VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

July 18, 2025

Ms. Lisa Blanchard, Administrator
Rutland Healthcare & Rehabilitation Center
46 Nichols Street
Rutland, VT 05701

Provider ID #: 475039

Dear Ms. Blanchard:

Enclosed is a copy of your acceptable plans of correction for the recertification conducted on **June 19, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475039	A. BUILDING _____ B. WING _____	C 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTLAND HEALTHCARE & REHABILITATION CENTER	46 NICHOLS STREET RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 6/18/2025 during an annual recertification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E 000	Rutland Center for Living and Rehabilitation provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigation, including report #24040, from 6/16/2025 through 6/18/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the residents' environment remained as free from accident hazards as is possible for 1 of 8 residents surveyed (Resident #29). Findings include: Per interview on 6/17/25 at 11:30 AM with Resident #29's Family Member, s/he stated that	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7/14/25

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.

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F 689	Continued From page 1 her/his parent was transferred to another room due to pest control issues. While the resident was in her/his new room, s/he got up during the night to use the bathroom and fell. S/he stated that s/he thinks the resident fell because there were no nonskid strips on the floor like there were in his/her previous room. S/he also stated his/her mother went to the hospital because s/he had a fractured hip from the fall. Per review of Resident #29's Care Plan dated 1/3/24, Resident #29 is at risk for falls related to limited mobility and cognitive impairment. Care plan interventions include nonskid strips on floor next to bed, created on 1/22/24, and nonskid strips in front of toilet, created on 4/6/25. Per interview on 6/17/2025 at 4:23 PM with the Business Office Manager and the Admissions Coordinator, they revealed that Resident #29 was relocated temporarily from her/his room to another room on a different unit on 4/28/25, due to a pest control issue in room his/her room. A nursing progress note dated 4/29/25 for Resident #29 reads, "The writer heard yelling for help. upon entering the residents room, the resident was found sitting on the floor. Resident said S/he was trying to get to the bathroom and slipped and fell (his/her temporary room)." Per review of progress notes dated 4/29/25, Resident #29 was sent to Rutland Hospital for further evaluation and assessment due to fall and complains of right hip pain Per review of progress note dated 5/2/2025, Resident #29 returned from the hospital after having right hip surgery.	F 689		

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F 689	Continued From page 2 Review of the Resident Management System (RMS) internal review of the fall revealed the facility is listing "poor lighting as an environmental factor; Devices: wheelchair as a psychological factor; Recent room change, Ambulating without assistance and a history of falls as Predisposing situation factors." On 6/18/25 at 8:20 AM , the Unit Manager confirmed that Resident #29 was transferred to a different room on a different unit on 4/28/25. This Unit Manager also confirmed there were no nonskid strips on the floor next to the bed, in the new room, at the time of the fall, as is indicated in Resident #29's care plan. During the survey, it was determined that the facility had implemented actions to correct the noncompliance prior to the start of the re-certification survey. The Performance Improvement Plan included: Resident #29 returned to their original room with nonskid strips. Unit to Unit Transfers, developed by the QAPI (Quality Assurance and Performance Improvement) team. The Plan includes: a written Communication form for resident room/unit to room/unit transfers. The plan includes verbal and written elements related to all residents transferring from one room/unit to another; information is gathered and shared by Licensed Nursing Assistants (LNA) and Nurses by completing the form and communicating a verbal report. Other participants involved in room changes will be a second check to ensure process is completed. As an example: the communication form will include interventions such as nonskid strips on the floor if indicated. The education for staff was implemented for	F 689		

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F 689	Continued From page 3 Nurses and LNA's and was completed on 4/30/25 with a completion date of 5/1/25 for the plan. Ongoing monitoring is in place for all room/unit transfers within the facility. Based on the facility submitting evidence of corrective action, the findings are cited as past noncompliance.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761	Education was immediately provided to RN #1 on medications being left at bedside: Medications are not to be left at bedside unless the resident has an order to self-administer their own medications in conjunction with the IDT determined that they have the decision-making capacity to do so safely. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. Education provided to the licensed nursing staff on medications being left at bedside: Medications are not to be left at bedside unless the resident has an order to self-administer their own medications in conjunction with the IDT determined that they have the decision-making capacity to do so safely. 3. The DNS or designee will do daily observational rounds during a med pass times daily for (4) four weeks then, weekly for (2) months to monitor the effectiveness of the plan.	

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F 761	Continued From page 4 Based on observation, interview, and record review, the facility failed to ensure medications were properly stored for 1 of 7 sampled residents (Resident #42). Findings include: Per observation on 6/16/25 at 11:37 AM, Resident #42 was observed in his/her bed with two pills in a medication cup on his/her lap. Per record review, the medication left with the resident was Apriso (Mesalamine; a medication used to treat ulcerative colitis) Oral Capsule Extended Release 24 hour 0.375 GM (grams): Give 4 capsules by mouth one time a day for Colitis before lunch. Per record review of the facility's "Storage of Medications" policy [last revised 1/2024] states, "3. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart." Per interview with RN #1 on 6/16/25 at 11:38 AM, RN #1 confirmed that she left the pills at Resident #42's bedside and should not have, stating, "I stepped out of the room after I gave [him/her] them."	F 761	4. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 5. Corrective action will be completed by Aug 3, 2025 **Tag F 761 POC accepted on 7/17/25 by G. Prefontaine/S. Stem**	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	The Hobart mixer was immediately cleaned, The dirty items that were observed on the storage rack were immediately removed and area was cleaned. The cracked plastic pitcher was immediately discarded and replaced with a new one. The soda gun was repaired and no longer leaks. Waltham put more traps out to control the fruit flies and the bananas are now being stored in covered	

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F 812	Continued From page 5 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined that the facility failed to store food in accordance with professional standards for food service safety. This deficiency has the potential to impact all residents in the facility. Findings include: During observation with the Food Service Director on 6/16/25 at approximately 11:00 AM, the initial tour of the kitchen revealed a dry storage room, with a covered Hobart mixer that was noted to have a dried yellow substance on the front of the mixer and a powdery substance on the base of the mixer. The Food Service Director stated that the mixer was ready for use in its current state and that the item is cleaned between uses. The Food Service Director observed the mixer and then confirmed the mixer was not clean in its current state. A storage rack containing pots and pans revealed a small "steam pan" (also known as a hotel pan or service pan, which is a rectangular or square pan used in food service for holding and serving food, particularly in steam tables or buffet-style setups where food needs to be kept warm) that was observed to be wet	F 812	containers. Crackers were dated with expiration date. Sliced uncovered pies, brown unlabeled liquid and the unlabeled frozen patties that were observed during survey were immediately discarded. The can opener was immediately cleaned. The dented cans have been removed and a location for dented cans have been put into place to be returned. Mess liners were added were cups are to be dried. Staff member shaved. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. Education provided to the dietary manager and dietary staff on food procurement, store/prepare/serve-sanitary requirements. 3. Education provided to the dietary manager and maintenance director to ensure there is an effective pest control program in place. 4. Food Director was educated on facial hair and hair covering/hair net requirements. 5. The Administrator or designee will do observational audit weekly four (4) weeks, then monthly for two (2) months to ensure the kitchen is clean, properly storage of items, dented cans in proper location and not in use, fruit flies under control, Cups being dried properly, facial	

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F 812	Continued From page 6 inside, and a small clear plastic pan was noted to have dried debris on the bottom. The Food Service Director confirmed that the rack was used for clean items and confirmed the wet and dirty pans. A plastic pitcher on top of the ice machine was observed to have gray tape on the bottom. The Food Service Director confirmed that the pitcher is used for obtaining ice and confirmed the tape on the bottom of the pitcher. S/he stated the pitcher was cracked and the tape was added as a result and could not be adequately cleaned. They stated, "It should be thrown away." Storage bins were noted under a stainless-steel table, on top of the stainless-steel table was a machine with an attached "soda gun" (or a bar gun which is a device used by bars to serve various types of carbonated and no-carbonated drinks) that was sitting in a square metal "steam pan" of water. The Food Service Director stated that the soda gun was leaking and had notified maintenance to fix it. Under the stainless-steel table were 4 rectangular bins with clear covers, 3 contained food and 1 was empty. One bin contained loose flour, one contained potato chips in their original packaging, and the other contained cake mixes, also in their original packaging the clear covers to all 4 bins were wet. None of the contents within the bins were wet. The Food Service Director stated that the water was coming from the leaking soda gun. Fruit flies were observed flying around the stainless-steel table. The Food Service Director confirmed the presence of numerous fruit flies and stated they were possibly coming from overripe bananas located in the dry storage room. A clear plastic bin of individually packaged saltine	F 812	hair covering/hair nets in use and to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 7. Corrective action will be completed by Aug 3, 2025. **Tag F 812 POC accepted on 7/17/25 by G. Prefontaine/S. Stem**	

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F 812	Continued From page 7	F 812		

crackers and a second clear plastic bin of graham crackers were observed. Neither bin had an expiration date marked on the bins or on the individual packages. The Food Service Director confirmed that the two cracker bins did not have expiration dates and the original boxes with the expiration dates had been discarded. The Dietician had joined the Food Service Director and stated that both the saltine and the graham crackers had been received "this month" (June). The Dietician confirmed that there was no expiration date written on the plastic bins. The Dietician wrote a date on masking tape and applied it to each bin.

During observations with the Food Service Director at approximately 11:21 AM, the walk-in cooler, revealed three trays of individual pieces of sliced pie uncovered and not dated. This was confirmed by the Food Service Director at the time of this observation. The can opener in the kitchen was observed to have dried debris on the blade, which the Food Service Director confirmed. S/he stated that the can opener is processed through the dishwasher twice daily; however, "it must have been missed after breakfast today."

The refrigerator in the kitchen revealed (2) 8-ounce glasses of a brown liquid, revealing no date. The Food Service Director stated that these had just been poured and confirmed they had not been labeled with a date. The freezer was noted to contain a clear plastic bag of frozen patties, but the contents of the plastic bag were unknown and the bag was not dated. This was confirmed by the Food Service Director, who stated that the product was Salisbury steaks and the package was not dated. S/he stated that they needed to

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F 812	Continued From page 8 throw these away because they were not dated and "staff know better." During observation with the Food Service Director of the stock supplies room/dry goods/canned goods, it was noted that (3) #10 cans (a specific size of metal can commonly used for food storage, especially for long-term or emergency preparedness. It is not a standard size can and is larger than typical grocery store canned goods) of Bushes Baked Beans and (1) #10 can of sliced pears were dented along the sides and bottom of all 4 cans and were on the shelves for use. The Food Service Director stated that these cans were in regular stock and would have been used for residents. They confirmed that these cans should not have been placed in stock but should have been set aside to be sent back for credit. Observation with the Food Service Director of the hallway between the dish room and the main kitchen, were 3 trays of blue coffee cups that were flipped upside down and were noted to be wet inside, on the sides and the bottom of each cup. The Food Service Director stated the coffee cups were ready for use. S/he was asked about the cups being turned upside down, directly on the trays and still wet inside, s/he stated that this is how s/he was instructed to dry them. S/he was asked how the cups would dry upside down on a tray with no air flow to dry the inside of the cups. S/he stated s/he was told to put the cups on a black plastic mesh on a tray to dry. The Food Service Director confirmed that the mesh wasn't placed under the cups, the cups were wet inside, and that they would not dry "like that." The Food Service Director was noted to have facial hair and was noted to have no hair	F 812		

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F 812	Continued From page 9 covering/hair net. S/he was asked about the policy specific to facial hair, and they stated covering was only needed when s/he was cooking. During an interview on 6/16/25 at approximately 3:00 PM with the contracted Food Services District Manager (DM), who was providing oversight to the facility, the DM confirmed the presence of fruit flies in the dry storage room. He also confirmed that the facility does have a pest control contract and is serviced regularly. The DM confirmed that facial hair must be covered in the kitchen area. This was also confirmed with the facility's policy titled "Staff Attire" (Revised 10/2023), which states "facial hair properly restrained." During observation on 6/18/25 at approximately 11:50 AM, a revisit to the kitchen revealed 2 trays of a pudding dessert in the walk-in cooler on a food rack that were not covered or dated. The Food Service Director confirmed the items were not covered or dated. A stainless-steel multiple-shelf cart holding pots and pans that had been cleaned in the sink was noted to have built up sticky, dark debris on the racks. The Food Service Director confirmed that the cart was dirty and stated that cleaning "hasn't been done in a while."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880	Education was immediately provided to the RN involved in the deficiency practice on enhanced barrier precautions and hand hygiene. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice.	

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F 880	Continued From page 10 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	2. Education provided to the nursing staff on enhanced barrier precautions and hand hygiene. 3. The DNS or designee will do daily infection control observational rounds daily for (4) four weeks then, weekly for (2) months to monitor the effectiveness of the plan. 4. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 5. Corrective action will be completed by Aug 3, 2025. **Tag F 880 POC accepted on 7/17/25 by G. Prefontaine/S. Stem**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure infection control measures were implemented regarding residents on enhanced barrier precautions and hand hygiene practices were completed for 1 of 4 residents sampled (Resident #25). Findings include: Per observation on 6/16/25 at approximately 11:00 AM, signage posted outside of Resident #25's room included an infection control "Enhanced Barrier Precautions" sign (EBPs), instructing anyone entering the room to have clean hands before and after leaving the room, and staff to wear gloves and gown during "High Contact Resident Care Activities" examples were provided on signage and included handling and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475039	A. BUILDING _____ B. WING _____	C 06/19/2025

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F 880	Continued From page 12 care of a feeding tube. During record review, Resident #25's Care Plan notes intervention of EBPs was initiated on 3/11/2025 due to "risk for MDRO (Multidrug-resistant Organisms) colonization/infection due to: indwelling devices: feeding tube." According to the Care Plan, EBPs are to "use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator), wound care (any skin opening requiring a dressing)." Review of Physician Orders for Resident #25 included "Enhanced barrier precautions related to feeding tube" for every shift with a start date of 3/11/25. Per observation on 6/18/25 at approximately 1:30 PM, Registered Nurse (RN) completing medication administration for Resident #25 there were two missed opportunities for hand hygiene, and stethoscope wasn't cleaned before and after use with resident. Hand hygiene wasn't observed after prepping medications at bedside and again wasn't observed after listening to bowel sounds with stethoscope. During the administration of medications through the PEG tube, a gown wasn't donned to perform the task per the EBPs criteria. An interview was conducted with the facility's RN Supervisor and RN on 6/18/25 at approximately 2:30 PM. The RN was asked regarding the EBPs signage on the resident's door and if these precautions needed to be followed for the medication administration observed at 1:30 PM.	F 880		

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F 880	Continued From page 13 S/he stated s/he was unsure and asked the RN Supervisor regarding the requirements for the precautions. The RN Supervisor confirmed for "all high contact activities a gown and gloves needs to be worn." RN then asked if this included medication administration which the RN Supervisor confirmed medication administration is included because the feeding tube (PEG) is be used to administer the medications. The Centers for Disease Control and Prevention recommends the use of gown and gloves (EBPs) for high-contact resident care activities, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO (multidrug resistant organisms) colonization.	F 880		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain an effective pest control program that ensures the facility is free of pests. This deficiency has the potential to impact all residents. Findings include: Per observation on 6/16/25 at approximately 11:00 AM during the initial tour of the facility kitchen area many fruit flies were observed in the dry storage room around a stainless-steel table. Across the room on top of a rack was noted to be a box of over ripe bananas with fruit flies. The	F 925	Waltham put more traps out to control the fruit flies and the bananas are now being stored in covered container. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. Education provided to the dietary manager and maintenance director to ensure there is an effective pest control program in place. 3. The Administrator or designee will do observational audit weekly four (4) weeks, then monthly for two (2) months to ensure effective pest control is in place and to monitor effectiveness of the plan.	

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F 925	Continued From page 14 Food Service Director confirmed that the fruit flies may be coming from the overripe bananas. Observation on 6/16/25 at approximately 11:15 AM revealed a large-sized moth flying and landing on clean dishes in the dishwashing room. The Food Service Director confirmed the moth was in the room and landing on the clean dishes. He confirmed the facility does have a pest control contract and is serviced regularly. During an interview on 6/16/25 at approximately 3:00 PM with the contracted Food Services District Manager (DM) providing oversight to the facility, s/he confirmed the fruit flies in the dry storage room and that the facility has a pest control contract and is serviced regularly. "Fruit flies are mainly attracted to extra ripe, fermenting fruits and vegetables. However, they are also drawn to things such as drains, garbage disposals, empty bottles and cans, trash bags, cleaning rags, and mops. Essentially, they are drawn to food waste and moist environments." https://www.arrowexterminators.com/learning-center/pest-library/flies/fruit-flies#:~:text	F 925	4. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 5. Corrective action will be completed by Aug 3, 2025. **Tag F 925 POC accepted on 7/17/25 by G. Prefontaine/S. Stem**	