STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675989	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brazos Valley Care Home	605 S Ave F Knox City, TX 79529

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 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** 49305 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice for 1 (Resident #28) of 5 residents reviewed for respiratory care. The facility failed to ensure that Resident #28's oxygen tubing was replaced every seven (7) days, according to physician's orders. This failure could place residents at risk for respiratory compromise and infection. Findings included: Review of Resident #28's face sheet revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Congestive Heart Failure (heart condition), Chronic Kidney Disease (condition causing kidneys to not function properly), Gastroesophageal Reflux Disease (digestive condition), Peripheral Vascular Disease (circulatory condition that reduces blood flow to the limbs), acquired absence of right leg below the knee, complete traumatic amputation of left leg at knee level, anxiety disorder, and hypertension (high blood pressure). Record review of Resident #28's annual MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #28 used oxygen therapy while a resident. Record review of Resident #28's comprehensive care plan, dated 07/25/24, revealed resident #28 required oxygen therapy related to Chronic Obstructive Pulmonary Disease. Record review of #28's current Physician Orders dated 03/06/24 revealed an order for oxygen to be administered at 2 liters/minute per nasal cannula (tube in nostrils) every shift as needed. Record review of Resident #28's Medication Administration History dated 09/01/24-09/30/24, revealed an order to change oxygen tubing, cannula/mask once a week. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/02/24 at 11:30 AM, Resident #28 had oxygen being administered at 2 liters/minute via nasal cannula. Oxygen tubing was dated 09/22/24. Resident stated staff usually changed out his oxygen tubing on the night shift and he did not recall when staff had last changed it. During an observation on 10/02/24 at 2:16 PM, Resident #28's oxygen tubing was dated 09/22/24. During an observation on 10/03/24 at 11:07 AM, Resident #28's oxygen tubing was dated 09/22/24. During an interview on 10/04/24 at 12:34 PM with the ADM, he stated he was not sure what the facility policy stated regarding changing of oxygen tubing. He stated nursing administration was responsible for assuring oxygen tubing was changed according to physician's orders. He stated he assumed staff had been trained on proper dispensing of oxygen therapy and changing oxygen tubing per orders. When asked to give a potential negative outcome for failure to change oxygen tubing per orders, the ADM stated he was not comfortable answering the question because he was not a clinician. During an interview on 10/04/24 at 12:50 PM with the DON, she stated the facility policy for changing oxygen tubing was that it was done every Sunday on the night shift and as needed. She said the night shift nurse was responsible for changing oxygen tubing. She stated she was responsible for assuring oxygen tubing was changed according to physician's orders. She stated staff are trained on proper dispensing of oxygen upon hire, annually and as needed. The DON stated a potential negative outcome for failure to change oxygen tubing according to physician's orders was an increased risk for infection. Record review of the facility-provided policy titled Oxygen Administration, revised October 2010, revealed: Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49154 Based on interviews and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week in the facility for 34 (4/1, 4/3, 4/6, 4/7, 4/8, 4/10, 4/11, 4/12, 4/13, 4/14, 4/20, 4/21, 4/27, 4/28, 5/7, 5/10, 5/11, 5/12, 5/24, 5/25, 5/28, 5/29, 5/30, 5/31, 6/1, 6/2, 6/7, 6/8, 6/14, 6/15, 6/21, 6/22, 6/25, and 6/29/2024) of 91 days reviewed for RN coverage. The facility failed to maintain RN coverage of eight hours a day for 34 days. This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care. Findings included: Record review of the facility's employee survey roster dated 10/2/24 revealed there were no RNs employed at the facility. Record review of Schedule Sheet dated April 2024 revealed there was not an RN scheduled to work on (4/1, 4/3, 4/6, 4/7, 4/8, 4/10, 4/11, 4/12, 4/13, 4/14, 4/20, 4/21, 4/27, and 4/28/2024). Record review of Schedule Sheet dated May 2024 revealed there was not an RN scheduled to work on (5/7, 5/10, 5/11, 5/12, 5/24, 5/25, 5/28, 5/29, 5/30, and 5/31/2024). Record review of Schedule Sheet dated June 2024 revealed there was not an RN scheduled to work on (6/1, 6/2, 6/7, 6/8, 6/14, 6/15, 6/21, 6/22, 6/25, and 6/29/2024). During an interview on 9/26/24 at 3:45 PM, the DON stated the facility did not have any RN coverage in April 2024 and that she covered some days in May and June 2024. She stated there were no other RNs employed at the facility in April, May, and June 2024 besides herself. During an interview on 9/26/24 at 4:25 PM, the DON stated she was not able to print out the RN time detail to show that No RN's were covering on the dates in question. She stated she did not punch in on a timesheet because she was a salaried employee. During an interview on 9/26/24 at 4:47 PM, the contracted staffing agency employee stated she was contacted by the facility about needing RNs to work at the facility. She stated she was not able to find any RN's that were willing to work at that facility. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/27/24 at 12:08 PM, the DON stated the facility was actively trying to employ an RN. She stated they had a strong online recruitment presence in social media and recruitment websites. She stated they had a job fair last year and would have another one on 10/8/24. She stated they were in communication with the Texas Workforce Commission. She stated, last year the previous ADM went to Midwestern University to try to recruit new graduates. She stated they did not have RN coverage in April, May, and June 2024 except on the days she worked because they were not able to get anyone hired and their weekend RN quit. She stated they started using a new contracted agency for RNs on June 26th to help provide RN staff when needed and have had coverage since. She stated the previous contracted staffing agency they used in April, May, and most of June were not consistent and most of the agency staff they said they assigned would not show up for the shift. She stated the facility policy required RN coverage 8 hours 7 days a week. She stated she was aware of all the days in April, May, and June that there was no RN coverage. She informed the corporate office of not having the RN coverage and was told to continue to actively look for one. She stated she was contacted by staff on each day of when the agency staff did not show up. She stated she thought the ADM was responsible to ensure RN coverage. She stated she was not required to fill those shifts to her understanding. She stated there was not necessarily a training she received for RN coverage requirements, but she was aware of the requirement from the Code of Federal Regulations and the State Operations Manual. She stated having an RN on coverage provided additional clinical skills. She stated LVNs could not administer IV lines (tube placed inside a vein) or IV push medications, however they did not accept those type of residents who require services that only RNs could do. She stated Hospice and she could pronounce deaths. She stated she did not think there was a negative outcome to not having RN coverage because the facility had all the necessary resources for LVNs to utilize such as Telehealth, a medical director they could call, the hospital was one block away from the facility, and emergency medical services could arrive within one minute. She stated she felt residents would get all their needs met by the LVNs, CNAs, and all other staff working at the facility. She stated she felt the RN was just another person working in the building. During an interview on 9/27/24 at 12:55 PM, the ADM stated he believed the facility policy required RN coverage for 8 hours per day, but he was not sure because he did not have the policy in front of him. He stated he was aware there were issues with RN coverage because they had implemented a Performance Improvement Plan during a Quality Assessment and Performance Improvement meeting. He stated he had been trying to get staff hired. He stated he placed advertisements in various places such as social media and the newspaper, and they will attend a job fair soon. He stated the facility used agency RNs to try and fill RN coverage shifts as well. He stated they facility and staff had access to Telehealth and their Medical Director was very responsive on weekends and holidays. He stated he could not recall receiving a specific training on RN coverage. He stated there were no other RNs on staff during the months of April, May, and June 2024 besides the DON. He stated he was responsible for ensuring RN coverage. He stated he did not think he could answer that question of what a negative outcome to the resident could be by not having RN coverage since he was not a clinician. He stated staff had access to Telehealth, if needed. He stated the DON could cover some of the shifts when an RN was needed however, he did not expect her to cover every shift because she could not work every day. Record review of the policy provided by the facility titled, Staffing, revised 9/28/23 revealed in part the following: (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy Statement - Our center provides sufficient nursing staff with the appropriate skills and competencies necessary to provide care and related services to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with resident care plans and the facility assessment. Policy and Implementation 4. The facility utilizes the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 (Resident #28) of 13 residents reviewed for clinical records. The facility failed to accurately document an oxygen tubing change for resident #28. This failure could place residents at risk of inaccurate and incomplete care. Findings included: Review of Resident #28's face sheet revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems), Congestive Heart Failure (heart condition), Chronic Kidney Disease (condition causing kidneys to not function properly), Gastroesophageal Reflux Disease (digestive condition), Peripheral Vascular Disease (circulatory condition that reduces blood flow to the limbs), acquired absence of right leg below the knee, complete traumatic amputation of left leg at knee level, anxiety disorder, and hypertension (high blood pressure). Record review of Resident #28's annual MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident was cognitively intact. Section O - Special Treatments, Procedures and Programs revealed Resident #28 used oxygen therapy while a resident. Record review of Resident #28's comprehensive care plan, dated 07/25/24, revealed resident #28 required oxygen therapy related to Chronic Obstructive Pulmonary Disease. Record review of #28's current Physician Orders dated 03/06/24 revealed an order for oxygen to be administered at 2 liters/minute per nasal cannula (tube in nostrils) every shift as needed. Record review of Resident #28's Medication Administration History dated 09/01/24-09/30/24, revealed an order to change oxygen tubing, cannula/mask once a week. Record review of Resident #28's Medication Administration History dated 09/01/24-09/30/24 revealed LVN A inaccurately signed for an oxygen tubing change on 09/29/24 for Resident #28, that did not occur. During an observation and interview on 10/02/24 at 11:30 AM, Resident #28 had oxygen being administered at 2 liters/minute via nasal cannula. Oxygen tubing was dated 09/22/24. Resident stated staff usually changed out his oxygen tubing on the night shift and he did not recall when staff had last changed it. During an observation on 10/02/24 at 2:16 PM, Resident #28's oxygen tubing was dated 09/22/24. During an observation on 10/03/24 at 11:07 AM, Resident #28's oxygen tubing was dated 09/22/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/04/24 at 11:39 AM with LVN A, she stated she worked the night shift, and she took care of Resident #28. She stated the facility policy for changing oxygen tubing was that the night nurses change them once a week, usually on Sunday night. She stated on 9/29/24 she documented that she changed Resident #28's oxygen tubing but did not change the tubing. She stated she usually pre-charts her initials ahead of time on routine things that she will be performing during her shift. She stated on 09/29/24 she failed to go back and remove her initials from Resident #28's Medication Administration History for the ordered oxygen tubing change. LVN A stated a potential negative outcome for not changing oxygen tubing and inaccurately documenting the change would be increased risk of infection and inaccurate resident care. During an interview on 10/04/24 at 12:34 PM with the ADM, he stated he assumed that the facility policy for accurate documentation of resident health records was that they were kept accurately. He stated nursing administration was responsible for staff training and monitoring of accurate documentation. He stated his expectation of staff for accurate documentation was that they follow policy and always document accurately in the health record. The ADM stated he did not want to speculate on the potential negative outcome for failure to accurately document resident health records because he was not a clinician. During an interview on 10/04/24 at 12:50 PM with the DON, she stated she was not aware that Resident #28's Medication Administration History contained inaccurate documentation for an oxygen tubing change on 09/29/24. She stated the facility policy for accurate documentation of resident health records was that nursing staff do not predate while charting and they assure accuracy of the health record. She stated staff were trained on proper documentation practices approximately quarterly. She stated her expectation of staff for accurate documentation practices was that they practice documentation accuracy at all times. She stated accuracy of documentation was monitored by the DON doing rounds and reviewing the records. She stated a potential negative outcome for failure to accurately document resident health records was inaccuracies and errors in care. Record review of the facility-provided policy titled Charting and Documentation, revised July 2017, revealed: Policy Statement .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. . 7. Documentation of procedures and treatments will include care specific details, including: a. The date and time the procedure/treatment was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49305 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 14 residents (Resident #11, #30 and #34) and 1 of 4 staff (LVN A) reviewed for infection control. LVN A failed to properly clean a multi-use medical device between each resident during medication administration for Resident #11, #30 and #34. These failures could place residents at risk for spread of infection and cross contamination. Findings included: During a medication pass observation on 10/03/24 at 08:58 AM, LVN A picked up the wrist blood pressure device from the top of the medication cart and took it to the room of Resident #11 and took her blood pressure on the left wrist. She then took the wrist blood pressure device and placed it on top of the medication cart. LVN A did not sanitize the wrist blood pressure device before or after use. During a medication pass observation on 10/03/24 at 09:27 AM, LVN A picked up the wrist blood pressure device from the top of the medication cart and took it to the room of Resident #30 and took her blood pressure on the right wrist. She then took the wrist blood pressure device and placed it on top of the medication cart. LVN A did not sanitize the wrist blood pressure device before or after use. During a medication pass observation on 10/03/24 at 09:46 AM, LVN A picked up the wrist blood pressure device from the top of the medication cart and took it to the room of Resident #34 and took her blood pressure on the left wrist. She then took the wrist blood pressure device and placed it on top of the medication cart. LVN A did not sanitize the wrist blood pressure device before or after use. During an interview on 10/03/24 at 10:04 AM with LVN A, she stated she did not sanitize the wrist blood pressure device prior to initial use on medication pass. She stated she did not sanitize the wrist blood pressure device between residents. LVN A stated the wrist blood pressure device should be sanitized between residents. She stated she had been trained on cross-contamination through her nursing education. She stated she was an agency nurse but received training by the DON for proper infection control practices as needed. LVN A stated the DON updated her on current training prior to working assigned shifts at the facility. LVN A stated there was a book of training kept at the nurse's station and it was the nurses' responsibility to review current training in the book. She stated a potential negative outcome for failure to sanitize multi-use devices between residents would be the transfer of diseases and infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/03/24 at 10:11 AM with the DON, she stated staff had not been trained to sanitize multi-use blood pressure cuffs between residents. She stated blood pressure cuffs were considered a non-critical item and the facility's policy did not require sanitizing those items. She stated she was responsible for conducting training for nursing staff and training was usually conducted on a one-to-one basis. She stated staff were trained on infection control practices upon hire and as needed. The DON stated a potential negative outcome for failure to sanitize multi-use devices between residents would be increased risk of infection to residents. In a subsequent interview on 10/04/24 at approximately 01:30 PM with the DON, she stated staff should sanitize multi-use blood pressure cuffs at the end of each shift and when they became soiled. The DON stated the best quality of care practice would be to sanitize all multi-use devices between residents. During an interview on 10/04/24 at 12:34 PM with the ADM, he stated he was not aware that staff were not sanitizing multi-use blood pressure devices between residents. He stated he could not quote the facility policy for properly sanitizing multi-use devices. The ADM stated nursing administration was responsible for staff training on infection control practices and proper sanitizing of multi-use devices. He stated his expectation of staff for properly sanitizing multi-use devices was that they follow orders. He stated a potential negative outcome for failure to properly sanitize multi-use devices would be the transmission of infection. Record review of the facility-provided policy titled Cleaning and Disinfection of Non-Critical Resident-Care Items, revised April 2020, revealed: Purpose The purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items. General Guidelines . 3. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care: . c. Non-critical items are those that come in contact with intact skin but not mucous membranes. (I) Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers. (2) Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location). . 4. Intermediate and low-level disinfectants for non-critical items include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Ethyl or isopropyl alcohol; b. Sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions); c. Phenolic germicidal detergents; d. Iodophor germicidal detergents; and e. Quaternary ammonium germicidal detergents (low-level disinfection only). Record review of the facility-provided policy titled Administering Medications, revised April 2019, revealed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 21. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, Gloves, isolation precautions, etc.) for the administration of medications, as applicable.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42515 Based on observations, interviews, and record reviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, on facility grounds in 1 of 2 smoking areas (North patio smoking area). The facility failed to ensure the grounds in the smoking area was free from trash. This failure could attract unwanted pests and cause the facility to have an unsightly appearance. The findings included: On 10/03/24 at 2:47 PM, an observation was made of the North patio smoking area. 1 plastic spoon, 10 pieces of white and clear miscellaneous trash, and 11 cigarette butts were noted in the grass area. On 10/03/24 at 4:51 PM, an observation was made of the North patio smoking area. 1 plastic spoon, 10 pieces of white and clear miscellaneous trash, and 11 cigarette butts were noted in the grass area. On 10/04/24 at 9:51 AM, an observation was made of the North patio smoking area. 1 plastic spoon, 10 pieces of white and clear miscellaneous trash, and 11 cigarette butts were noted in the grass area. On 10/04/24 at 10:16 AM, an interview was conducted with the Housekeeping Supervisor (HS) and he stated the Maintenance Supervisor (MS) and himself were responsible for keeping the grounds outside the facility clean of trash. The HS stated the housekeepers went to the smoking area to take out the trash only, not to pick up the trash in the grass/yard. The HS stated the MS and himself usually cleaned trash out of the yard every Wednesday, but it did not happen this week. The HS stated the last time the smoking area grounds had been cleaned of trash was the previous Wednesday on 09/25/24. The HS stated he was busy with survey duties this week and that was why the trash had not been picked up yet. The HS stated he did not know of a potential negative outcome to the residents and stated the trash did look bad in the North patio smoking area. On 10/04/24 at 10:31 AM, an interview was conducted with the MS and he stated the HS and himself were responsible for keeping the grounds outside the facility clean from trash. The MS stated they were trained to pick up trash on Wednesdays, but it was not done this week due to survey duties performed. The MS stated he did not know a potential negative outcome to the residents. On 10/04/24 at 10:41 AM, an interview was conducted with the Adm and he stated the HS and the MS were responsible for picking up trash outside on the facility grounds. The Adm stated the wind blows frequently in that area and that was probably why there was trash in the North patio smoking area. The Adm stated he did not know a potential negative outcome to the residents. The Adm was asked for a policy related to trash in the smoking area or on facility grounds outside and he stated he was not sure if the facility had one, but he would look. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675989	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brazos Valley Care Home	605 S Ave F Knox City, TX 79529

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure titled, Maintenance Policies & Procedures, undated, reflected the following: b. Clean up any debris, especially broken glass, on sidewalks and patios immediately. All debris is a potential hazard to our residents