Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Butler	103 East Nursery Butler, MO 64730

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on interview and record review, the facility failed to ensure a Third Party Liability (TPL- a form that is used by nursing homes to present a complete account of all the resident's remaining personal funds after a resident passed away) form was completed and submitted to MO Health Net within 30 days of death for three deceased residents (Residents #219, #220, and #221); and the facility failed to ensure a check with the remaining funds was submitted within 5 days of discharge for one discharged resident (Resident #218. This practice potentially affected four discharged residents. The facility census was 70 residents. 1. Review of Resident #219's resident fund information showed: - The resident passed away on [DATE]; at the time of the resident trust review, it had been 36 days since the resident's death. - The resident had $200.11 in his/her account when he/she passed away. During an interview on [DATE] at 11:42 A.M., the Business Office Manager (BOM) said he/she sent a check to the funeral home on [DATE] and he/she had not completed a TPL form into MO Health Net within 30 days of the resident's death. 2. Review of Resident #220's resident fund information showed: - The resident passed away on [DATE]; at the time of the resident trust review, it had been 91 days since the resident's death. - The resident had $87.30 in his/her account, when he/she passed away. During an interview on [DATE] at 11:45 A.M., the BOM said he/she sent a check to the funeral [NAME] on [DATE] and he/she had not submitted a TPL form to MO Health Net within 30 days of the resident's death. 3. Review of Resident #221's resident fund information showed: - The resident passed away on [DATE]. (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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident had $498.65 in his/her account, when he/she passed away. During an interview on [DATE] at 11:49 A.M., the BOM said he/she sent the balance of the resident's funds back to the state. Review of a copy of the TPL showed the TPL was submitted in [DATE] which was 70 days after the resident's death. 4. Review of Resident #218's resident trust information showed: - The resident discharged for m the facility on [DATE]. - The resident had a balance of $20.00 in his/her account when he/she discharged from the facility. During an interview on [DATE] at 12:38 P.M., the BOM said: He/she had to wait until the end of [DATE] to process the check because there was a hair care charge for that resident was incurred. - He/she knew the hair care charges existed at the time of the resident's discharge. - He/she notified the family about the resident's balance. - The family said to take out the amount for the hair care charge out of the residents' balance and - He/she sent the balance of the resident's funds on [DATE]. During a phone interview on [DATE] 3:20 P.M., the BOM said: - He/she was trained that if he/she was sending money back to the state, then he/she was filling out and submitting the TPL forms. - He/she was not aware that he/she had to fill out and submit the TPL forms on any resident that received Medicaid or Medicare.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 19016 Based on observation, interview and record review, the facility failed to update the intervention for the continued use of a knee brace for one sampled resident (Resident #2); to update the care plan with new interventions as needed; and to ensure the fall care plan was implemented for one sampled resident (Resident #41) who fell after being left alone in the dining room and did not have on proper footwear out of 18 total sampled residents. The facility census was 70 residents. Review of the facility's Falls Management policy revised 12/22/22 showed: -The fall assessment should be completed upon admission, quarterly, with a significant change and each fall occurrence. -If identified risk is present the interventions should be communicated to facility staff on the care plan. -After a fall occurs the licensed nurse would initiate a risk management event reporting process to include: --A physical assessment. --Injuries sustained. --Fall occurrences were to be documented in the clinical record including the environmental, situational or psychological and situational factors, location, time found, position, adaptive equipment, actions taken and new interventions implemented. -The physician and responsible party should be notified. -Witness statements should be obtained and resident statements were to be obtained. -The residents' care plan would be reviewed and revised with each fall occurrence and new interventions implemented. 1. Review of Resident # 2's Admission Record showed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hemiplegia and Hemiparesis (paralysis and weakness on one side of the body) following a stroke. Review of the resident's Fall Risk care plan initiated on 4/26/19 showed: -An intervention initiated 4/26/19 to make sure the resident had on appropriate shoes or non-slip footwear when up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An intervention initiated 4/4/22 for resident to be up in wheelchair primarily for mobility and to propel himself/herself. Assistance needed of one to two staff with walker and gait belt for transfers. -NOTE: There were no updated interventions to the care plan related to the resident's fall. Review of the resident's Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting) care plan, revised 4/26/19, showed: -An intervention was in place for: Resident's left knee gives out at times and he/she needed to wear a left knee brace when up. Do not make adjustments to settings. If the brace needed adjusting notify the therapy department. -The intervention was revised 5/8/19 showing the resident's left knee gives out at times and he/she needed to wear a left knee brace when up. Ensure the brace was on underneath his/her clothing. Do not make adjustments to setting. If the brace needed adjusting notify the therapy department. Review of the resident's physician orders showed no order for the left knee brace. Review of the resident's Fall Risk Assessment, dated 5/16/23 showed the resident: -Exhibited loss of balance while standing. -Required hands on assistance to move from place to place. -Had decreased muscle coordination. -Had the potential for his/her blood pressure to drop significantly between lying and standing positions. -Was able to stand, pivot, and transfer. -Was not able to consistently bear weight on both legs. -Could consistently bear weight on one leg, grip with both hands, tolerate pressure on the mid to lower back, and follow simple instructions. Had a joint replacement. -Required supervision or limited physical assistance for transfers. -Was at high risk for falls. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 5/19/23 showed the resident: -Was severely cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required substantial/maximum assist (staff does more than 50 percent of the effort) for repositioning and transferring. -Independently wheeled 50 feet in his/her manual wheelchair. Review of the resident's Fall Risk Assessment, dated 6/4/23 showed the resident: -Had a fall. -Was unable to independently come to a standing position. -Exhibited a loss of balance. -Required hands on assistance to move from place to place. -Had decreased muscle coordination. -Was at high risk for falls. Review of the resident's Fall Incident Report, dated 6/6/23, showed: -A statement from Certified Nurses Aide (CNA) B stated he/she was transferring the resident to the bedside commode with a gait belt and helping the resident pull down his/her pants. The resident started to fall and CNA B lowered the resident to the floor and called for help. -A note written on 6/4/23 at 6:30 A.M. showed: --The floor was wet from the resident trying to use the commode prior to falling. --The resident complained of pain in his/her left lower extremity and his/her left foot was twisted in an upward position. --Emergency Medical Services (EMS) transferred the resident to the hospital. -Predisposing factors included improper footwear and an intervention showed make sure the resident wears proper footwear. -A progress note, dated 6/6/23 showed: --The resident had a fall resulting in left tibia and fibula fracture(s). --The fall was witnessed in the resident's room on 6/4/23 at 3:25 A.M. --After interviews it was determined the root cause of the fall was the resident's left knee giving out while standing causing his/her leg to buckle. --The resident did not have his/her knee brace in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Since the resident's fall he/she had been a two-person mechanical lift transfer. -The electronic Kardex showed staff how they were to care for residents and before the resident's leg break it showed staff were to use a walker and knee brace for the resident's transfers. -After the fracture the Kardex showed the resident was a two-person mechanical lift. -There was also a communication sheet for CNAs that showed the resident was a two-person mechanical lift following the fall. Observation on 3/28/24 at 1:34 P.M. showed Certified Medication Technician (CMT) B and CNA E transferred the resident from his/her wheelchair into his/her bed using a total mechanical lift. During an interview on 3/28/24 at 1:40 P.M. CMT B said: -Before the resident broke his/her tibia he/she transferred with one or two person assistance using a walker and his/her knee brace. On a good day the resident could transfer with only one staff. -The resident was supposed to wear the knee brace at all times when up and for all transfers according to the resident's Kardex information. -He/She learned of the resident's fall through shift report and through the daily communication book. Communication forms showed the resident changed to a mechanical lift status after the injury. During an interview on 3/28/24 at 1:45 P.M. CNA E said: -Since the resident's fracture all transfers were done with the total mechanical lift. -Before that the resident stood with a walker while wearing his/her knee brace during transfers. During an interview on 3/29/24 at 10:09 A.M. CNA C said: -Prior to the resident's fall the resident was transferred with two staff. The resident used a walker and staff used a gait belt. He/She couldn't ambulate, but could transfer with staff assistance. -The resident was supposed to wear TED hose and a leg brace for all transfers and throughout the day. -The TED hose and leg brace could be taken off if the resident was in bed, but had to be put back on before the resident got out of bed. -Since the resident's fracture staff have used a mechanical lift to transfer the resident. During an interview on 3/29/24 at 10:56 A.M. the Administrator said: -The resident had a knee brace when he/she came to the facility on admission and there was an intervention for the brace. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident always slept in the recliner in the dining room and still usually slept there because the resident tried to get out of bed a lot. -He/She had only left the resident alone for five minutes the night of the fall. -The resident was not supposed to be left unattended in the dining room, so he/she did his/her rounds when the resident was sleeping. He/She had continued to leave the resident alone in the dining room because he/she had to change other residents and was the only CNA working the unit at night. He/She just always did his/her rounds when the resident was sleeping. -The electronic Kardex showed the resident was supposed to be assisted by staff using a gait belt for transfers. Observation on 3/28/24 at 1:49 P.M. showed: -The resident was sitting in his/her room in his/her wheelchair. -CMT B applied a gait belt on the resident. -The resident used a walker while standing as CMT B and CNA E helped him/her stand and walked with the to his/her bed. During an interview on 3/28/24 at 1:54 P.M. CMT B said: -The resident transferred with one or two person assistance, depending upon his/her behaviors. -Since there were always two CNAs on the day shift they normally used two staff even when the resident did not have behaviors. -The resident was able to walk short distances such as from the toilet to his/her bed. During an interview on 3/29/23 at 10:22 P.M. CNA C said: -The resident had always transferred with a gait belt and a walker with one to two staff assisting. -Sometimes the resident could ambulate short distances and sometimes not, depending upon if the resident was upset. -Most of the time the resident used a wheelchair and transferred with the use of a gait belt and walker. -The resident had an intervention that he/she couldn't be left alone in the dining room. -He/She also had to wear non-skid socks because the resident refused to wear his/her shoes. -The electronic Kardex showed the resident's interventions. During an interview on 3/29/24 at 10:56 A.M. the Administrator said: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medicalodges Butler		STREET ADDRESS, CITY, STATE, ZIP CODE 103 East Nursery Butler, MO 64730	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was left unattended in the dining room and had a fall resulting in a hematoma. -The DON updated the resident's care plan after the falls on 11/15/23 and realized the intervention to not leave the resident alone in the dining room was no longer appropriate, but had forgotten to remove it. -After the 11/26/23 fall staff had been educated to make sure the resident wore non-skid socks. During an interview on 3/29/24 at 11:25 A.M. the MDS Coordinator said the resident had the following interventions as of 11/26/23: -Wear non-skid socks, initiated on 11/8/23. -Weight bearing as tolerated with one staff and the use of a gait belt and walker for standing, transfers and ambulation, initiated on 11/10/23. -Don't leave the resident unattended in the dining room, initiated 11/15/23. During an interview on 3/29/24 at 12:40 P.M. the DON said: -After the resident fell a second time on 11/15/23 the IDT added the intervention the resident shouldn't be left alone. -The intervention was only meant to be for a few days, but was not removed as it should have been. -The resident was not wearing non-skid socks on 11/26/23 when he/she fell and staff were educated to make sure he/she was wearing them at all times. -All resident falls are reviewed within 24 to 48 hours by the IDT. -Interventions are first initiated by the nurse on duty at the time of an accident or fall and then reviewed and adjusted as needed by the IDT. -The care plan interventions should be kept updated and reflect the resident's current needs.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43345 Based on interview and record review, the facility failed to identify, assess and provide supportive interventions for one sampled resident (Resident #63), with a diagnosis of Post-Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), out of 18 sampled residents. The facility census was 70 residents. Review of Trauma-Informed Care Implementation Center (https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/) copyright 2021 showed: -Trauma-informed care shifts the focus from What's wrong with you? to What happened to you? -A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation - past and present - in order to provide effective health care services with a healing orientation. -Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors. -Trauma-informed care seeks to: --Realize the widespread impact of trauma and understand paths for recovery; --Recognize the signs and symptoms of trauma in patients, families, and staff; --Integrate knowledge about trauma into policies, procedures, and practices; and --Actively avoid re-traumatization. A policy was requested, and the facility did not have a policy on PTSD/trauma informed care. 1. Review of Resident #63's Level One Pre-Admissions Screening and Resident Review (PASRR) (federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment.) dated 2/23/24 showed the resident had a diagnosis of PTSD. Review of the resident's Transfer/Discharge Report showed the resident was admitted to the facility on [DATE] with a diagnosis of PTSD. Review of the Order Summary Report (OSR) dated 2/23/24 showed the following physician's orders: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sertraline ((a type of antidepressant drug (used to relieve depression) that inhibits the reabsorption of serotonin (a compound present in blood platelets and serum, which constricts the blood vessels and acts as a neurotransmitter (a chemical substance that is released at the end of a nerve fiber by the arrival of a nerve impulse and, by sending it across the nerve junction, causes the transfer of the impulse to another nerve fiber, a muscle fiber, or some other structure) by neurons, so increasing the availability of serotonin as a neurotransmitter) medication give 200 milligrams (mg) by mouth at bedtime for Major Depressive Disorder (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts). Review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 2/29/24 showed: The resident had a moderate cognitive impairment. -Had PTSD. Review of the resident's care plan revised 3/3/24 showed: -He/She used therapeutic psychotropic medications related to disease process for PTSD, and Major Depression. -PTSD was not addressed in the care plan. -The resident's triggers were not addressed. -The resident's interventions were not addressed. -The resident was on an antidepressant medication for PTSD. During an interview on 3/25/24 at 10:26 A.M. the resident said: -He/she had a diagnosis of PTSD. -The facility was doing nothing for it. -He/she had PTSD due to being in the military in the past but did not want to discuss the details or triggers. During an interview on 3/28/24 at 9:13 A.M., Certified Medication Technician (CMT) A said: -The resident had PTSD. -He/She was unsure what his/her triggers are, or his/her inventions were. -The resident had not had any behaviors. -He/She would look on the care plan for the triggers and interventions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 9:15 A.M., Certified Nurse's Assistant (CNA) A said: -Was unsure if the resident had a diagnosis of PTSD. -He/She did not know the resident's triggers or interventions. During an interview on 03/28/24 at 9:19 A.M., Registered Nurse (RN) A said: -The MDS Coordinator was responsible for care plan development. -He/She did not know if the resident had a diagnosis of PTSD. -He/She did not know the resident's triggers or interventions. -The information of the resident's triggers and interventions should have been in the care plan. During an interview on 3/28/24 at 9:32 A.M., the MDS Coordinator said: -He/She was responsible for care plan development. The care plan should accurately reflect the resident's condition at the time it was developed along with diagnosis. -He/She was responsible for all the information needed for the PTSD care plan. -The care plan should have had the triggers and the interventions. -The staff should have been made aware of the resident's triggers and interventions. -The care plan did not have this information of residents' triggers and interventions in it. During an interview on 3/28/24 at 12:40 P.M., Director of Nursing (DON) said: -The MDS Coordinator was responsible for the care plans. -It was his/her expectation that if the resident had a diagnosis of PTSD, it would be addressed in the care plan to include triggers and interventions. -The MDS Coordinator was responsible for the information for the PTSD care plan. -The care plan would have addressed the triggers and the interventions. -It was his/her expectation that the nurses and CNAs would know a resident's triggers and interventions. -The Inter-disciplinary Care Team (IDT) audited the care plans. -He/She was ultimately responsible to ensure the care plan were correct for the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 19916 Based on observation and interview, the facility failed to remove dust and food debris from under the reach-in refrigerators at the back of the kitchen; failed to maintain the gasket (a mechanical seal which fills the space between two or more mating surfaces, generally to prevent leakage from or into the joined objects) in the door to the white upright freezer in good repair; failed to remove a buildup of dust from the sprinkler heads over the 3 compartment sink, the sprinkler heads and pipes over the automated toaster and ice maker machine; and failed to remove debris from the spray wand of the automated dishwasher. This practice potentially affected all residents in the facility. The facility census was 70 residents. 1. Observations on 3/25/24 from 9:18 A.M. through 9:38 A.M., during the initial kitchen tour, showed: - A buildup of food debris and dust under the reach-in refrigerators at the back of the kitchen. - A buildup of dust and debris under and behind the ice making machine. - A buildup of dust on the sprinkler heads and the sprinkler pipes over the 3-compartment sink and the automated toaster. - A 9 inch (in.) crack on the gasket of the white upright freezer. 2. During an interview on 3/25/24 at 2:54 P.M., the Dietary Manager (DM) said he/she notified the Maintenance Assistant to clean the sprinkler heads, the ceiling vents and the light fixtures about three 3 weeks prior to 3/25/24. 3. Observation on 3/27/24 from 6:21 A.M. through 9:12 A.M., showed: - At 6:21 A.M., there was the presence of debris in the nozzle of the lower spray wand of the automated dishwasher. -A buildup of food debris and dust under the reach-in refrigerators at the back of the kitchen -A buildup of dust and debris under and behind the ice making machine. - A buildup of dust on the sprinkler heads and the sprinkler pipes over the 3-compartment sink and the automated toaster. - A 9 in. crack on the gasket of the white upright freezer. 4. Observation on 3/27/24 at 8:55 A.M., showed debris was still present in the spray wand of the automated dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/27/24 at 8:55 A.M., the DM said the spray wands are supposed to be cleaned nightly. During an interview on 3/27/24 at 8:56 A.M. Dietary Aides (DA) C (who washed dishes at the time) said he/she did not notice the debris in the dishwasher spray wand. During an interview on 3/27/24 at 9:06 A.M., the DM said he/she had not noticed the damaged gasket on the white upright freezer. During an interview on 3/27/24 at 9:12 A.M., the DM said it had been at least a week or more that they have not gotten under and behind the reach in refrigerators and the under the ice machine.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to ensure there was negative airflow as required in the soiled utility room close to the South Hall and in the restrooms of the following resident rooms: 123, 122, 102, and the restrooms of shared rooms of 30/28, 31/33, 29/27, 19/21, 16/14, 15/17, 12/10 and 13/11. This practice potentially affected at least 20 residents who resided in or used those areas. The facility census was 70 residents. **Note: Air flow was tested by holding one piece of tissue paper to the ceiling vent. If the paper was drawn up then negative air flow was present; if the paper was not drawn to the ceiling vent, then negative airflow was absent. 1. Observation with the Maintenance Director on 3/26/24, showed: - At 12:09 P.M., there was not any negative airflow in the soiled utility room close to the south nurse's station. - At 12:14 P.M., there was not any negative airflow from the ceiling vent of the restroom of resident room [ROOM NUMBER]. - At 12:15 P.M., there was not any negative airflow from the ceiling vent of the restroom of resident room [ROOM NUMBER]. - At 12:41 P.M., there was not any negative airflow from the ceiling vent of the restroom of resident room [ROOM NUMBER]. - At 2:24 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 30/28. - At 2:26 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 31/33. - At 2:28 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 29/27. - At 2:30 P.M., there was not any negative airflow from the ceiling vent of the restroom of resident room [ROOM NUMBER]. - At 2:42 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 19/21. - At 2:45 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 16/14. - At 2:47 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 15/17. (continued on next page)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 2:49 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 12/10. - At 2:53 P.M., there was not any negative airflow from the ceiling vent of the shared restroom of resident rooms 13/11. During an interview on 3/27/24 at 3:11 P.M. the Maintenance Director said: - A switch which controlled the negative air flow vents in the North and East areas, was turned off in the attics. - The switch which controlled the ceiling vents in the areas on the South side (the South side Soiled utility room and resident rooms [ROOM NUMBERS]), was no longer working. During an interview on 3/27/24 at 3:14 P.M., the Administrator said back in January 2024, when it was really cold outside, he/she asked that the ceiling vents be turned off to reduce draft that would come in.

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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. 19916 Based on observation and interview, the facility failed to maintain the East hall attic area free of openings that could let in potential pests, and failed to maintain that attic area free of debris that indicated evidence of pests; failed to maintain the South hall attic area free of hay/straw which indicated the presence of pests and failed to maintain the tat area over the dementia unit free of pests which were once in that attic as evidenced by animal droppings and the presence of feathers. This practice potentially affected 40 residents who resided in or used those areas. The facility census was 70 residents. 1. Observation on 3/26/24 at 9:19 A.M., with the Maintenance Director of the East attic area showed: - Two openings at the outer wall end of the attic where the screen was not properly sealed against the entrance of pests. - The presence of some type of nest. 2. Observation on 3/26/24 at 10:41 A.M., with the Maintenance Director of the South attic area, showed the presence of a large amount of hay/straw towards the outer wall end of the attic. 3. Observation on 3/26/24 at 10:53 A.M., with the Maintenance Director of the attic area over the dementia unit, showed the presence of straw/hay, feathers and animal droppings. During a phone interview on 4/4/24 at 10:19 A.M., the Maintenance Director said: - He/she went into the attic areas once per month. - In certain instances, he/she was not able to get to all areas of the attic, so he/she did not notice the hay/straw towards the outer wall.