STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525410	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Health and Rehabilitation Center	729 Park St Antigo, WI 54409

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure 1 resident (R) (R1) of 4 sampled residents received care and treatment to maintain their highest practicable physical well-being.R1 was at risk for constipation due to reduced mobility and the use of pain medication. R1's medical record contained incomplete bowel and bladder tracking upon admission, incomplete shift monitoring for bowel movements, and a delayed response for signs of constipation. In addition, staff did not consistently complete monitoring for incontinence, food and fluid intake, and repositioning. On 4/25/26, R1 was sent to the hospital and diagnosed with stercoral colitis (inflammation of the colon caused by fecal impaction, which can lead to perforation) as well as urinary retention and severe bilateral hydronephrosis (swelling of one or both kidneys that occurs when urine cannot drain properly into the bladder and backs up). Findings include:The facility's Bowel Management policy, revised 4/24/25, indicates: It is the practice of this facility to conduct a comprehensive evaluation to ensure each resident receives appropriate treatment and services to support their overall health and wellbeing. It is also the expectation to complete routine monitoring for potential bowel complications (constipation, ileus, impaction). Facility practices may include: 1. Identification of history of patterns of bowel bladder function. 2. Identification of mobility limitations which affect elimination. 3. Reviewing medications and diagnoses which affect bowel and bladder functions. 4. Routine monitoring and evaluation of bowel functioning. 5. Identification of appropriate treatment plans for the resident .Comprehensive bowel data collection and evaluation may include: a. Known history of relevant medical diagnosis .c. Medication regimen review related to bowel regimen or concerns for potential side effects regarding bowel health. Procedure: (This section was blank on the policy.)The facility's Hydration (Food/Fluid) Monitoring policy, revised 10/3/24, indicates: .The resident will be monitored for signs and symptoms of .Dehydration .including, but not limited to .decreased urinary output .fluid overload .electrolyte imbalance. Documentation: .Record beverage intake in the designated locations (meal intake records, Medication Administration Record (MAR) as indicated) .Record output in designated locations (MAR or output records).The facility's Offering/Serving Bedtime Snacks policy, revised 2/26/25, indicates: It is the practice of the facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis. Guidelines: 1. Nursing staff offer a bedtime snack to residents .on a daily basis .5. It may be necessary for nursing staff to assist a resident with intake of a snack .6. Intake of bedtime snack is documented in the medical record.On 5/21/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including fracture of the right acetabulum (a cup shaped structure in the pelvis/hip) and dislocated right shoulder with sling following a fall, osteoarthritis, and severe protein calorie malnutrition. R1's Minimum Data Set (MDS) assessment, dated 4/30/26, indicated R1 was rarely or never understood. The MDS assessment indicated R1 was always incontinent of bowel and bladder, required extensive assistance for toileting, substantial/maximal assistance for mobility, and supervision for eating/drinking. R1 received therapy for weakness and reduced mobility and required a full body lift for transfers. admission notes indicated R1 was non-weight bearing status. R1's pain care plan contained (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions to monitor/document for side effects of pain medication and observe for constipation.R1's bowel care plan indicated R1 would have a bowel movement (BM) at least every 3 days and contained interventions to monitor and record BMs and implement BM protocol as needed.R1's bladder care plan indicated R1 was incontinent of bladder and was not on a trial voiding program. The care plan contained interventions to monitor/document signs/symptoms of no ouput (4/16/26) and prompt toileting/toilet upon request (4/22/26). R1's nutrition care plan indicated R1 had a nutritional problem and contained an intervention to monitor and record meal/fluid intakes per facility protocol. R1's skin care plan indicated R1 had potential/actual impairment to skin integrity and contained an intervention to turn and/or reposition every 2-3 hours. R1's communication care plan indicated R1 had a communication problem and contained an intervention to anticipate and meet needs.R1 had the following physician orders:~ Hydrocodone-acetaminophen 5-325 milligrams (mg), 1 tablet by mouth every 4 hours as needed (PRN) for moderate to severe pain. (R1's Medication Administration Record (MAR) indicated R1 received the medication.)~ Milk of Magnesia, give every 24 hours PRN for constipation per bowel protocol~ Bisacodyl rectal suppository, give every 24 hours PRN for constipation per bowel protocol~ Fleet rectal enema, 1 applicator rectally every 24 hours PRN for constipation per bowel protocol~ Daily monitoring for signs/symptoms of malnutrition, such as .constipation/diarrhea .R1's medical record indicated R1 was transferred to the Emergency Department (ED) on 4/25/26 and admitted to the hospital. Hospital admission records, dated 4/25/26, indicated R1 presented with a chief complaint of concern over possible bowel obstruction and was admitted with severe constipation with stercoral colitis likely secondary to narcotic use in the setting of immobility, dehydration, and acute kidney injury. A computerized tomography (CT) scan of the abdomen/pelvis indicated no evidence of intestinal obstruction. R1 had a prominent rectal stool burden with rectal expansion that measured up to 7 centimeters (cm). R1 was also admitted with diagnoses of acute kidney injury, urinary retention, severe bilateral hydronephrosis (swelling of one or both kidneys that occurs when urine cannot drain properly into the bladder and backs up). There was evidence of urinary bladder outlet obstruction with severe distention of the bladder. Straight catheterization was completed with 1,475 milliliters (ml) of output. Following hospitalization, R1 enrolled in Hospice services and transferred to an assisted living (AL) facility. A Hospital admission History and Physical, dated 4/25/26, indicated R1 had a diagnosis of severe protein calorie malnutrition. R1 was previously diagnosed with severe protein calorie malnutrition and continued with poor oral intake per R1's son. Additional diagnoses included generalized weakness, physical deconditioning, failure to thrive, and dehydration for which R1 received 1 liter of normal saline in the ED.On 5/21/26 at 11:45 AM, Surveyor interviewed Family Member (FM)-H who indicated R1 was in the hospital for 3 days following a hip fracture prior to being admitted to the facility. R1 was in the facility for 8 days and was readmitted to the hospital for 7 days. FM-H indicated the facility did not monitor R1's liquids and solids. FM-H indicated R1 was weak and confused and staff provided a large, heavy mug of water at the bedside which R1 could not lift. FM-H indicated staff did not offer to assist R1 with drinking from the mug. FM-H indicated when another family member visited 3 or 4 days after admission, R1 stated R1 was thirsty and had dry, chapped lips. The family member noted R1 could not lift the water mug independently. FM-H was at the facility during the one and a half days prior to R1's transfer to the hospital. Staff indicated R1 was not eating or drinking and had not had a bowel movement. Upon arrival at the ED, FM-H indicated an ED physician stated R1 had a bed sore on the buttocks. FM-H indicated the facility's wound nurse indicated the area was urine irritation, not a pressure injury. FM-H indicated the area on R1's buttocks was referered to as a stage 2 (pressure injury) when R1 was enrolled in Hospice services and transferred to an assisted living facility. FM-H indicated FM-H was told in the ED that R1's bowels were backed up. R1 required intravenous (IV) fluids for hydration. FM-H also indicated the hospital removed nearly 1.5 liters of urine from R1's bladder. R1's bowel monitoring records and MAR indicated the following:~ 4/16/26: Bowel monitoring was not completed on the PM and night (NOC) shifts.~ 4/17/26: R1 did not have a BM on the AM or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM shifts. Bowel monitoring was not completed on the NOC shift.~ 4/18/26: R1 did not have a BM on the AM, PM, or NOC shifts.~ 4/19/26 (day 3): Bowel monitoring was not completed on the AM and NOC shifts. R1 did not have a BM on the PM shift.~ 4/20/26 (day 4): R1 did not have a BM on the AM shift. Bowel monitoring was not completed on the PM and NOC shifts. ~ 4/21/26: R1 had a small BM on the AM shift (documented at 1:59 PM). Bowel monitoring was not completed on the PM shift. R1 did not have a BM on the NOC shift. (Of note: This is the first documented BM for R1 from 4/16 to 4/21 (5 days).)~ 4/22/26: R1 did not have a BM on the AM, PM, or NOC shifts. A bisacodyl rectal suppository was administered at 7:43 PM. (The suppository was documented as effective on 4/23/26 at 9:16 AM.)~ 4/23/26: R1 had a small BM on the AM and PM shifts and no BM on the NOC shift. A suppository was administered at 10:55 PM. (The suppository was documented as ineffective on 4/24/26 at 8:27 AM.)~ 4/24/26: Director of Nursing (DON)-B completed a manual extraction of BM. R1 had a medium BM on the AM shift, a small BM on the PM shift, and no BM on the NOC shift.~ 4/25/26: A suppository was administered at 5:24 AM which was documented as ineffective at 7:25 AM. A fleet enema was administered at 7:26 AM which was documented as ineffective at 9:11 AM. R1 was sent to the ED for evaluation. (Of note: Milk of Magnesia was not administered from 4/16/26 to 4/25/26.)R1's bladder continence/incontinence documentation indicated the following:~ 4/16/26: Documentation was not completed on the PM and NOC shifts.~ 4/17/26: Documentation was not completed on the NOC shift.~ 4/19/26: Documentation was not completed on the AM shift. ~ 4/20/26: Documentation was not completed on the PM and NOC shifts.~ 4/21/26: Documentation was not completed on the PM shift.(Of note: Output in ml was not completed for any of the entries.) R1's meal/fluid intakes documentaton indicated the following:~ 4/16/26: Documentation was not completed for 2 of 2 opportunities.~ 4/17/26: Documentation was not completed for 1 of 3 opportunities.~ 4/19/26: Documentation was not completed for 2 of 3 opportunities.~ 4/20/26: Documentation was not completed for 2 of 3 opportunities. ~ 4/21/26: Documentation was not completed for 1 of 3 opportunities.~ A nutritional evaluation, dated 4/22/26, indicated: Meal intake 0-25%, occasional acceptance of bedtime (HS) snack. Fluid intake 0-1500 ml. Plan/Recommendations: Poor appetite .will continue to monitor intakes. R1's medical record included tracking records labeled activities of daily living (ADLs) which indicated 2 of 26 meals contained no documentation; 6 of 26 meals contained code 98 which was not one of the options in the identification key for eating; 8 of 26 meals indicated R1 had 0% intake of food. Documentation for 2 meals indicated R1 was independent and completed the activity with no assistance or helper. Of the two meals, R1 ate 0% of one and 25% of other. Surveyor noted 1 of 26 meals was coded to indicate R1 was dependent on staff. R1 ate 100% of the meal (the only entry during R1's stay in which R1 ate 100% of a meal). HS snack monitoring contained missing documentation for 3 of 9 days.R1's turning/repositioning documentation indicated the following:~ 4/17/26: Documentation was not completed on the NOC shift.~ An initial wound assessment, dated 4/18/26, indicated R1 had fragile skin and incontinence-associated dermatitis on the left buttock.~ 4/19/26: Documentation was not completed on the AM shift.~ 4/20/26: Documentation was not completed on the PM and NOC shifts.~ 4/21/26: Documentation was not completed on the PM shift. A progress note, dated 4/24/26 at 2:42 PM, indicated staff spoke with R1's son and daughter-in-law regarding R1's overall condition. R1's family stated they were aware R1 was not eating well and not progressing. Comfort cares and Hospice services were reviewed. R1 was alert and answering questions appropriately. Staff assisted R1 with eating. R1 took approximately 12 bites and drank approximately a half glass of milk.A progress note, dated 4/25/26 at 1:34 PM, indicated R1 was transferred to ED that morning for evaluation of no BM despite enema and bowel aids. R1's bladder was palpable. A CT scan showed probable pneumonia; bowels show constipation; a straight cath obtained 1400+ ml of urine.A progress note, dated 4/26/26 at 9:10 AM, indicated a hospital nurse stated R1 was admitted with stercoral colitis and continued to have small but frequent BMs. On 5/21/26 at 12:02 PM, Surveyor interviewed Certified Occupational Therapy Assistant (COTA)-J who indicated R1 was weak and in discomfort and had a hard time following commands. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	COTA-J believed R1 could feed R1's self but did not want to because R1 was not feeling well.On 5/21/26 at 12:04 PM, Surveyor interviewed Physical Therapy Assistant (PTA)-K who indicated R1 fatigued easily and either did not understand or did not want to when asked to take a drink. PTA-K indicated a family member who visited stated R1 was more confused than they had ever seen.On 5/21/26 at 2:15 PM, Surveyor interviewed DON-B who confirmed it was safe to assume if bowel monitoring was not documented, R1 did not have a BM. DON-B indicated the facility does not have a written bowel protocol and the policy is vague. DON-B indicated DON-B expects staff to administer Milk of Magnesia on day 3 of no BM, a suppository on day 4 of no BM, and a fleets enema on day 5 of no BM. DON-B confirmed R1's medical record did not contain consistent tracking of fluid intake and confirmed a snack should be offered each evening. DON-B confirmed R1's repositioning documentation was incomplete.On 5/21/26 at 2:32 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I and DON-B. who indicated LPN-I tried to give R1 Milk of Magnesia on approximately 4/19/26 (LPN-I could not recall the exact date), however, R1 was not able to tolerate it and did not drink it. LPN-I indicated LPN-I did not document the attempt because R1 did not take the medication. LPN-I indicated LPN-I administered a suppository on 4/22/26 which was ineffective. When Surveyor indicated the documentation stated the suppository was effective, LPN-I indicated R1 only had a small BM, so LPN-I told the NOC shift nurse it was ineffective and to repeat the suppository on the NOC shift. LPN-I reviewed R1's MAR and confirmed the NOC shift nurse did not administer a suppository. LPN-I thought the NOC shift nurse noted R1's MAR indicated the 4/22/26 suppository was effective and did not readminister a suppository despite being told by LPN-I to do so. LPN-I indicated LPN-I administered a suppository again on the 4/23/26 PM shift because R1's abdomen was distended and R1 was uncomfortable. LPN-I confirmed the suppository was also ineffective. Surveyor reviewed bowel monitoring documentation for 4/22/26 with LPN-I who confirmed the documentation indicated R1 did not have a BM on the AM, PM, or NOC shifts. LPN-I indicated R1 could lift the water mug if there was a little bit of water in it and could drink from it with a straw. LPN-I indicated R1 could lift and drink from a 4-ounce cup. DON-B indicated DON-B completed manual extraction of BM for R1 on 4/24/26. DON-B confirmed a suppository and enema administered on 4/25/26 were ineffective. DON-B confirmed there were no documented attempts to treat R1's bowels until 4/22/26 and confirmed R1's bowel monitoring was incomplete. DON-B confirmed what was documented between 4/16/26 and the 4/21/26 AM shift (4.5 days) indicated R1 did not have a BM. Documention on 4/21/26 indicated R1 had a small BM on the AM shift and no BM again until small BMs on the 4/23/26 AM and PM shifts. Documentation on 4/24/26 (the date of manual extraction) indicated R1 had a medium BM on the AM shift and a small BM on the PM shift. On 5/21/26 at 2:00 PM and 3:50 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated R1 had multiple medical issues upon admission and was at high risk for constipation due to pain medication. NHA-A indicated if a resident does not eat supper, Certified Nursing Assistants (CNAs) should tell the nurse. All residents should get an HS snack if they would like one. NHA-A indicated R1 was not eating because R1 was not hungry and did not want to eat.

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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. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 51 residents residing in the facility. The cooler, counters, and areas underneath kitchen equipment were not in a clean condition.Drywall near the exterior kitchen doors contained holes.Findings include:The 2022 Federal Food Code documents at 6-501.12 Cleaning, Frequency and Restrictions: Cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or preparedThe 2022 Federal Food Code documents at 6-202.15 Outer Openings, Protected: Outer openings of a food establishment shall be protected against the entry of insects and rodents by: (1) Filling or closing holes and other gaps along floors, walls, and ceilings; (2) Closed, tight-fitting windows; and (3) Solid, self-closing, tight-fitting doors.The 2022 Federal Food Code documents at 6-501.17 Absorbent Materials on Floors, Use Limitation: Cleanliness of the food establishment is important to minimize attractants for insects and rodents, aid in preventing the contamination of food and equipment, and prevent nuisance conditions. A clean and orderly food establishment is also conducive to positive employee attitudes which can lead to increased attention to personal hygiene and improved food preparation practices. Use of specified cleaning procedures is important in precluding avoidable contamination of food and equipment and nuisance conditionsOn 5/21/26 at 9:00 AM, Surveyor completed a tour of the kitchen and noted the following: ~ Debris, crumbs, and rodent traps underneath the stoves and oven. On 5/21/26 at 9:20 AM, Surveyor interviewed [NAME] (CK)-E who indicated the areas do not get cleaned well.~ Two holes in the outer kitchen wall next to a counter. One hole was toward the back of the counter on the left and contained a pipe. The other hole was in the drywall between the kitchen and dish area.~ A hole large enough for a rodent to enter the building near the employee entrance door outside the main kitchen. ~ A pile of long grain and wild rice that Surveyor initially mistook for rodent droppings. On 5/21/26 at 10:30 AM, Surveyor and Maintenance Staff (MS)-C observed the holes in the walls and doorway. MS-C was not aware of the holes.On 5/21/26 at 10:45 AM, Surveyor interviewed Dietary Manager (DM)-D who confirmed staff had seen rats and a rat was caught in the kitchen one month ago. DM-D also indicated staff who arrived for work in the morning noted bread and cake had been gnawed. DM-D indicated kitchen staff have been using the microwave as a breadbox and there is a sign on the bread rack to ensure staff do not leave anything out overnight. DM-D verified the importance of ensuring areas underneath counters and equipment and behind boxes are clean when rodents have been observed so staff can tell if there are any remaining issues.

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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** Based on observation, staff interview, and record review, the facility did not maintain an effective pest control management program. This practice had the potential to affect all 51 residents residing in the facility.The kitchen contained multiple traps for rodents, including rats. Staff statements were inconsistent regarding knowledge of rats, the number of rats caught, who set the traps, and who managed the traps. The facility did not provide documentation that a pest control company was called when rats were first observed in the kitchen.Findings include:The facility's undated Pest Control policy indicates: .3. Document problems found during inspections and the remedial actions taken .11. Cover exterior openings in the buildings foundation with screen wire or wire mesh. On 5/21/26 at 9:00 AM, Surveyor entered the kitchen and observed 2 metal traps in the dry storage area, 3 traps in the dishwashing room, and approximately 5 traps in the main kitchen area under counters and equipment. On 5/21/26 at 9:10 AM, Surveyor asked Dietary Aid (DA)-F about the traps underneath the sink where DA-F was working. DA-F indicated rats were seen in the kitchen. DA-F indicated staff arrived to work earlier in the week and found bread products that had been chewed. DA-F indicated Maintenance Staff (MS)-C was in the kitchen earlier in the week and closed up a hole underneath the dish area where the rats could be entering. DA-F indicated MS-C was taking care of the traps. DA-F indicated all food that had been gnawed or chewed was thrown away. DA-F confirmed none of the food was served to residents. On 5/21/26 at 9:40 AM, Surveyor interviewed and entered the dish area with MS-C. When Surveyor asked about a hole covered with mesh and steel wool where a pipe came out of the wall underneath the sink, MS-C indicated MS-C had covered the hole at the end of April due to rodent concerns. When Surveyor asked what kind of rodents, MS-C stated mice. When asked if there were concerns about rats, MS-C indicated MS-C had not heard any rat concerns prior to that week. When asked if MS-C had seen a video of a rat in the kitchen, MS-C indicated no. MS-C indicated MS-C first heard of a video last week when kitchen staff said they saw a rat. Regarding the traps in the kitchen, MS-C indicated MS-C only took care of 2 sticky traps in the dishroom and the facility's pest control company took care of 2 metal traps in the dry storage area. MS-C indicated MS-C did not take care of the other traps in the main kitchen. MS-C stated MS-C was not aware rats were caught in the kitchen and was only aware of small mice. During the interview, Surveyor requested the last 6 months of pest control company visits. MS-C indicated MS-C would contact the pest control company since MS-C did not have the documentation onsite.At 10:30 AM, Surveyor completed an outside tour with MS-C and showed MS-C [NAME] and areas alongside the building, including one that contained a bunnies nest. MS-C was not aware of the areas and stated MS-C needed to take care of some of the areas. Surveyor also pointed out areas in the kitchen where there were holes in the drywall, including an outer wall in a corner behind a counter outside the dishroom, in the same wall adjacent to the dishroom, and next to an outer door outside the main kitcehn door where staff entered near the timeclock.On 5/21/26 at 10:45 AM, Surveyor interviewed Dietary Manager (DM)-D who indicated maintenance staff set all the traps in the kitchen. DM-D indicated the rodent problem had been going on for a few months. DM-D indicated kitchen staff observed bread products that had been nibbled on. DM-D instructed staff not to leave anything out and to use the microwave as a breadbox. DM-D indicated Nursing Home Administrator (NHA)-A knew about the issue approximately a month ago after DM-D threw away a large rat that was caught in one of the traps. DM-D stated DM-D picked up the trap and threw it out. DM-D indicated DM-D told NHA-A who was going to talk to MS-C. DM-D confirmed MS-C put the mesh under the dishwasher on 5/19/26 (not the end of April as MS-C had indicated). On 5/21/26 at 3:41 PM, Surveyor asked Director of Nursing (DON)-B if DON-B had received a video from staff of a rat in the kitchen. DON-B indicated DON-B received a poor quality grainy video of a small animal in the kitchen but could not say if it was a rat. DON-B indicated DON-B received the video months ago and passed the video onto NHA-A. On 5/21/26 at 11:08 AM, Surveyor interviewed (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NHA-A who indicated NHA-A first heard of a recent rat concern this week. NHA-A indicated NHA-A talked to DM-D that morning and just found out DM-D caught a rat in a trap approximately 6 weeks ago. Surveyor asked about NHA-A's use of the words recent concern and asked when NHA-A was made aware of a previous concern. NHA-A indicated the facility educates staff in the spring and fall because the facility is in the country. NHA-A indicated as soon as NHA-A found out about the concern, NHA-A did a walk-through of the kitchen, began education about pest control, and stated if staff see something they should say something. Surveyor requested the past 6 months of pest control logs. NHA-A indicated the pest control company was contacted, however, the pest control staff was on the road and would send the logs to the facility as soon as possible. Surveyor requested the phone number for the pest control company and receipts for paid bills. In a subsequent interview at 4:05 PM, NHA-A indicated NHA-A had never seen a video of a rat in the kitchen. On 5/21/26 at 11:38 AM, Surveyor contacted the facility's pest control company via phone but did not receive a return call. The facility provided bills from the pest control company which indicated bills were sent twice monthly. The bills did not indicate how many traps the company kept, where the traps were located, concerns identified on each visit, or what was completed during each visit. On 5/21/26 at 12:41 PM, Surveyor reviewed the facility's education and staff signature pages. Surveyor interviewed DA-G who indicated DA-G had worked every day since Monday (5/18/26) and was not provided education about pest control. DA-G's signature was not on the staff signature page. On 5/21/26 at 4:05 PM, Surveyor informed NHA-A of the inconsistencies in the timeline of events, when issues were known and by who, who was managing which traps, when various areas of mitigation for rodents were implemented, and that not all staff who worked in the kitchen that week were educated. Due to the inconsistencies and the fact that staff education was incomplete, the facility did not meet the standard for an effective pest control program.