nurse aides are the only staff assisting residents during meals. As of [DATE], there are no uncertified nurse aides on the nursing schedule. Staff A is no longer employed at the facility. Last date of employment was [DATE]. The DON/Administrator and/or designee will audit staff for compliance with walkie talkie usage at random during their shift. The DON/Administrator and/or designee will also audit the nursing daily schedule sheets at random to ensure licensed/certified staff are scheduled. Any concerns will be reported to the Administrator immediately and addressed in facility QA. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The scope lowered from a J to a G at the time of the survey after ensuring the facility implemented education and their policy and procedures. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required supervision or touching assistance with eating. The resident had diagnoses including diabetes. The Care Plan initiated [DATE] identified Resident #1 had a recent swallow study with recommended mechanical soft with ground meat diet and honey thick liquids. The resident declined. Resident #1 and his family were aware of the risks per a managed or negotiated shared risk agreement. 2) According to the MDS assessment dated [DATE] Resident #3 scored 7 on the BIMS indicating severe cognitive impairment. The resident required substantial/maximal assistance with eating. The resident had diagnoses including non-Alzheimer's dementia and multiple sclerosis. The Care Plan initiated [DATE] identified Resident #3 had a swallowing problem related to dsyphagia. Interventions included all staff informed of special dietary and safety needs, alternate small bites and sips, check mouth after a meal for pocketed food and debris, remove and report as needed. The resident had oral/dental health problems related to poor oral hygiene. He did not have his own teeth. Interventions included diet as ordered. Consult with the dietician and change if chewing/swallowing problems. In a statement dated [DATE] Staff A signed on [DATE] she was in the dining room at the end of supper feeding another resident (Resident #3) around 6:15 p.m. Resident #1 sat across the table from her. Staff A saw Resident #1 take a bite of his sandwich. He chewed and swallowed it and then made a gasping/muffled whistling noise. He picked up a glass of water and took a drink and kept gasping. No liquid ran out of his mouth. Staff A went behind him and tried to put her arms around him for the Heimlich, but couldn't fit her arms around him. She called for help and the walkie talkie didn't work. Staff A pounded on Resident #1's back to see if something would lodge loose. Staff D Dietary Aide (DA) heard Staff A yelling and ran to get help. Resident #1 never lost consciousness. Resident #1 kept trying to take drinks and Staff A had to take the cup out of his hand as he kept trying. Time lapse between when he started choking and when the nurse's arrived, approximately 3 minutes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes dated [DATE] at 7 p.m. documented Staff C Licensed Practical Nurse (LPN) was giving on coming nurse Staff B LPN report at approximately 6:20 p.m. when Staff D came running, stating a resident choked in the dining room. Staff B ran to the dining room while Staff C looked up code status and grabbed vital sign equipment and ran to the dining room. When Staff C entered the dining room a NCNA said Resident #1 started choking. Resident #1 could not talk or cough. His lips were blue and teeth were clenched together. Staff B started thrusts while this nurse called 911 at approximately 6:23 p.m. while running for the crash cart. When Staff C reentered the dining room, Staff B stated she got a small chunk of food to come up. Resident #1 still did not cough and Oxygen (O2) read low at 50%. O2 applied via a mask. The Ambulance arrived and took over. The Progress Notes dated [DATE] at 9:01 p.m. documented at approximately 6:20 p.m. Staff B Licensed Practical Nurse (LPN) was getting shift report at the nursing station when Staff D came and notified her Resident #1 choked in the dining room. Staff B and Staff C ran to the dining area. Staff A was in the dining area helping Resident #1 lean forward and encouraging him to cough. Resident #1 was awake, but unable to speak or cough. The resident noted to have blueish purple lips. Back blows given while the resident sat forward then abdominal thrusts performed by Staff B while Staff C called 911 at 6:23 p.m. and obtained the emergency cart. Resident #1 able to dislodge a piece of bread after multiple thrusts, then resident gasped and had some air movement. Resident #1 had his teeth clenched and had a whistle when breathing with fast shallow respirations. No secretions noted and lips appeared less blue in color. Helped Resident #1 sit forward and encouraged him to cough. He didn't cough, but made a growl noise. Abdominal thrusts done again to see if there were anymore food that could be dislodged, but none did. Resident #1 continued to clench his teeth so unable to look inside of his mouth. Resident #1 remained awake, Oxygen (O2) applied via mask. When pulse oximetry checked it read 51%-60% (normal ,d+[DATE]%). Emergency Medical Technicians (EMTs) arrived and took over and applied their oxygen source. Resident #1 transferred to a cot then left the facility. The ambulance Prehospitalization Care Report dated [DATE] documented Resident #1's primary impression of esophageal obstruction and secondary hypoxemia (low level of O2 in the blood). Resident #1 visibly tried to breathe and cough with no success. He had cyanosis of the face, head, hands, and arms (deep purple dark blue in color) and lethargy. Resident #1 had his jaw clenched closed with his lips open. EMS used a suction device on the patient, one attempt. Unable to see inside due to his jaw being clenched and nothing seen inside the cheeks. The resident's color improved to red in color with some cyanosis present (lighter blue purple) and he had grunting/gasping sounds present and breathing labored. Oxygen increased to 8 liters and his 02 saturation improving. The hospital report dated [DATE] at 6:42 p.m. documented Resident #1 presented per EMS from the facility with complaints of choking at supper. The Heimlich attempted with a small amount of bread expelled. EMS tried the manual vac device with no output retrieved. He struggled to breath with 15 L non-re breather on per EMS with oxygen saturations at 68%. When placed on BiPAP he improved to 86% oxygenation. His family was called and was at the bedside. A physical exam revealed Resident #1 in acute distress. He showed tachypnea (rapid, shallow breathing), accessory muscle usage (the use of muscles other than primary respiratory muscles to assist with breathing), respiratory distress and retractions present. Decreased air movement, wheezing, rhonchi and rales present. Mottling (skin developing a patchy or marbled appearance, often with shades of red, purple or blue) up to the residents umbilicus (navel). Resident #1 unable to voice concerns or needs due to condition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Final diagnoses included: Choking due to food in larynx, Parkinson's disease, Aspiration pneumonia of both lungs due to regurgitated food, Acute respiratory failure with hypoxia, End of life care. Resident #1 remained on BIPAP until all of his family arrived. Time of death: [DATE] at 10:40 p.m. from cardiac arrest due to acute respiratory failure and a choking incident from Parkinson's disease. On [DATE] at 12:25 p.m. Staff A said she sat in the assisted area with Resident #1 and one other resident, Resident #3. Staff A sat by Resident #3 because he needed more assistance. Resident #1 took a bite of his tenderloin sandwich and Staff A heard him make a gasp. She looked over and Resident #1 tried to get a hold of his water and got it up to his mouth, but he really couldn't take any in. Staff A went over and told Resident #1 to cough but he wasn't able to do that so she tried to put her arms around him and do the Heimlich maneuver, but she couldn't get her arms around him and the wheelchair arms. While she did some back blows Staff A said she used her walkie to try to call for help, but she didn't get any response, so she started yelling that she needed help. Staff D from the kitchen came out and asked what she needed, and she told her a resident choked and she needed the nurse. Staff D ran to get her. Staff A thought Resident #1 was getting some air but not a lot. When the nurse came, she took over. Staff A said she was not certified as a nurse aide. She had worked in an assisted living previously, and didn't have to be certified to work in that area. The Administrator was willing to give her a shot at being an aide and they were going to set her up with testing out so she could be a certified aid, but with the holidays it was hard to get a date. She has since then moved and no longer working at the facility. Staff A said she had not been certified in CPR, but she knew how to do it and the Heimlich maneuver, and in fact had performed CPR on someone previously. On [DATE] at 1:35 p.m. Staff C stated she thought the event with Resident #1 went as well as they could have expected. She said the NCNA, Staff A said she had been trying to call over the walkie for help. Staff C was giving the night nurse report when the dietary staff (Staff D) came and told them she needed help. They had heard nothing over the walkie. She said Staff B took off running while she got vital sign equipment and checked code status. She said they did things as quick as they could. She said the only delay was not getting the message over the walkie. She said they never heard any call for help come over the walkie. On [DATE] at 7:45 a.m. Staff B LPN stated as soon as Staff D came running and said they needed help she went to the dining room. And when she got to the dining room she started working with Resident #1. She said the only thing that she could think of that would have gotten them there quicker would be a call over the walkie. She said they never heard any call for help over the walkie. She said Staff A's walkie wasn't working later either because she had call lights on and Staff B told her they had been on too long. Staff A said she didn't have any call lights on. Her walkie had either died or wasn't working because she didn't get her call lights. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a statement signed and dated [DATE], Staff D was in the middle of the dining room picking up dishes and the aide was over in the back helping residents. Staff D heard the aide ask if one of the residents in the assisted dining was ok. Directly after that Staff D heard her yell hey he is choking go get help. Staff D dropped what she was doing and ran down the halls looking for someone. She did not see anyone in the halls, nobody was at the nurse's station either. Staff D ran down a hall and did not see anyone in the rooms, but saw some people at the other station. Staff D told them they had someone choking in the dining room. One of them took off running to the dining room and the other messaged people on the walkie. Staff D did not see or hear the aide using a walkie talkie. Staff D heard her yell to go get help so she did. On [DATE] at 12:45 p.m. the Administrator stated nurse aides could work for up to 4 months if they had the skills and competencies with a Registered Nurse (RN). Staff A had that with the Director of Nursing (DON) at a previous facility. That facility closed and they all transferred to this facility. An application dated [DATE] showed Staff A worked as a Training CNA from ,d+[DATE] to ,d+[DATE] at another facility training to take the CNA test. From ,d+[DATE] to ,d+[DATE] she worked in a restaurant where she served customers food and beverages. Staff A signed the job description for a Certified Nursing Assistant (CNA). A CNA/Nurse Aide-Skills and Competency checklist with a date of hire [DATE] (at previous facility) and had items dated and checked under met objectives. The facility Job Description: Aide in Training (CNA Scholarship) revised [DATE] documented the facility would enroll a candidate directly into a state certified Certified Nursing Assistant (CNA) course, either prior to joining their team, or request a candidate join their team in a non-certified capacity for a predetermined allotted time, prior to their investment in a CNA course and testing. As a non-certified aide in training, they would play a vital role in providing direct resident care and assisting the nursing and medical staff in delivering high quality healthcare services. Essential job functions included performing all duties and responsibilities under the direct supervision of the nursing staff.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 26527 Based on personnel file review and staff interview the facility failed to ensure sufficient nursing staff with appropriate training to provide supervision during a meal for 1 of 2 staff reviewed (Staff A). The facility reported a census of 46 residents. Findings include: Staff A's personnel file contained an application dated 9/17/24 showing Staff A worked as a Training Certified Nursing Assistant (CNA) from 8/2024 to 9/2024 at another facility, training to take the CNA test. From 7/2021 to 7/2024 Staff A worked in a restaurant where she served customers food and beverages. Staff A signed the job description for a CNA. A CNA/Nurse Aide-Skills and Competency checklist with a date of hire 8/28/24 (at previous facility) had items dated and checked under met objectives dated 8/31 or 9/3/24. The observer signature identified as the Director of Nursing (DON). The personnel file lacked training by a state approved program or enrollment in a CNA class. In a statement dated 12/5/24 Staff A signed on 12/4/24 she was in the dining room at the end of supper feeding another resident (Resident #3) around 6:15 p.m. Resident #1 sat across the table from her. Staff A saw Resident #1 take a bite of his sandwich. He chewed and swallowed it and then made a gasping/muffled whistling noise. He picked up a glass of water and took a drink and kept gasping. No liquid ran out of his mouth. Staff A went behind him and tried to put her arms around him for the Heimlich, but couldn't fit her arms around him. She called for help and the walkie talkie didn't work. Staff A pounded on Resident #1's back to see if something would lodge loose. Staff D Dietary Aide (DA) heard Staff A yelling and ran to get help. Resident #1 never lost consciousness. Resident #1 kept trying to take drinks and Staff A had to take the cup out of his hand as he kept trying. Time lapse between when he started choking and when the nurse's arrived, approximately 3 minutes. On 1/7/25 at 12:45 p.m. the Administrator stated nurse aides could work for up to 4 months if they had the skills and competencies with a Registered Nurse (RN). Staff A had that with the Director of Nursing (DON) at a previous facility. That facility closed and they all transferred to this facility. The facility Job Description: Aide in Training (CNA Scholarship) revised 3/14/24 documented the facility would enroll a candidate directly into a state certified Certified Nursing Assistant (CNA) course, either prior to joining their team, or request a candidate join their team in a non-certified capacity for a predetermined allotted time, prior to their investment in a CNA course and testing. As a non-certified aide in training, they would play a vital role in providing direct resident care and assisting the nursing and medical staff in delivering high quality healthcare services. Essential job functions included performing all duties and responsibilities under the direct supervision of the nursing staff.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 26527 Based on personnel file review and staff interview, the facility failed to ensure an individual applying for a position as a nurse aide could prove that he or she had recently successfully completed a training and competency evaluation program, or was a full time employee in a training and competency program approved by the State for 1 of 2 staff reviewed (Staff A). The facility reported a census of 46 residents. Findings include: Staff A's personnel file contained an application dated 9/17/24 showing Staff A worked as a Training CNA from 8/2024 to 9/2024 at another facility, training to take the CNA test. From 7/2021 to 7/2024 she worked in a restaurant where she served customers food and beverages. Staff A signed the job description for a Certified Nursing Assistant (CNA). A CNA/Nurse Aide-Skills and Competency checklist with a date of hire 8/28/24 (at previous facility) had items dated and checked met objectives dated 8/31 or 9/3/24. The observer signature identified as the Director of Nursing (DON). The personnel file lacked training by a state approved program or enrollment in a CNA class. On 1/7/25 at 12:45 p.m. the Administrator stated nurse aides could work for up to 4 months if they had the skills and competencies with a Registered Nurse (RN). Staff A had that with the Director of Nursing (DON) at a previous facility. That facility closed and they all transferred to this facility. The facility Job Description: Aide in Training (CNA Scholarship) revised 3/14/24 documented the facility would enroll a candidate directly into a state certified Certified Nursing Assistant (CNA) course, either prior to joining their team, or request a candidate join their team in a non-certified capacity for a predetermined allotted time, prior to their investment in a CNA course and testing. As a non-certified aide in training, they would play a vital role in providing direct resident care and assisting the nursing and medical staff in delivering high quality healthcare services. Essential job functions included performing all duties and responsibilities under the direct supervision of the nursing staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26527 Based on record review and staff interview, the facility failed maintain a system of drug reconciliation to identify disposition of a missing pill for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 46 residents. Findings include: The Progress Notes dated 9/27/24 at 8 a.m. documented staff reported Resident #4 had a missing Methadone 1/2 tab to equal 2.5 mg. A Self Report documented on 9/27/24 at approximately 6:45 a.m. the Administrator in Training (AIT) received notification from Staff F Registered Nurse (RN) that during narcotic count they noted a discrepancy in Methadone count for Resident #4 of a 2.5 mg tablet of Methadone missing. At Approximately 6 a.m. oncoming Certified Medication Assistant (CMA), Staff G began count of the narcotics in one of the carts and noticed the incorrect count of Methadone for Resident #4. There were only 15 tablets of Methadone, but should have been 16. As of 10 p.m. on 9/26/24 all of the narcotic count was correct and signed off by the off going CMA and oncoming Staff H Licensed Practical Nurse (LPN). A narcotic count completed by the Director of Nursing (DON) and the AIT on 9/27/24 at approximately 5 p.m. revealed all other controlled substances were accounted for per nursing documentation. The internal investigation determined the missing medication could not be found. The medication was a scheduled narcotic to be given at approximately 8 a.m. and 8 p.m. per the electronic health record. At 10 p. m. all controlled substances were accounted for and at 6 a.m. 1 pill missing during count. The overnight nurse Staff H, per her statement, indicated she did not know where the medication went and she was the only one with access to the medication cart during that time. Staff H sent her statement via email. She wrote she arrived to her scheduled shift at 10 p.m. They had one nurse and two CMA's working from both med carts passing meds. The nurse and the CMA mentioned it had been a really busy, chaotic night. Staff H asked how she could help and the nurse and CMA instructed her in a few things they still needed done and Staff H did those tasks. When it came time to count narcotics Staff I CMA and Staff H counted one of the two carts together. All of the narcotics were removed from the drawers and set on the cart. Staff I had the narcotic count sheet and Staff H had the narcotics. Staff H did not visualize the narcotic count sheet as they counted. Staff H visualized the narcotics and counted them in the cassettes and relayed the number to Staff I and she then confirmed the number was correct. Staff H then counted the other cart with the nurse. It was med change over and Staff H was very busy changing out the medications and it took a good portion of her shift. As Staff H finished that around 4:30 a.m. she then signed off the narcotic check book, trying to be proactive and get things ready for the on coming shift. Around 5:30 a. m. or so one of the CMA's came in and took the keys for one of the carts and Staff H passed early a.m. medications. Another CMA came on shift and counted the cart with the other CMA that came in at 5:30. The CMA then stated the count was off for a medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Staff Investigation Questionnaire dated 9/27/24 documented the Director of Nursing investigated the missing medication and a CMA did not follow facility policy to count with off going staff. She counted by herself and found medication missing. The Controlled Drug Count Record for September 2024 showed missing signatures/initials on 9/1, 6, 7, 8, 13, 16, and 20/24. Education given to nurses and CMAs on the controlled substance procedure on 9/27/24 and 9/30/32 by the AIT. Staff H taken off the schedule pending investigation. The facility Controlled Substance updated 10/29/22 identified the purpose included to complete a physical inventory of narcotics at each change of shift by 2 nurses to identify discrepancies and need for reconciliation and accountability, to assure controlled drugs were handled, stored and disposed of properly, and to assure proper record keeping for controlled drugs. The procedure for controlled substance count included one authorized person was responsible for narcotics utilization every shift Going off duty and coming on duty, authorized persons must count and validate accuracy of narcotics supply for every resident at the change of every shift. Narcotic records are reconciled by a physical count of the remaining narcotic supply at the change of each shift by the oncoming and outgoing licensed nurse/designee. After the supply is counted and justified each nurse must record the date and his/her signature to verify the count was correct. The nurse going off duty surrenders the narcotics key to the oncoming nurse after the narcotics count was reconciled.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 26527 Based on observation, and staff and resident interview, the facility failed to maintain an effective pest control program. The facility reported a census of 46 residents. Findings include: On 1/6/24 at 1:50 p.m. Resident #2 sat in her room in her wheelchair. She said the first time she saw a mouse in her room was sometime in November and she got up and went to her top drawer dresser and opened it. There was a mouse sitting on top of her underwear. It startled her and she fell . She said the second time she saw a mouse in her room is when it came in and got into a sticky trap. Then one of the staff members took it out of the room for her. She didn't know what they did with it and she didn't care. She just couldn't stand the idea of having a mouse in her room. On 1/7/25 at 9:40 a.m. Staff E Certified Nursing Assistant (CNA) stated they have had a mouse infestation. Residents and family had brought it up. She said they had to clean out drawers with mouse droppings in them. It didn't seem to be getting any better. On 1/9/25 7:45 a.m. Staff B Licensed Practical Nurse (LPN) stated there were mice, and a staff member saw one the previous day. It had been going on for awhile. On 1/9/25 at 8:08 a.m. Resident #5 stated she had just seen a mouse this past week. She was looking down and saw a mouse. If she had not been looking down she would not have seen it. She thought she had seen something before, but couldn't quite look quick enough. They have put out sticky traps. The Maintenance Man came in Resident #5's room and stated the pest control person had just been there and sent pictures of areas mice may be getting in. He brought some sealant for an area by the register in Resident #5's room. On 1/9/25 at 11:05 a.m. Resident #2's family member stated they have had mice for awhile. Resident #2 had been startled by a mouse in her dresser drawer, and they had to clean the drawers several times due to their droppings, and they chewed on things. He said the pest control person came this week and found a mouse in one of the sticky traps in Resident #2's room. He took it and said he would take care of it. A pest control report dated 1/7/25 documented all conditions were still active and observable during the inspection. Added conditions pertaining to rooms inspected due to increased rodent activity. Mice were reported in 9 rooms. Four rooms had potential points of entry needing sealed. On 1/9/25 at 1:50 p.m. the Administrator confirmed awareness of the mouse infestation and there had been a change in pest control companies.