STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555195	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Rosa Villa	2018 N Del Rosa Ave San Bernardino, CA 92404

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record the facility failed to ensure resident's needs and preferences were met when: An appropriate bed mattress was not accommodated upon request for 1 of 20 sampled residents (Resident 107) after returning from the hospital to maintain comfort. An evaluation for a power wheelchair was not coordinated upon request for 1 of 20 sampled residents (Resident 116) to accommodate her inability to self propel a manual wheelchair.These failures resulted in Resident 107 experiencing discomfort and the inability to sleep in his bed and the potential for loss of independence for Resident 116 when their needs were not met. Findings:1.During a review of Resident 107's face sheet (demographic data), Resident 107 was readmitted to the facility on [DATE] with diagnoses which included fluid overload, and hypoxemia (low oxygen levels in the blood). During a review of Resident 107's admission Minimum Data Set (MDS- assessment tool), MDS assessment indicated Resident 107 has intact cognition. During a concurrent observation and interview on 2/8/26 at 10:10 a.m. and on 2/9/26 at 9:30 a.m. with Resident 107 in the room, Resident 107 was observed sitting up in his wheelchair. Resident 107 stated he reported his bed mattress was uncomfortable, and he had informed different staff about the issue since returning from the hospital. Resident 107 stated that due to the discomfort, staff were aware that he had been sleeping in a chair every night in the lobby and had not slept in his bed since his hospital discharge and no interventions were initiated to resolve the issue. During an interview on 2/9/26 at 9:49 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that she was not aware of Resident 107's issue with the bed mattress. However, LVN 1 confirmed Resident 107 was observed sitting in his wheelchair most of the time. During a concurrent interview and record review on 2/9/2026 at 9:51 a.m. with Environmental Services Director (ESD), the work order request logbook dated 2/1/26 to 2/8/26 indicated no evidence a request for a bed mattress was made. The ESD stated that he was not informed about Resident 107's bed mattress issue. During a review of the facility's policy and procedure titled Quality of Care/Accommodation of Needs dated March 2021 indicated Our facility 's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. Policy Interpretation and implementation.g. providing a variety of types. furniture in rooms.so that residents with.mobility can independently arise to standing position. 2. During a review of Resident 116's Face Sheet (Demographics) dated 2/11/26, the Face Sheet indicated Resident 116 was admitted to facility on 8/12/24 with diagnoses which included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rigidity, and slow, imprecise movements). During an interview on 2/9/26 at 9:50 a.m. with Resident 116, Resident 116 stated she requested the staff for a powered wheelchair to use to be more independent because she cannot use a manual wheelchair by herself due to her diagnoses. Resident 116 stated she requested the powered wheelchair from multiple staff since her admission and there had been no follow up information regarding the status of her request. During an interview on 2/10/26 at 3:05 p.m. with Director of Rehab (DOR), DOR stated the Rehab department performs screenings and provides the physician with recommendations for a powered wheelchair for residents in the facility. She stated she was not informed by nursing staff that Resident 116 requested a powered wheelchair and staff should notify her of a resident's request by leaving a written note or verbally in person. During an interview on 2/11/26 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the nursing staff is responsible for communicating a resident's concerns or requests with the appropriate departments. During an interview on 2/11/26 at 10:15 a.m. with Social Services Director (SSD), SSD stated she is involved in coordinating and ordering specialized equipment for resident's use, but nursing staff had not informed her of Resident 116's request for powered wheelchair. During a review of Resident 116's Individual Psychotherapy Progress Note, dated 1/26/26, the progress note indicated, Encouraged communication with staff regarding mobility options and equipment needs. Motivation to increase activity and social engagement was evident. Coordinate with nursing and rehabilitation staff regarding wheelchair evaluation and mobility planning. During a review of policy and procedure (P&P) titled, Assistive Devices and Equipment, dated January 2020, the P&P indicated, Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement individualized care plan interventions related to actual needs for two of 20 sampled residents (Resident 6 and 73) when: Multiple observation over several days showed Resident 6 had long, visibly dirty fingernails.For two consecutive days, Resident 73 remained in bed without participation in activities.These failures resulted in staff not being provided with interventions to deliver individualized care and placed residents at risk of unmet needs. Findings: During a review of Resident 6 face sheet (demographic data) and quarterly Minimum Data Set (MDS- assessment tool) dated 1/4/26, the face sheet showed Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia (decline in memory function). During a concurrent observation and interview on 2/8/26, at 10:56 a.m. with Resident 6 in the dining room, Resident 6 was observed with long, visibly dirty fingernails.During a meal observation on 2/8/26 at 12:02 p.m. Resident 6 was seen eating and touching her food with both hands. When asked about the condition of her fingernails, Resident 6 stated I know.During a concurrent observation and interview on 2/9/26 at 11:02 a.m. in Resident 6's room, with Certified Nursing Assistant (CNA) 1, Resident 6 fingernails remained long and dirty. CNA 1 stated she did not notice the condition of Resident 6's fingernails.During an interview on 2/9/26 at 9:52 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated CNAs were responsible for cutting/cleaning residents' fingernails.During a concurrent observation and interview on 2/10/26 at 8:50 a.m. with CNA 2, Resident 6 remained with long dirty fingernails. CNA 2 stated she did not observe the condition of Resident 6's fingernails.During a review of the Activities of Daily Living (ADL) care plan dated 2/14/24 and last reviewed 1/13/26, indicated At risk for decline in self-care and mobility skills. However, the care plan showed no individualized goals or interventions addressing hygiene needs, including nail care.During an interview on 2/12/26 at 9:22 a.m. with Minimum Data Set (MDS-assessment tool) Coordinator 1, MDS 1 stated care plans should be individualized according to residents' needs, specific goals and interventions.During a review of the facility's policy and procedure (P&P) titled Care Planning-Interdisciplinary Team with a revised date of September 2013, indicated Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 2. During a review of Resident 73's face sheet (demographic data) and quarterly Minimum Data Set (MDS- assessment tool) dated 1/27/26, the face sheet indicated Resident 73 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis on one side of the body). MDS assessment indicated Resident 73 had severe cognitive impairment.During observation on 2/8/26 from 10:27 a.m. to 11 a.m. and on 2/9/26 at 10:12 a.m. to 11 a.m., Resident 73 was in bed without participation in activities or offered activities for two consecutive days.During an interview on 2/9/26 at 10:25 AM with Certified Nursing Assistant (CNA 1), CNA 1 stated she did not ask or offer Resident 73 to be up in the Geri-chair (medical chair for individuals with limited mobility).During an interview on 2/9/26 at 10:41 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 73 did not have a physician's order to be up in a Geri-chair; however, LVN 1 stated that CNAs could still get her up.During an interview on 2/9/26 at 3:34 p.m. with the Activity Director (AD), Activity Director stated staff should provide Resident 73 with 1:1 activities such as Spanish music and read Spanish books while in room and up in the dining room.During a review of Resident 73's Activity care plan dated 5/5/21, indicated One/One: resident needs one on one activity visits to provide social interaction and mental/sensory stimulation.; however, the interventions did not address the music and the books as part of the activity's plan.During an interview on 2/12/26 at 9:16 a.m. with MDS 1, MDS 1 stated care plans should be individualized according to residents' needs, specific goals and interventions.During a review of the facility's policy and procedure (P&P) titled Care Planning-Interdisciplinary Team with a revised date of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	September 2013, indicated Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary assistance for one of 20 sampled residents (Resident 6) with personal hygiene specifically nail care. This failure resulted in Resident 6 not being provided and receiving necessary activities of daily living (ADL) assistance to maintain personal hygiene. Findings:During a review of Resident 6's face sheet (demographic data), the face sheet indicated Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia (decline in memory function).During a review of Resident 6's quarterly Minimum Data Set (assessment tool) dated 1/14/26, Resident 6 required assistance in her personal hygiene.During a concurrent observation and interview on 2/8/26, at 10:56 a.m. with Resident 6 in the dining room, Resident 6 was observed with long, visibly dirty fingernails.During a meal observation on 2/8/26 at 12:02 p.m., Resident 6 was seen eating and touching food with both hands. When asked about the condition of her fingernails, Resident 6 stated I know.During a concurrent observation and interview on 2/9/26 at 11:02 a.m. in Resident 6's room, with Certified Nursing Assistant (CNA 1), Resident 6 fingernails remained long and dirty. CNA 1 stated she did not notice the condition of Resident 6's fingernails.During an interview on 2/9/26 at 9:52 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated CNAs were responsible for cutting/cleaning residents' fingernails.During a concurrent observation and interview on 2/10/26 at 8:50 a.m. with CNA 2, Resident 6 remained with visibly long dirty fingernails. CNA 2 stated she did not observe the condition of Resident 6's fingernails.During an interview on 2/12/26 at 9:05 a.m. with Director of Nursing (DON), DON stated CNAs were responsible for maintaining and providing ADL assistance to the residents.During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADL), Supporting dated March 2018, indicated, Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with a. hygiene (bathing, dressing, grooming, and oral care).

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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** Based on observation, interview and record review, the facility failed to keep the environment safe and free from hazards for 1 of 20 sampled residents (Resident 28) when safety interventions to prevent falls were not implemented. These failures placed Resident 28 at risk for potential falls and injuries. During a review of Resident 28's Face Sheet (Demographics), the Face Sheet indicated Resident 28 was readmitted to the facility on [DATE] with diagnoses which included Encephalopathy (brain dysfunction that often results in altered mental state), Multiple Sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord).During an observation on 2/8/26 at 10:30 AM, in Resident 28's room, Resident 28 was resting in bed, with the bed elevated in a high position from the ground. Resident 28 was wearing a wristband that indicated Fall Risk.During a concurrent observation and interview on 2/9/26 at 9:30 a.m. with Certified Nursing Assistant (CNA) 4 in Resident 28's room, Resident 28 was resting in bed which was again raised in a high position from the floor. The Resident's call light was found underneath the bed on the floor. CNA 4 confirmed bed was in a high position and stated Resident 28 was considered a high risk for fall and the bed should be lowered to prevent injury. CNA 4 stated the call light should be within the resident's reach and was not when it was found under Resident 28's bed.During an interview on 2/10/26 at 10 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 28 was a fall risk and safety interventions should be in place to prevent falls, including keeping her bed in a low position and having the call light within reach.During a review of Resident 28's care plan Falls dated 12/18/24, the care plan indicated goals were to minimize risk for falls and the interventions included, Keep bed in low position. Keep call light within reach.During a review of the facility's policy and procedure (P&P) titled, Falls/Fall Risk Management, dated September 2012, the P&P indicated, . the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide necessary respiratory care and services for two of 20 sampled residents (Resident 5 and Resident 107) when: Resident 5's oxygen cannula tubing (medical device to deliver oxygen) was not changed for twelve days (12 days) past the required time frame.Resident 107 did not receive the prescribed respiratory treatments following his return to the facility.These failures placed Resident 5 and Resident 107 at risk for compromised respiratory health status and avoidable decline in health. Findings:During a review of Residents 5's face sheet (demographic data), Resident 5 was readmitted to the facility on [DATE] with diagnosis including pneumonia (lung infection).During a concurrent observation and interview on 2/8/26 at 10:04 a.m. with Resident 5, there was an oxygen cannula tubing with a date label of 1/27/26 at bedside. Resident 5 stated the oxygen was used two (2) days ago (on 2/6/26).During an interview on 2/9/26 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated all cannula oxygen tubing should be replaced every three (3) days and the charge nurses were responsible for changing oxygen tubing.During an interview on 2/12/26 at 9:05 a.m. with Director of Nursing (DON), DON stated charge nurses were responsible for changing the oxygen cannula tubing and Infection Preventionist (IP) was responsible for overseeing that the task was done.During a review of the facility's policy and procedure (P&P) titled Prevention of Infection Respiratory Equipment with revised date of November 2011, indicated The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff.Change the oxygen cannula and tubing every seven (7 days) or as needed.2. During a review of Resident 107 face sheet (demographic data), Resident 107 was readmitted to the facility on [DATE] with diagnoses which included fluid overload, and hypoxemia (low oxygen levels in the blood).During a review of Resident 107's admission Minimum Data Set (MDS- assessment tool) dated 11/13/2025, MDS assessment indicated Resident 107 was cognitively intact.During a review of the physician's order dated 2/4/26 indicated [name of medication] to inhale orally via nebulizer (medical device that turns liquid medicine into a mist that can be inhaled) every 6 hours as needed for shortness of breath, hypoxia (a condition where body tissues do not receive enough oxygen); Initiate Incentive Spirometer (medical device used to measure lung volume and speed of air in between respiration) three times a day for 5 to 10 breath cycle or as tolerated for 10 days. During a concurrent observation and interview on 2/8/26 at 10:10 a.m. and 2/9/26 at 9:30 a.m. with Resident 107, a nebulizer machine was observed without set-up and there was no Incentive Spirometer found at bedside. Resident 107 was observed to have coughs and stated he was experiencing slight shortness of breath in between his activities.During an interview on 2/10/26 at 9:20 a.m. with Resident 107, Resident 107 stated he had not received any breathing treatments since his readmission. Resident 107 further stated the Incentive Spirometer was not provided since returning from the acute hospital.During an interview on 2/10/26 at 9:35 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 107 had orders of respiratory treatments; however, LVN 1 stated the respiratory prescribed treatments were not administered/provided on 2/9/26 to 2/10/26 during her shift. LVN 1 also confirmed the nebulizer machine had no set up and there was no Incentive Spirometer equipment at bedside,During a review of the Medication Administration Record (MAR) dated February 2026, there was no documentation indicated that the prescribed respiratory medication via nebulizer were administered, offered, attempted or refused by Resident 107.During an interview on 2/12/26 at 9:05 a.m. with Director of Nursing (DON), the DON stated all respiratory medications should have been administered according to physician's order.During a review of the facility's policy and procedure titled Respiratory Treatment dated 8/1/24, indicated It is the policy of this center that residents receive respiratory treatments and monitoring per their physician's orders, standards of practice and plan of care.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure hot food was served at an acceptable temperature (above 135 degrees Fahrenheit [F- measurement of temperature]) to be appetizing for two of 20 sampled residents (Resident 67 and Resident 116).This failure had the potential to affect meal and food intake which could impair the nutrition status of the residents.During an interview on 2/8/26 at 11 a.m. with Resident 67 in the resident's room, Resident 67 stated the food was not good and she did not like to eat the food served. Resident 67 stated the food would also be delivered cold, which did not make it appetizing to eat and she would often not finish her meal because of it.During an interview on 2/8/26 at 3:30 p.m. with Resident 116 in the resident's room, Resident 116 stated she did not like the food that was served because it was not palatable when the food tray was cold by the time it was delivered to her room.During a review of the facility's menu titled, February 9-15, 2026, the menu for Monday 2/9/26 indicated the lunch meal of Regular diet included Fish with Tarragon, Cajun Country Rice, Creamed Spinach, Sweet Corn Salad, and Fruit Bavarian Cream.During a test tray observation and interview on 2/9/26 at 12:28 p.m. with the Dietary Supervisor (DS) in the dining room, a food tray of the regular diet was removed from the last meal cart for delivery to the residents' rooms and the temperatures of the food were taken. On the regular tray, the entree of Fish with Tarragon was 126.8 degrees F and the Cajun Country [NAME] was 127.8 degrees F when the temperature was taken with a thermometer. The DS acknowledged the low food temperatures of the food and stated it should be served warmer.During a review of the 2022 Federal Food and Drug Administration Food Code (FDA Food Code), Section 3-501.16 titled, Time/Temperature Control for Safety. Holding, FDA Food Code indicated, Food shall be maintained. held at a temperature of 54 degrees Celsius (130 degrees F) or above.During a review of the facility's policy and procedure (P&P) titled, Food Preparation and Service, undated, the P&P indicated, Proper hot and cold temperatures are maintained during food distribution and service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a safe, sanitary, and comfortable environment for one of 20 sampled residents (Resident107) when Resident 107 did not receive education/training in infection control practices when emptying his urinary bag.These failures had the potential to place Resident 107 at risk for infection, and contamination that could affect his overall health condition.Findings: During a review of Resident 107's face sheet (demographic data) and admission Minimum Data Set (MDS- assessment tool), Resident 107 was readmitted to the facility on [DATE] with diagnoses which included fluid overload, and hypoxemia (low oxygen levels in the blood). MDS assessment indicated Resident 107 has intact cognition.During a concurrent observation and interview on 2/8/26 at 10:10 a.m. with Resident 107, Resident 107 was observed with urinary drainage bag with covering attached to his wheelchair and he stated the staff were not coming in to empty the urinary bag and had been emptying the urine by himself. Resident 107 was observed removing the drainage port, showing how to empty it, and replacing the port without gloves or performing hand hygiene before and after the task.During an interview on 2/9/26 at 9:43 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 107 was not his regular assigned resident, and he was not aware of the urinary bag.During an interview on 2/9/26 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated CNAs were responsible for emptying urinary bags. LVN 1 could not state if Resident 107 was screened to perform self-emptying the urinary bag.During an interview on 2/11/26 at 10:08 a.m. with Infection Preventionist (IP), IP could not confirm if there was documentation indicating Resident 107 was assessed as capable of managing his own catheter care, nor any documentation of resident education, supervision or competency evaluation related to catheter-bag emptying.During a review of the facility's policy and procedure titled Infection Prevention and Control Program with revised date of October 2018, indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview and record review, the facility failed to maintain an effective pest control program, when staff failed to report the presence of flying insects in room [ROOM NUMBER] shared bathroom. This failure had the potential to pose significant health risks to residents, visitors and staff.Findings:During an interview conducted on 2/9/26 at 10:56 a.m. with Resident 14, Resident 14 stated there was a lot of bugs inside his bathroom. Resident 14 stated he informed staff about the bugs last week but they did nothing about it. Resident 14 stated he could not remember the staff name or the specific date when he told staff.During an observation on 2/9/26 at 10:57 a.m. in room [ROOM NUMBER] shared bathroom, there was large amount of small dark colored flying insects inside the bathroom and large amount that were resting around the toilet seat.During a concurrent observation and interview on 2/9/26 at 11 a.m. with the Administrator and Environmental Service Director (ESD) in room [ROOM NUMBER] bathroom, the Administrator and the ESD stated they were unaware of the bugs issue inside the bathroom. The Administrator and the ESD confirmed the large amount of flying insects.During a concurrent interview and record review on 2/10/26 at 9:56 a.m. with the ESD, the ESD stated he was not notified by any staff regarding the insects inside room [ROOM NUMBER] bathroom. The ESD provided a communication folder (a folder used by facility staff to report maintenance issues) for review. The folder indicated there was no documented evidence that staff reported or communicated the issue.During a review of the facility's policy and procedure (P&P) titled, Pest Control with a revision date of May 2008, the P&P indicated, Our facility shall maintain an effective pest control program.