

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2024
NAME OF PROVIDER OR SUPPLIER  Fowler Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  221 2nd St Fowler, CO 81039	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observations, record review and interviews, the facility failed to ensure care for residents was provided in a manner and in an environment that maintained or enhanced the residents' dignity and respect in full recognition of their individuality.</p> <p>Specifically, the facility failed to ensure an adequate system was in place to provide meal services in a timely fashion to residents waiting to be served in the dining room.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Respect and Dignity policy, revised February 2021 was provided by the nursing home administrator (NHA) on 3/13/24 at 3:54 p.m., It read in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p> <p>II. Meals served timely</p> <p>A. Posted mealtimes</p> <p>The posted meal times for the main dining room were scheduled to begin breakfast at 7:00 a.m. to 9:00 a.m., lunch at 11:00 a.m. to 1:00 p.m. and dinner at 5:00 p.m. to 6:00 p.m.</p> <p>B. Resident observations and interviews</p> <p>On 3/11/24 at 11:05 a.m. Resident #4 arrived at the dining room for lunch. He sat at his dining table waiting patiently for his meal as he watched the other residents eat and leave the dining room.</p> <p>Resident #4 said he usually had to wait for quite a while before he was served. Resident #4 said he thought the staff had forgotten about him as he continued waiting to be served.</p> <p>Resident #22 was observed waiting at the dining table for 35 minutes.</p> <p>The resident said she usually had to wait for a while before she received her meal.</p> <p>C. Additional observations</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/11/24</p> <p>-At 4:00 p.m. six residents were sitting in the dining room. Four of the residents were sitting in wheelchairs.</p> <p>-At 4:05 p.m. Resident #4 arrived at the dining room in his wheelchair. The resident sat by his dining table waiting to be served.</p> <p>-At 4:15 p.m. there were 10 residents seated by their dining tables. Three of the residents had been served and they were eating dinner.</p> <p>-At 4:20 p.m. some of the staff started passing out drinks and others started taking resident's meal orders.</p> <p>-At 4:30 p.m. Resident #3 arrived at the dining room and sat across the dining table with Resident #4. The two residents stared at each other as they waited for their dinner.</p> <p>-At 4:40 p.m. Resident #3 was served dinner and he started eating as Resident #4 sat across the dining table watching his tablemate eat his dinner.</p> <p>-At 4:44 p.m. Resident #4 received his dinner and started eating. The resident left the dining room shortly after being served and ate only about 20% of his meal.</p> <p>3/12/24</p> <p>-At 10:45 a.m. residents started arriving at the dining room.</p> <p>-At 11:00 a.m. 13 residents were waiting in the dining room ready for lunch.</p> <p>-At 11:00 a.m. Resident #22 arrived at the dining room.</p> <p>-At 11:15 a.m. the facility staff were all standing around the dining area counter with none of them interacting with the residents who were seated at the dining room.</p> <p>-At 11:30 a.m. Resident #22 received her lunch 30 minutes after she arrived at the dining room.</p> <p>III. Staff interview</p> <p>The dietary manager (DM) was interviewed on 3/12/24 at 1:05 p.m. The DM said the facility practiced open dining seating and meals were served on a first come first served basis. The DM said staff would take orders as soon as the residents arrived and pass the meal order to the cook.</p> <p>She said the problem with the dining room meal times was the miscommunication between the kitchen and staff assisting in the dining room. The DM said the facility staff should have been in the dining room earlier enough to know which resident arrived first. She said she would educate the staff to ensure residents who were seated at the same dining table received their meals promptly.</p> <p>The regional registered dietitian (RRD) was interviewed on 3/12/24 at 1:12 p.m. She was told of the observations above. The RRD said residents seated at the same dining table should receive their</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>meals in a reasonable amount of time. She said there was dignity concern when resident waited too long after their tablemate already received their plate of food. She said residents should not wait too long at the dining table while they were seated watching their tablemates eat. The RRD said it was a dignity issue that could escalate resulting in behavior issues. She said some of the residents could leave the dining room without eating their meals.</p> <p>The RRD said she would coordinate with the DM to provide education to the facility staff to ensure residents receive their meals within a reasonable period during meal times.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews, the facility failed to notify the provider according to physician orders for one (#28) of five residents reviewed for unnecessary medications out of 17 sample residents.</p> <p>Specifically, the facility failed to notify and document Resident #28's elevated blood sugar levels to the provider as directed on the physician's order.</p> <p>Findings include:</p> <p>I. Facility policy and procedures</p> <p>The Hypoglycemia or Hyperglycemia policy and guidelines, revised 2011, was provided by the nursing home administrator (NHA) on 3/13/24 at 3:54 p.m. The policy read in pertinent part,</p> <p>The facility would ensure medications were administered per established physician's parameters. Staff would document all labs/treatments in nurse's notes and on the medication sheets.</p> <p>II. Resident #28</p> <p>A. Resident status</p> <p>Resident #28, over 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included type II diabetes mellitus, personal history of traumatic brain injury, unspecified dementia and long-term (current) use of insulin.</p> <p>The 12/24/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required staff assistance for bed mobility, grooming, toileting, and one-person assistance with transfers with a gait belt. The resident had no behaviors. The resident was administered insulin for seven days and injections for seven days.</p> <p>B. Record review</p> <p>The physician's order dated 1/8/24 at 2:15 p.m. revealed to administer Humalog U-100 unit/milliliter insulin (insulin lispro) once in the evening, inject 13 units subcutaneously. Notify physician if blood glucose is less than 60 or greater than 400. (&amp;lt;60 or &amp;gt;400)</p> <p>Order dated 1/8/24 at 2:15 p.m. Administer lantus solostar U-100 insulin 30 units/milliliter subcutaneously at bedtime and notify physician if blood glucose was less than 60 or greater than 400 (&amp;lt;60 or &amp;gt;400).</p> <p>The care plan for diabetes mellitus was revised on 12/28/23. The interventions were for staff to administer Humalog per physician's order and notify physician if blood glucose was (&amp;lt;60 or &amp;gt;400).</p> <p>The January 2024 medications administration record (MAR) revealed on 1/1/24 that Resident #28 blood</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>sugar level was 464 over the parameter set in the physician's order and on 1/20/24 the resident blood glucose level obtained was 504 above the physician's order parameters.</p> <p>The February 2024 MAR revealed on 2/14/24 that Resident #28 blood sugar level was 412 over the parameter set in the physician's order and on 2/29/24 the resident blood glucose level obtained was 407 above the physician's order parameters.</p> <p>-There was no documentation in the nursing progress note indicating that the provider was notified.</p> <p>III. Staff interviews</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 3/13/24 at 3:30 p.m. The LPN said the four dates on the resident's MARs revealed the resident insulin levels were elevated above the parameters indicated on the physician's order and there should be documentation that the physician was notified. She said nurses should follow physician orders. She said not documenting that the physician was notified indicates that it did not happen. She said insulin parameters were important because the resident might have experienced high blood sugar levels which would require the physician to adjust the amount of insulin to administer. She said not notifying the physician for the proper dose of insulin could cause the resident to experience shock, become comatose or have an increase in symptoms related to her diagnosis.</p> <p>The director of nursing (DON) was interviewed on 3/13/24 at 3:50 p.m. The DON said the four dates on the resident's MARs revealed the resident's blood glucose levels were elevated above the parameters on the physician's order and the staff should have notified the provider and documented in the nursing progress note. The DON said there was no documentation indicating the physician was notified. She said she was not sure why there was no documentation of the physician's notification for those dates that the resident's blood glucose levels were elevated. The DON said if the nurse failed to document it meant the physician was not notified as ordered. She said the facility would provide education to nurses to ensure they follow physician's orders and document their actions.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for four of four staff reviewed.</p> <p>Specifically, the facility had not completed annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for certified nurse aide (CNA) #2, CNA #3, CNA #4 and CNA #5.</p> <p>Findings include:</p> <p>I. Record review</p> <p>CNA #2 (hired on 6/1/21), CNA #3 (hired on 10/2/21), CNA #4 (hired on 2/11/19) and CNA #5 (hired on 11/2/21) did not have an annual performance review completed. The CNAs did not have an in-service education plan based on the outcome of the review.</p> <p>II. Staff interview</p> <p>The nursing home administrator (NHA) was interviewed on 3/12/24 at 1:30 p.m. She said she could not locate the performance reviews for CNA #2, CNA #3, CNA #4 and CNA #5. She said she was not aware the performance reviews needed to include a regular in-service plan based on the outcome of these reviews. She said going forward she would ensure the performance reviews were completed annually to ensure best care was being delivered to the residents.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and interviews the facility failed to store, distribute and serve food in a sanitary manner in two of two kitchen nourishment refrigerators.</p> <p>Specifically, the facility failed to ensure nutritional beverages were labeled and dated when opened in the kitchen nourishment refrigerators.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved from: <a href="https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf">https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf</a>.</p> <p>It revealed in pertinent part, A date marking system that meets the criteria stated in (1) and (2) of this section may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (a) of this section; Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (b) of this section; or Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the Department upon request. (Retrieved 3/14/24).</p> <p>II. Observation</p> <p>On 3/11/24 at 9:47 a.m. the following was observed at the main kitchen nourishment refrigerators during the initial kitchen tour:</p> <p>-In the first nourishment refrigerator, there were two opened undated and with no labels of thickened liquid containers.</p> <p>-In the second nourishment refrigerator, there were four cartons of opened juice containers, (one apple juice, one tomato juice, one grape juice and one orange juice) there were no labels and they were not dated.</p> <p>On 3/12/24 at 10:21 a.m. the following was observed at the main kitchen nourishment refrigerators during the follow-up visit to the kitchen:</p> <p>-In the first nourishment refrigerator, there were two opened undated and with no labels of thickened liquid containers.</p> <p>-In the second nourishment refrigerator, there were four cartons of opened juice containers, (one</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>apple juice, one tomato juice, one grape juice and one orange juice) there were no labels and they were not dated.</p> <p>III. Staff interviews</p> <p>The dietary manager (DM) was interviewed on 3/12/24 at 11:30 a.m. The DM said the kitchen staff should have all opened juice cartons dated and labeled to be aware of how long it has been opened to avoid distributing contaminated beverages to any resident. She said the kitchen staff were trained to understand the importance of labeling. She said the staff might have forgotten to label those beverages in the nourishment refrigerators. The DM said she would educate the kitchen staff to ensure open cartons and containers were labeled and dated properly.</p> <p>The regional registered dietitian (RRD) was interviewed on 3/12/24 at 11:51 a.m. The RRD said all opened dairy products and food kept in the refrigerators were to be labeled and dated. She said undated food items and beverages could potentially get someone sick when opened for a long period and had become contaminated. The RRD said she had advised the DM to provide education to all the kitchen staff to ensure all food items and opened beverages were dated when kept in the refrigerator.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on record review and interviews, the facility failed to ensure mandatory submission of direct care staffing based on payroll roll data.</p> <p>Specifically, the facility failed to ensure staffing data entered in the Payroll-Based Journal (PBJ) system was accurate.</p> <p>Findings include:</p> <p>The facility had a change of staff during the first quarter.</p> <p>I. Record review</p> <p>The PBJ stuffing report for quarter one (10/1/23 to 12/31/23) showed the following triggered area:</p> <p>-Failed to Submit Data for the Quarter</p> <p>II. Interview</p> <p>The nursing home administrator (NHA) was interviewed on 3/13/24 at 10:45 a.m. She said during the last quarter there had been a staff change. She said she tried to submit the data, however, it was not submitted correctly. When she went back to the system to correct the errors, she was unable to make the necessary corrections and the data was not accepted. She said she had not had any issues submitting data since the incident. She said it was important to submit the data timely and correctly.</p>		

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<p>F 0923</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and staff interviews, the facility failed to provide adequate ventilation by means of mechanical ventilation for one resident bathroom and two resident shower rooms.</p> <p>Specifically, the facility failed to ensure resident bathroom vents were free from lint and the exhaust fans were functioning.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Exhaust Fan and Ventilation policy, dated 1/25/24, was provided by the nursing home administrator (NHA) on 3/13/24 at 3:54 p.m. The policy read in pertinent part, The facility would check all exhaust fans in bathrooms, shower room soiled and clean utility rooms, janitor's closets, kitchen, and sink and laundry areas and oxygen room.</p> <p>The facility would ensure that airflow is sufficient enough to hold a piece of paper to the vent when operating.</p> <p>Clean vents using vacuum and air compressor to remove all dust.</p> <p>II. Observation</p> <p>An observation of the resident environment was completed on 3/12/24 at 12:40 p.m.</p> <p>The exhaust fans in shower room [ROOM NUMBER] had no audible sound and was not functioning.</p> <p>As a measure of checking the function of each fan, a small square of single ply toilet paper was placed against the vent. The exhaust fans were unable to hold the toilet tissue in place which indicated the fans did not function properly.</p> <p>The vent in shower room [ROOM NUMBER] had lint and cobwebs around the surface.</p> <p>The bathroom vent in room [ROOM NUMBER] had lint and cobwebs around the surfaces of the vent.</p> <p>III. Staff Interview</p> <p>The environmental tour was conducted with the maintenance director (MTCE) on 3/13/24 at 11:40 a.m. The MTCE said the exhaust fan in one of the resident's main shower rooms was not functioning. The MTCE said he would have to check the motors on all halls to see why the vent in the shower room was not functioning as it should. The MTCE said the ventilation fans in every resident's shower rooms and bathrooms should be in good working condition. He said the vents in the resident's toilet and the resident's shower rooms should be clean.</p>