STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	656 Dillon Way Aurora, CO 80011

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#6) of three residents reviewed were free from abuse out of 18 sample residents. Specifically, the facility failed to protect Resident #6 from physical abuse by certified nurse aide (CNA) #7. Findings include:I. Facility policy and procedureThe Abuse policy, revised September 2025, was provided by the nursing home administrator (NHA) on 12/16/25 at 3:42 p.m. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's medical symptoms.The Resident Rights policy, revised February 2021, was provided by the NHA on 12/16/25 at 3:42 p.m. The policy read in pertinent part, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms; e. self-determination; f. communication with and access to people and services, both inside and outside the facility; g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; h. be supported by the facility in exercising his or her rights; and,i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility.II. Resident #6A. Resident statusResident #6, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included multiple contractures and reduced mobility.The 9/9/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident was dependent on staff for activities of daily living (ADL).B. Facility investigationThe 10/22/25 facility investigation revealed the following:The social services director (SSD) was notified that CNA #7 refused to stop care when Resident #6 had asked the CNA to. The resident yelled out for the CNA to stop. Resident #6 reported pain at the time of this incident but the facility found no lingering physical or mental injury. CNA #7 was suspended following the incident. The SSD interviewed Resident #6 on 10/22/25. The resident told the SSD that CNA #7 entered his room and asked if he was ready to be changed. The resident said CNA #7 pushed him really hard against the wall. The resident said he told CNA #7 that he was hurting him and that he tried to lay back. The resident said CNA #7 then pushed him harder into the wall and his knees were pushed into the window. The resident said he asked CNA #7 to stop and he did not. The resident said he was yelling out and CNA #7 still did not stop. Resident #6 told the SSD that nobody should be treated like that and said he was afraid of CNA #7. The resident said he no longer wanted to be in the facility if CNA #7 was around. The SSD asked the resident if he would feel (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alright if CNA #7 cared for other residents at the facility and not him. Resident #6 said he would be okay if he never saw CNA #7 again. The investigation documented Resident #15 was interviewed on 10/22/25 by the SSD. Resident #15 was Resident #6's roommate at the time of the incident and was present at the time of incident. Resident #15 said he was behind a curtain during the incident, but heard his roommate yell and ask CNA #7 to stop. Resident #15 said CNA #7 continued despite Resident #6's requests. Resident #15 said he did not believe CNA #7 had any business caring for people. The investigation documented CNA #7 provided a written statement, dated 10/28/25, describing the details of the incident and Resident #6's allegation. The statement documented CNA #7 asked Resident #6 if she could change him and the resident responded that he did not need to be changed. CNA #7 then asked Resident #6 if it was okay if she checked the resident for incontinence. CNA #7 said the resident responded that he did not need to be changed. CNA #7 documented the resident was wet and smelled of feces. CNA #7 wrote that she educated the resident about the importance of being changed to protect the skin. CNA #7 said Resident #6 responded that he did not need to be changed. CNA #7 documented that the resident made a personal attack against her, identified her as a man and then asked for a female CNA. CNA #7 wrote that she then changed the resident. CNA #7 said the resident said stop and that she responded that she was almost done and would not bother him again. C. Resident #15 interviewResident #15 (roommate of Resident #6) was interviewed on 12/16/25 at 12.10 p.m. Resident #15 said he had overheard the incident (on 10/22/25) from behind a curtain. Resident #15 said CNA #7 had continued to change Resident #6's briefs, despite Resident #6 refusing help from CNA #7. Resident #15 said CNA #7 then pushed Resident #6 into a wall following his refusal, causing Resident #6 to scream loudly. Resident #15 said the scream caused a nurse to come in from the hall to see what was going on. III. Staff interviewsCNA #2 was interviewed on 12/16/25 at 9:49 a.m. CNA #2 said Resident #6 was pleasant to work with and did not generally refuse care. CNA #2 said Resident #6 could be a bit hesitant and nervous about receiving care when being assisted, but she personally had a good rapport with the resident.The NHA and the interim director of nursing (DON) were interviewed together on 12/16/25 at 4:07 p.m. The NHA said the facility had not received any previous concerns regarding CNA #7. The NHA said several residents did not like to work with her. The NHA said Resident #6 had reported pain in his knee at the time of the event, but had no continuing health effects from the incident on 10/22/25. The NHA said all staff received training on abuse and resident rights, but no additional training was provided following the incident. The NHA said CNA #7 was fired following the incident and was reported to the Department of Regulatory Agencies ([NAME]). The NHA said he believed this to be an isolated incident and they had no other staff complaints.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a thorough investigation of alleged misappropriation of funds for two (#1 and #4) of two residents out of 18 sample residents.Specifically, the facility failed to maintain thorough documentation that an alleged violation was thoroughly investigated for the misappropriation of Resident #1 and Resident #4's funds/property. Findings include:I. Facility policy and procedureThe Community Standard Operating policy and procedure, dated 9/4/25, was provided by the nursing home administrator (NHA) on 12/16/25. It read in pertinent part, This policy outlines the community's zero-tolerance stance against resident abuse, neglect, misappropriation of resident property, and exploitation by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Resident and family training and education is offered at least annually. A Concern/Complaint Report form is completed, in writing, when missing items (clothing, personal care items, jewelry,) are reported. Staff and families are encouraged to complete the reports as necessary. Management staff completes a thorough investigation. The social services director/designee maintains a file of concern/complaint reports and the community action taken. In addition to an investigation by the police department, the community conducts an internal investigation. While the investigation is ongoing, the alleged assailant has interventions implemented to help ensure the safety of the alleged victim as well as other residents. The investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident.II. Occurrence of misappropriation of funds for Resident #1 on 8/1/25A. Facility investigationThe facility's investigation, dated 8/2/25, was provided by the NHA on 12/16/25. The investigation revealed the following: On 8/2/25 Resident #1 reported to the NHA that two unidentified individuals entered her room and asked Resident #1 for her debit card to purchase snacks. Resident #1 gave the two individuals her debit card and they never returned with Resident #1's debit card or snacks.Resident #1 described the two assailants as one individual wearing business attire and the other person in nursing clothes. Camera footage reviewed by the NHA revealed no pertinent information matching the description of the two individuals entering Resident #1's room at the time of the alleged incident. The investigation documented the business office manager wrote a letter that documented the resident did not have a debit card while at the facility. -However, the resident had a bank account prior to admission and the details of which bank and what type of account the resident held was unknown to the facility. The facility failed to document if they took any action to obtain the resident's banking information to investigate whether or not the resident had a debit card for her account and to determine if there were any unauthorized charges on her account (see record review and interviews below).The facility investigation documented six other residents who were interviewed regarding the incident. -However, the facility failed to interview facility staff or family.The incident was reported to the police; however the facility did not follow up with the police to see if the case was still active or closed. The facility investigation was closed because the resident was discharged to the hospital before the investigation was completed and did not return to the facility. For this reason, the facility concluded the investigation was unsubstantiated.-However the facility did not continue the investigation to determine if there were any other residents at risk of being victimized by financial exploitation. B. Resident #1 (victim)1. Resident statusResident #1, age less than 65, was admitted on [DATE] and discharged to the hospital on 8/11/25. According to the December 2025 computerized physician orders (CPO), diagnoses included drug induced polyneuropathy, unspecified asthma, depression and hypothyroidism.The 7/25/25 minimum data set (MDS) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required substantial assistance with all of her activities of daily living (ADL). 2. Record reviewReview of progress notes dated 8/1/25 to 8/4/25 failed to document: -When Resident #1 alerted facility staff of the missing debit card; and, -Attempts to contact Resident #1's family to obtain the resident's banking documentation for the investigation. 3. Staff interviewsThe business office manager was interviewed on 12/16/25 at 3:52 p.m. The business office manager said she had no involvement in the facility's investigation into Resident #1's allegation of misappropriation of funds but was working with the resident to complete a health insurance application. The business office manager said, during the time Resident #1 was in the facility, the resident did not have a debit card in her possession. The business office manager said Resident #1 moved from another state and the facility was trying to get a hold of Resident #1's husband by telephone to obtain bank statements. The business office manager said Resident #1's husband would not contact the facility. The business office manager said she also attempted to contact Resident #1's daughter to obtain bank statements. The business office manager said Resident #1 was sent out to the hospital and transferred to a different facility upon her discharge from the hospital and the application process ended. -However, the facility's investigation did not document any of the business office manager's efforts to work with the resident to gain banking information (see facility investigation above).The NHA was interviewed on 12/16/25 at 4:07 p.m. The NHA said the social services director (SSD) was the designated facility investigator and conducted the investigations and reported the findings for his review. The NHA said the facility made attempts to contact Resident #1's family by telephone but never received any calls back. -However the facility's investigation failed to document who the facility tried to contact or how many times they tried to contact the resident's family and what, if any, information they left for the family member in the messages left. III. Occurrence of misappropriation of funds for Resident #4's on 11/4/25 by Resident #17A. Facility investigationThe facility's investigation, dated 11/3/25, was provided by the NHA on 12/16/25. The investigation revealed the following: On 11/3/25 Resident #4 reported to the SSD that he voluntarily provided his bank account and card information to Resident #17, as Resident #17 assisted Resident #4 with placing orders for fast food and online purchases. The investigation documented Resident #4 told the SSD that he later reviewed his bank statements and found multiple unauthorized transactions, including several Cash App (an online money payment system letting users send and receive money for purchases) money transfers being sent directly to Resident #17 as the recipient. Resident #4 said those transfers were made without his consent. Resident #4 reported an Uber eats (meal delivery system) transaction totaling over $375.00, which he did not authorize. -However, the investigation failed to document the facility's efforts to find out who received this money or what the transaction paid for. The investigation documented Resident #17 was interviewed on 11/3/25 by the SSD and Resident #17 said that all transactions made using Resident #4's account were authorized by Resident #4. Resident #17 said she did not have a Cash App account and was unaware of the nature of the Cash App transactions or why her name appeared in connection with them. The investigation documented that the SSD interviewed two other residents in the facility and one resident told the SSD that Resident #4 was constantly buying food and other things for some of the residents in the facility. The second resident said Resident #4 had Resident #17 ordering from his bank account everyday. The facility reported the incident to the police.-However there was no documentation of follow-up with the police to obtain the status of the investigation.The facility's investigation identified several staff members to interview for the investigation but the staff interviews never occurred. The facility determined they did not need to interview staff (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because the residents interviewed revealed Resident #4 was willingly purchasing items for them (see NHA interview below). -However, Resident #4 said he did not authorize the Cash App or Uber eats transactions. -The facility's investigation failed to include an interview statement with the business office manager, the staff member who was managing the residents' funds (see business office manager interview below).The facility ended the investigation without documentation of a review of Resident #4's banking records or any investigation into Resident #17's funds and the facility concluded the allegation of misappropriation of Resident #4's funds was unsubstantiated (see NHA interview below). B. Resident #4 (victim)1. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, diabetes mellitus with chronic kidney disease and bipolar disorder. The 11/19/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He required moderate assistance with dressing, and bathing. 2. Resident #4 interviewResident #4 was interviewed on 12/16/25 at 10:09 a.m. Resident #4 said the social services staff had been helping with the investigation process. He said it had been three or four months now and nobody had followed back up with him to let him know what they found out. Resident #4 said that he had put a freeze on his debit card while the matter got sorted out.Resident #4 said he did not feel pressured by any of the residents in the facility to make purchases using her debit card. He said he did not want to say anything more and did not want other residents finding out he was talking because he had to live with the people in here and did not want any problems. Resident #4 denied giving other residents his banking information or allowing other residents to use his debit card without his permission.3. Record reviewResident #4's care plan, revised on 11/19/25 following the facility's investigation, revealed Resident #4 had a history of poor money management and would often misplace or forget that he had spent his money and then he made accusations the money was stolen.-However the facility's investigation documented the resident's allegation of stolen funds was not a pattern of behavior and failed to document how they came to the conclusion other than possibly based on other resident interviews obtained during the investigation. -Interviews obtained on 12/16/25 from facility staff revealed more information than what was in the facility's investigation dated 11/3/25. The facility was not able to provide sufficient evidence that they fully investigated and held documentation that they thoroughly investigated the allegation of misappropriation of funds by interviewing staff members who possibly witnessed the incident and made efforts to examine banking and financial information that could help the investigator make a most accurate determination of findings (see interviews below).C. Resident #17 (assailant) 1. Resident statusResident #17, age less than 65, was admitted on [DATE]. According to the December 2025 CPO, diagnoses included multiple sclerosis, unspecified asthma, anxiety disorder and lymphedema.The 11/19/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She required substantial assistance with all ADLs. 2. Resident #17's interviewResident #17 was interviewed on 12/16/25 at 1:50 p.m. Resident #17 said that she had not been asked by other residents to make purchases from their accounts. Resident #17 said she had not felt pressured by staff or other residents to make purchases. Resident #17 said no one had ever tried to offer her money. Resident #17 said she banked outside of the facility and had three different debit cards. She said she had had no issues with her debit cards. D. Staff interviewsThe business office manager was interviewed on 12/16/25 at 11:05 a.m. The business office manager said the facility managed Resident #4's income. The business office manager said Resident #4 did not frequently requested to take out large amounts of money out of his facility account. The business office manager said instead, he usually asked for $10.00 or $20.00 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at a time. The business office manager said she was aware of Resident #4's allegation of stolen funds from his outside bank account but she did not participate in the investigative process for that allegation. The business office manager said the facility had taken Resident #4 to his bank multiple times so he could straighten out his account and manage the small amount he had left in the account. The business office manager was unsure of the current amount in Resident #4's outside bank account and thought it could be at zero, since he had no regular income going into that account. The business office manager had no documentation of the resident's outside account in his financial records. The SSD was interviewed on 12/16/25 at 11:14 a.m. The SSD said the facility offered to assist Resident #4 with his finances, but he refused any assistance. The SSD said the facility staff were aware that Resident #4 gave out his banking information to his peers. The SSD said the facility's process for investigating misappropriation of property included notifying the business office manager to see if the resident had taken money out of their account recently. The SSD said she would determine if the resident had the mental capacity to manage and keep money in their room. The SSD said she would trace the residents actions to see if the money and spending could be accounted for. The SSD said the facility had offered to help Resident #4 with his finances including managing his outside banking account but he refused the assistance. The SSD said Resident #4 had a pattern of giving his bank information to other residents to treat his friends in the facility to a meal. The SSD said there had also been times where Resident #4 could not recall how he spent his money. The SSD said the facility attempted to obtain bank statements from him, but Resident #4 would not provide documentation. The SSD said at times, Resident #4 became difficult to work with. The SSD said Resident #4 had a pattern of misappropriating his money and reporting to the facility. The SSD said Resident #4 appeared not to care about the issue anymore due to his lack of participation with the investigation process. The NHA was interviewed on 12/16/25 at 2:35 p.m. The NHA said the SSD began the investigation. The NHA said he finalized the investigation and reported to the State Agency. The NHA said either he or the SSD reported incidents to law enforcement. The NHA said a good investigation would include interviewing the residents involved and determining if the item was lost, stolen or misplaced. The NHA said Resident #4 and Resident #17 both used each other for money. He said it all depended on who got their money first each month. The NHA said fast food purchases were a common and frequent purchase for both residents. The NHA said Resident #4 often forgot what he purchased and when he saw the charges on his account he assumed someone stole his money. The NHA said all facility staff were aware of the residents using each other's funds and debit cards for various purchases, including food and other items. The NHA said the facility had a recent town hall meeting where staff re-educated the residents on the importance of not using their money on other residents and the effects it could have on their insurance and retirement benefits. The NHA said he would attach the sign-in sheet for town hall meetings to future investigations of misappropriation to show the facility was addressing the issue and providing a thorough investigation. The NHA said the blank staff interview forms were never completed for Resident #4's investigation because after staff interviewed other residents in the facility, the investigative staff determined this was a pattern of mutual spending between Resident #4 and Resident #17.-However the facility failed to document the pattern of mutual spending in the investigation report or how they came to that conclusion in order to document a complete and thorough investigation.

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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. Based on observations, record review and interviews, the facility failed to maintain an effective pest control program so the environment was free of pests.Specifically, the facility failed to prevent and take adequate measures to eliminate cockroaches within the facility kitchen, the resident dining room, resident rooms, resident shower rooms and in the facility hallways. Findings include:I. Professional referenceAccording to the Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by:-Routinely inspecting incoming shipments of food and supplies-Routinely inspecting the premises for evidence of pests-Using methods, if pests are found, such as trapping devices or other means of pest control as specified under; and,-Eliminating harborage conditions. (Chapter 6)II. Facility policy and procedureThe Pest Control policy, undated, was provided by the nursing home administrator (NHA) on 12/16/25 at 3:42 p.m. The policy read in pertinent part, The facility shall maintain an effective pest control program.III. ObservationsOn 12/15/25 at 6:54 a.m. there was a large spill of a red syrup liquid on a tray. The tray was on a shelf underneath the counter. The floor in the main kitchen and the shelves were soiled with crumbs and food debris. On 12/15/25 at 7:50 a.m. multiple cockroaches were seen crawling on the wall near the baseboard in shower room two. Threw were also dead cockroaches near the baseboard in shower room twoOn 12/15/25 at 8:02 a.m. a cockroach was crawling on the floor in the resident common area.On 12/16/25 at 9:05 a.m. a dead cockroach was in the middle of the hallway near the resident common areaOn 12/16/25 at 9:24 a.m. a glue based cockroach trap was observed in shower room two. The trap was about three by six inches and was covered in cockroaches. Most of the cockroaches appeared to be dead, however one was seen wriggling on the trap.IV. Resident interviews and observations Resident #5 was interviewed on 12/15/25 at 7:32 a.m. Resident #5 said there were a lot of cockroaches in her room and she would watch them crawl on her wall all night. Resident #5 said the last few days have been slightly better and there have been less cockroaches. She said she still saw several in her room every night. Resident #5 said she did not feel enough was being done to combat the cockroaches.Resident #7 was interviewed on 12/15/25 at 8:02 a.m. Resident #7 said cockroaches were a problem throughout the facility. He pointed to the wall in the hallway lounge bringing attention to a live cockroach crawling around where he was sitting. Resident #7 said he also saw a lot of them in the shower room and his room.Resident #18 was interviewed on 12/16/25 at 1:02 p.m. Resident #18 said there were cockroaches everywhere in the facility. Resident #18 said he had lived in the facility for multiple years and said the cockroach infestation began about a year ago. He said the roaches had never been eliminated. Resident #18 said he has found cockroaches in his bed, saw them on the dining room tables during meal time and crawling all over the floor. The resident said a friend in the facility had found a cockroach in her food.Resident #18 said the facility had closed some rooms down for cockroach treatment, but had told him they did not have enough money to close and treat the entire facility aggressively.V. Record reviewPest control records were provided by the NHA on 12/18/25. Records for the last four visits revealed cockroach activity throughout the facility. The records documented the following treatments:-Pest control service on 10/24/25 revealed multiple areas had cockroach activity including the kitchen, bathroom, breakroom and basement. -Pest control service on 11/7/25 revealed both rodent and cockroach activity was found in the kitchen interior areas. The area was treated with boractin powder and a full flush was recommended.-Pest control service on 11/19/25 revealed cockroach and mice activity had been found and the kitchen was specifically treated. -Pest control service on 12/1/25 revealed cockroach activity in the kitchen. The (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kitchen area was closed and treated. One resident room was also treated.Resident council minutes from 10/8/25 documented the about concerns about cockroaches in the facility. The facility responded they were seeking a different pest control provider. The November 2025 and December 2025 resident council meetings revealed the residents continued to complain about the cockroach problem despite some minor improvement.VI. Staff interviewsThe dietary manager (DM) was interviewed on 12/15/25 at 7:02 a.m. The DM said the facility had problems with cockroaches. The DM said the cockroaches were mainly in the residents' rooms, but sometimes they came into the kitchen area. The DM said the facility was serviced by a pest control provider She said the cockroach problem in the kitchen during service hours was slowly improving. The DM said they had a cleaning schedule for the kitchen which targeted different areas each day for a deeper cleaning. The DM said she would have staff clean up the juice machine counter area and would consider increasing the frequency of the target area for deeper cleaning. Housekeeper (HK) #2 was interviewed on 12/16/25 at 9:11 a.m. HK #2 said although he did not clean the showers he saw some cockroaches in other areas of the facility including in the resident's rooms while cleaning. Certified nurse aide (CNA) #3 was interviewed on 12/16/25 at 9:30 a.m. CNA #3 said he saw most of the cockroaches inside the residents' rooms. CNA #3 said he had recently returned from vacation and said he thought they were much better since he had returned.HK #1 was interviewed on 12/16/25 at 9:40 a.m. HK #1 said she saw the most cockroaches in the shower room. She said she saw about three cockroaches per day in the shower room.Registered nurse (RN) #5 was interviewed on 12/16/25 at 10:34 a.m. RN #3 said she saw a few cockroaches in the building while working the day shift but thought they were probably more active at night.The maintenance director (MTD) was interviewed on 12/16/25 at 11:28 a.m. The MTD said the cockroach infestation had begun a few months ago. He said it got especially bad about three months prior, which led to the facility changing pest control services about two months ago. The MTD said since the new pest control service took over they had closed the kitchen and fumigated certain areas of the facility to eliminate the cockroach problem. The MTD said he thought there were far fewer cockroaches now than there were previously. He said there were still likely some in the building. The MTD said he believed they were on the right track and were continuing to see less and less cockroaches.