STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on record review and interview it was determined the facility failed to report allegations of abuse within 2 hours of the allegation and an injury of unknown origin within 24 hours to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 3(#10, #8, #2) residents involved in 14 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 9/18/24 at 9:24 AM a review of facility reported incident MD00186088 revealed Resident #10 made a statement to his/her spouse that the person who drew his/her blood, smacked [him/her] in the head. There was no date of the incident on the report. There was no investigation provided to the surveyor to determine the date of the incident. Review of the intake report for MD00186088 the received date was 11/28/22. The facility did not supply the surveyor with email confirmations as to when the report was sent in and when the final report was sent in. On 9/16/24 at 10:46 AM an interview was conducted with the Director of Nursing (DON) who stated she couldn't find the investigation. On 9/17/24 at 9:24 AM an interview was conducted with the NHA who stated that he could not find the file or investigation related to this facility reported incident. 2) On 9/18/24 at 9:24 AM a review of facility reported incident MD00183662 revealed Resident #10 made a statement to his/her spouse that the person who drew his/her blood, smacked [him/her] in the head. There was no date of the incident on the report. There was no investigation provided to the surveyor to determine the date of the incident. Review of the intake report for MD00183662 the received date was 9/21/22. The facility did not supply the surveyor with email confirmations as to when the report was sent in and when the final report was sent in. On 9/16/24 at 10:46 AM an interview was conducted with the Director of Nursing (DON) who stated she couldn't find the investigation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 9:24 AM an interview was conducted with the NHA who stated that he could not find the file or investigation related to this facility reported incident. 37586 3) Review of the Facility Reported Incident MD00181568 Initial Report Form on 09/16/2024 at 12:48 pm revealed the initial report was sent to OHCQ on 8/2/22 at 14:33 which was not within 2 hours of an alleged physical abuse as alleged by Residnet #8. There were no email confirmations provided to the surveyor to corroborate the exact time the report was submitted to OHCQ. The administrator and the director of nursing could not locate the facility incident report or the investigation they stated they completed. The DON and administrator is aware of this being a deficiency. 42886 4) On 9/13/24 at 8:00 am, the survey team provided the facility with a list of facility reported incidents (FRIs) that required a review of the facility investigation. This list included FRI MD00180624 which was report of alleged employee to resident abuse involving resident #2. This FRI was sent to the State of Maryland's Office of Health Care Quality on 12/20/21. On 9/16/24 at 10:00 am, the DON admitted the facility investigation for FRI MD00180624 involving resident #2 was unable to be found. On 9/18/24 at 11:30 am, the surveyor reviewed the medical records and was unable to determine if the facility reported the alleged employee to resident abuse timely to the State of Maryland.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 31145 Based on review of facility administrative records, facility investigations, and staff interview, it was determined the facility failed to thoroughly investigate incidents of alleged abuse, neglect, and misappropriation of property. This was evident for 4 (#10, #8, #2, #30) residents involved in 14 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 9/18/24 at 9:24 AM a review of facility reported incident MD00186088 revealed Resident #10 made a statement to his/her spouse that the person who drew his/her blood, smacked [him/her] in the head. There was no date of the incident on the report. There was no investigation provided to the surveyor to determine the date of incident. There was no evidence that staff were interviewed and that the incident was investigated. On 9/16/24 at 10:46 AM an interview was conducted with the Director of Nursing (DON) who stated she couldn't find the investigation. On 9/17/24 at 9:24 AM an interview was conducted with the NHA who stated that he could not find the file or investigation related to this facility reported incident. 2) On 9/18/24 at 9:24 AM a review of facility reported incident MD00183662 revealed Resident #10 made a statement to his/her spouse that the person who drew his/her blood, smacked [him/her] in the head. There was no date of the incident on the report. There was no investigation provided to the surveyor to determine the date of the incident. There was no evidence that staff were interviewed, and that the incident was investigated. On 9/16/24 at 10:46 AM an interview was conducted with the Director of Nursing (DON) who stated she couldn't find the investigation. On 9/17/24 at 9:24 AM an interview was conducted with the NHA who stated that he could not find the file or investigation related to this facility reported incident. 37586 3) Record review was completed on 9/16/24 at 12:30 PM for facility reported incident MD00181568. On 8/2/22 it was reported to the police by resident # 8 that someone took resident # 8 purse and struck her/him in the head with the purse. Resident # 8 called the police to report this. The resident never reported this to the facility until after the police arrived. A skin assessment was completed on 8/26/22 and Social Work conducted a wellness visit on 7/29/22. On 9/16/24 at 12:30 PM, this surveyor requested the facility incident report that was completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The administrator and the director of nursing could not locate the facility incident report or the investigation they stated they completed. The DON and administrator is aware of this being a deficiency. 42886 4. On 9/13/24 at 8:00am, the survey team provided the facility with a list of facility reported incidents (FRIs) that required a review of the facility investigation. This list included FRI MD00180624 which was report of alleged employee to resident abuse involving resident #2. This FRI was sent to the State of Maryland's Office of Health Care Quality on 12/20/21. On 9/16/24 at 10:00am, the Director of Nursing (DON) admitted the facility investigation for FRI MD00180624 involving resident #2 was unable to be found. On 9/18/24 at 11:30am, the surveyor reviewed the medical records and was unable to determine if the facility thoroughly investigated the alleged incident employee to resident abuse. 5. On 9/16/24 at 8:50am, the surveyor reviewed the facility investigation of an alleged incident of misappropriation of a resident's funds (MD00207057). The facility reported that the misappropriation incident occurred on 6/12/24. Review of the facility investigation revealed that the facility investigation failed to indicate the room numbers for resident statements and failed to provide information on the interventions used to alleviate future issues of misappropriation for resident #30. On 9/16/24 at 10:15am, during an interview with the Administrator, the surveyor explained the facility's issues with investigation of the alleged misappropriation of resident #30's funds. The surveyor pointed out that the investigation failed to put room numbers on the resident witness statements and there was no evidence that the facility applied interventions to stop future incidents of misappropriation of resident #30's funds. The Administrator stated that he/she believed that resident #30 was given a lock-box to aid in preventing misappropriation of funds.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31145 Based on the review of a complaint, medical record review and interview with staff, it was determined that the facility failed to timely implement wound care orders for a resident with a scrotal ulcer. This was evident for 1 (Resident #35) of 28 complaints reviewed during a complaint survey. The findings include: On 9/17/24 at 8:00 AM a review of complaint MD00177503 revealed concern about being notified that Resident #35 had a pressure ulcer on the sacrum on 9/28/21. On 9/17/24 at 8:00 AM a review of Resident #35's medical record revealed Resident #35 was admitted to the facility in July 2021 with diagnoses that included a urinary tract infection, obstructive and reflux uropathy, anemia, dementia, and Downs syndrome. Resident #35 was admitted with a foley catheter for the obstructive and reflux uropathy. Obstructive uropathy occurs when urine cannot drain through the urinary tract. Urine backs up into the kidney and causes it to become swollen. Reflux nephropathy is a condition in which the kidneys are damaged by the backward flow of urine into the kidney. A foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. Review of progress notes documented that on 9/28/21 Resident #35 was noted with an ulcer on the dorsal scrotum. There was no further documentation in progress notes about that ulcer and there were no skin sheets related to the ulcer. Review of Resident #35's October 2021 Treatment Administration Record (TAR) revealed an order for Calmoseptine ointment 0.44-20.6% (Menthol-Zinc Oxide) to be applied to sacrum every shift and to the groin. On 9/17/24 at 12:29 PM an interview was conducted with the Director of Nursing (DON). The DON was informed that there was no skin sheet for the ulcer and no further documentation. The DON stated that Resident #35 did receive treatment for the ulcer and it did heal. The surveyor informed the DON that the ulcer was noted on 9/28/21 but treatment was not put in place until 10/1/21 and there was no documentation regarding the size and description of the ulcer. The DON confirmed the finding but said it did heal within 15 days and it was probably caused by the foley catheter tubing.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 31145 Based on medical record review, policy review, and interview, it was determined the facility staff failed to ensure the physician wrote, dated, and signed progress notes at each resident's visit. This was evident for 1 (Resident #24) of 28 complaints reviewed during a complaint survey. The findings include: On 9/16/24 at 11:37 AM Resident #24's medical record was reviewed and revealed a 2/21/24 physician's note. Review of the note revealed the physician signed the note on 2/29/24. Continued review of Resident #24's medical record revealed a 2/28/24 note that was signed by the physician on 3/7/24. A 3/6/24 physician's note was signed by the physician on 3/19/24. A 3/8/24 physician's note was signed on 3/19/24 and a 3/13/24 physician's note was signed by the physician on 3/19/24. On 9/17/24 at 10:40 AM the Physician Visits Policy, that was given to the surveyor by the Nursing Home Administrator (NHA) documented, Policy Explanation and Compliance Guidelines, letter f. remind the physician to date and sign all orders and write a progress note. Number 2. documented, The physician should d. date, write and sign a progress note for each visit. On 9/17/24 at 10:45 AM the surveyor reviewed the physician notes with the NHA and showed him the dates. The NHA stated that the physician moved out of state and no longer worked at the facility. The NHA stated understanding and agreed that the notes were not signed at the of the visit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of complaint MD00977840, interviews, and medical record review, it was determined the facility failed to ensure that pain and anxiety medications were available to a resident. This was evident for 1 (#18) of 28 complaints reviewed during a complaint survey. The findings include: On 9/13/24 at 12:14 PM complaint MD00197840 was reviewed and alleged that the facility often ran out of Resident #18's medications and that at times the resident would be verbally abusive towards the nursing staff when his/her medications were not given. The complainant reported that the resident would often call 911 when he/she was not given his/her medication. On 9/13/24 at 12:26 PM an interview was conducted with Resident #18 who was asked if he/she had any concerns. Resident #18 stated he/she had issues with pain medication being available and it made him/her mad. The resident did admit that in the past he/she would call 911 about his/her pain medications. On 9/17/24 at 2:24 PM Resident #18's medical record was reviewed and revealed Resident #18 was admitted to the facility in 2021 with diagnoses that included chronic pain syndrome, opioid dependence, cerebral infarction, anxiety disorder, and Parkinson's disease. Review of a 9/1/24 change in condition note documented that Resident #18 called 911 due to pain medication not being available. The note documented that the writer of the note called the pharmacy and reordered the medication, and the pharmacy stated that the medication was on the next pharmacy run. The pharmacy was called back so an authorization could be obtained to pull the medication from the Omnicell (back-up pharmacy storage). As the writer was on the phone the resident had already called 911. Review of a 9/6/24 pain management note documented a 2/2/24 x-ray of the left hip demonstrated moderate osteoarthritis. The note documented that the resident called 911 for transfer to the emergency department due to leg pain and that Resident #18 had no remaining Oxycodone 10 mg. remaining and the nurse was awaiting a signed C2 form to fax to the pharmacy to refill. The note documented the resident returned to the facility later in the day and that the Oxycodone 10 mg. was delivered to the facility in time for the next dose. The note finished with, ongoing assessments to closely monitor and identify pain necessary to attain or maintain highest physical mental and psychosocial well-being. Review of Resident #18's physician's orders revealed the resident was prescribed Oxycontin ER 20 mg. every 12 hours for pain, Gabapentin 300 mg. every 12 hours for nerve pain, Tizanidine 2 mg. 2 times per day for muscle pain, Tylenol 325 mg. (2) every 6 hours prn (when needed) for pain level 1-4 and Oxycodone 10 mg. every 4 hours prn pain level 5-10. Resident #18 also received Lorazepam 1 mg. twice per day for anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of eMAR (Medication Administration Record) notes documented when the Oxycontin ER 20 mg. was not available. The Oxycontin was a pain medication that was to be administered every day, twice per day. On 3/5/24 at 9:05 AM it was documented, Medication was not available, pharmacy stated it was not available in the Omnicell. The medication was re-ordered, and pharmacy stated that it would be delivered stat. Spoke with [name] from pharmacy. On 4/23/24 at 11:24 AM it was documented, Awaiting pharmacy delivery, to be delivered today. [name of physician] notified gave order to administer when med arrives no c/o pain or discomfort. Oncoming nurse aware. On 5/11/24 at 9:11 AM it was documented that the Lorazepam, not available at this time. On 5/12/24 at 22:03 (10:03 PM) it was documented, pharmacy called for Lorazepam med and reported it will be delivered tomorrow and am nurse to call for authorization in case med is not available by 9 AM. Code given for night med. On 5/12/24 at 22:08 the Pyxis was frozen, and the nurse was unable to pull the medication. The nurse called the help line, and the machine was rebooted 3 times with no success. On 6/8/24 at 20:03 (8:03 PM) it was documented that the Oxycontin 20 mg. was pending delivery. On 6/9/24 at 12:39 PM it was documented, Nurse contacted pharmacy to check the status of medication. Nurse spoke with representative that stated that would have to send a message to provider for a call back to the nurse for authorization code On 7/1/24 at 13:40 (1:40 PM) it was documented for the Oxycontin 20 mg. on order. On 7/3/24 at 13:40 it was documented for the Oxycontin 20 mg. writer call pharm who stated that is on the next pharm run. On 7/18/24 at 9:31 AM for the Oxycontin 20 mg. it was documented, awaiting medication to arrive from pharmacy. On 9/17/24 at 3:10 PM an interview was conducted with Licensed Practical Nurse (LPN) #4 who stated, I make sure his/her meds are here. The problem is agency staff is not ordering the meds and then we don't have them. If you don't order the Oxycontin or Oxycodone by Thursday, they won't have it for the weekend. You will have to call the doctor and get him to fax the authorization to the pharmacy and then we have to wait to get a code to get in out of the PIXIS. On 9/17/24 at 3:12 PM an interview was conducted with the Director of Nursing (DON). She stated that the resident had a prn (when needed) Oxycodone and that they will run out. The DON stated Resident #18 was unpredictable and wanted immediate action related to the pain medication and even if a nurse is in the other room with a patient, [he/she] won't wait. [He/she] will call 911. The DON stated that Resident #18 was seen by pain management multiple times. The surveyor asked if the medication should be on hand, especially if they know the resident had this type of pain and had behaviors when he/she couldn't immediately get the pain medication. The DON stated, you are right. The medication should be ordered when they are getting low, so it gets here and is on hand. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:03 AM a second interview was conducted with the DON about the concern with medication availability for medication that is standardly given every day, not the prn medication. The DON stated, it is an ongoing struggle. I am clearly saying between the pharmacy and us it is ongoing and we are working on it, and it has gotten better but it is an ongoing process. We utilize contractors. So, I have a note on each medication cart that says in case a medication is not available what the process is to be done. Omnicell is the back-up. If the medication is not there, we check with pharmacy to see if it is on order or in route to the facility. We notify the doctor so he can give an alternative. On 9/18/24 at 11:24 AM the DON brought the QAPI plan that she started in January 2024, and she stated the issue had greatly improved. The surveyor explained that the concern was not with the prn medication, it was with the medication that the resident was to receive daily and that as recently as 9/1/24 the Oxycontin 20 mg. was not available, and Resident #18 called 911. QAPI for the issue was started in January 2024 and the problem still existed on 9/1/24. On 9/18/24 at 1:15 PM the Nursing Home Administrator and Corporate Nurse were informed of the concern.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 30428 Based on medical record review and interview with family and facility staff, it was determined that the facility failed to ensure medical records were complete, accurate and up to date related to residents' status in the facility. This was evident during the review of 2 of 38 (#22 and #24) residents reviewed during a complaint survey. The findings include: 1. Review on 9/13/24 at 10:26 AM of the medical record for Resident #22 revealed a discharge to the hospital on 12/26/23. According to the resident's family, when called on 9/16/24 at 12:54 PM, s/he passed away on 1/3/24. Further review of Resident #22's medical record revealed that on 1/9/24 an initial activity assessment was completed and uploaded into Resident #22's medical record. This concern was brought to the attention of the DON on 9/16/24. She followed up with the activity director who stated that she had the information on paper, but it was not uploaded into the computer and available for others to review until 1/9/24. The DON stated that she educated the activity director on timely documentation at that time. 31145 2) A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. On 9/16/24 at 11:37 AM Resident #24's medical record was reviewed and revealed a 2/21/24 physician's note. Review of the note revealed the physician signed the note on 2/29/24, however the vital sign section of the progress note had vital signs that were dated 2/29/24, the same date that the physician signed the note. It did not reflect the actual vital signs of the day of the visit, which was 2/21/24. Continued review of Resident #24's medical record revealed a 2/28/24 note that was signed by the physician on 3/7/24. The vital sign section of the medical record had vital signs dated 3/7/24, which was not the date of the exam. A 3/6/24 physician's note was signed by the physician on 3/19/24, however the vital signs were dated 3/14/24 at 13:00 (1:00 PM). That was the date that the resident was transferred to the hospital, not the date of the exam. A 3/8/24 physician's note was signed on 3/19/24, however the vital signs were dated 3/14/24 at 13:00, the date the resident was transferred to the hospital, not the date of the exam. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/13/24 physician's note was signed by the physician on 3/26/24, however the vital signs were dated 3/14/24 at 13:00, the date the resident was transferred to the hospital, not the date of the exam. On 9/17/24 at 8:04 AM the physician progress notes and vital signs were shown to the DON. The DON did not realize the vital signs were not the date of the visit. On 9/17/24 at 10:45 AM the physician notes were reviewed with the Nursing Home Administrator (NHA). He was shown the dates of the vital signs. The NHA confirmed the findings.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of a complaint, interviews, and documentation review, it was determined the facility failed to have an effective pest control program as evidenced by numerous reports and observation of mice throughout the facility. This had the potential to affect all residents in the facility. The findings include: On 9/13/24 at 11:15 AM a review of complaint MD00209294 alleged that there was an infestation of mice running throughout the facility, and even getting up on some of the patient's beds. I know for sure that the third-floor manager is aware and that admissions is aware. It's not fair to the residents or the families to have that additional worry or fear. On 9/13/24 at 11:39 AM the complainant was interviewed and stated there were mice and she had to set traps in her mother's room. The complainant stated she spoke to the Nursing Home Administrator (NHA) about it, and he stated that it will take time. On 9/13/24 at 12:32 PM Resident #36 was interviewed and stated he/she saw a mouse the other night. On 9/13/24 at 12:41 PM an interview was conducted with Resident #33. Resident #33 stated, yesterday my daughter put mice traps under the dresser, behind the door, and under the chair. The resident stated I can't stand it. It makes me uncomfortable. I have to make sure no parts of my sheets or blanket touch the floor, so the mice don't climb up the bed. The NHA said it will take a while to get rid of them. On 9/13/24 at 1:00 PM a review of the TELS report documented mice were seen in room [ROOM NUMBER], 214, 223, 217, and 233. On 9/13/24 at 1:00 PM a review of pest activity log sheets documented on 7/9/24 there were 4 mice reported by staff on the second floor. On 7/11/24 mice were reported by the resident in room [ROOM NUMBER]. On 8/7/24 mice were reported in room [ROOM NUMBER] and 321. On 8/16/24 mice were reported in room [ROOM NUMBER] and 325. On 8/27/24 a mouse was reported in room [ROOM NUMBER] and on 9/11/24 a mouse was reported in the social services office. On 9/13/24 at 1:00 PM a review of the pest control company notes dated 7/12/24 documented a staff member reported seeing a mouse in the stairwell next to the elevator. Residents in rooms [ROOM NUMBER] reported seeing a mouse. On 8/8/24 the note documented mice were reported in rooms [ROOM NUMBER]. On 8/15/24 a mouse was reported in room [ROOM NUMBER] and 321. On 8/20/24 rooms 325, 316, 223, and 114 were baited for rodents (mice). Activity was found primarily under and around the HVAC units. On 9/13/24 at 1:07 PM observation was made on the ground floor by the kitchen of the exit door in the hallway propped wide open with a board underneath the door. There were no employees outside of the door and there were no employees in the hallway. The surveyor observed one employee walk down the hallway and into the kitchen, which was located in front of the open door. The employee did not address the open door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215077	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/13/24 at 2:08 PM the NHA was interviewed and stated, I am well aware of the problem. The pest control company went through the whole ceiling and there were certain entry areas up there where they put traps. I have been here almost a year and a half, and we just started having the problem. The NHA was informed of the surveyor's observation of the open door on the ground floor. The NHA stated he did not know why the door was open. The surveyor informed the NHA that having the door wide open invited any rodent or animal access to the inside of the building. On 9/16/24 at 8:47 AM the Director of Maintenance (DOM) was interviewed and stated the pest control company had been at the facility and up and underneath the crawl spaces and that they were baiting those areas and the ceilings. The surveyor asked the DOM what good was setting the traps in those places when the ground floor door was propped open which invited any type of rodent or animal in the building. The DOM stated he was not aware about the open door but acknowledged that new strips were just ordered for the bottom of the door due to the gap. The DOM stated the strips just came in and that he was going to work on that this morning. The DOM stated, as far as the door, that is an educational thing. Everyone should be coming through the front door. On 9/16/24 at 11:23 AM the complainant spoke to the surveyor and informed that Resident #33 saw a mouse in his/her room again last night. On 9/18/24 at 10:08 AM the DOM stated to the surveyor, I have seen that door propped open more than 50 times since you said something. They go outside and smoke and the smokers should not be out there. They should be using the front door. On 9/18/24 at 1:15 PM the administrative staff was informed at the exit conference of the concern regarding mice.