

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Edgemoor Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 655 Park Center Drive Santee, CA 92071	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the kitchen failed to ensure safe food handling practices during tray line, of pureed diets (when food has been ground, and strained to a soft, smooth consistency, like a pudding), served to 16 of 157 residents. This failure had the potential for residents on pureed diets to experience foodborne illnesses. Findings: An observation of lunch puree diet preparation was conducted with [NAME] 1 (CK 1) on 12/3/25 at 8:30 A.M. CK 1 stated they had 16 residents receiving puree diets, but they prepare 18 servings for request of extra-large portions. The main entree for the day was pizza. An observation was conducted of Food Service Worker 2 (FSW 2) during lunch tray line on 12/3/25 at 12:05 P.M. The pureed diet consisted of layered pureed crust, topped with pureed sausage and pepperoni, topped with a red sauce, and finished with white cheese sauce. FSW 2 was observed dipping a blue handle scoop into a red buck (a designated bucket which contains water and disinfectant solution), located on a shelf below the tray line table. FSW 2 then placed the wet blue handle scoop within the white cheese sauce and continued service for pureed diets. At the time of this observation, the tray line was filling the first of five food carts, starting with Santa [NAME]. An interview was conducted with the Chief of Nutritional Services (CNS) and Registered Dietitian 1 (RD 1) on 12/3/25 at 3:25 P.M. The CNS and RD 1 were informed of the observations conducted during tray line. The CNS stated the scoop should have been allowed to dry before placing in the chess sauce to avoid contamination. The CNS left the room to ask FSW 2 if the scoop was placed in the red bucket and then placed in the chesses sauce. The CNS returned stating FSW 2 admitted to dipping the scoop in the red buck after rinsing it in water, because it dirty from food by the handle. FSW 2 stated she should have allowed the scoop to dry first and she did not. The CNS stated because the scoop was placed in the while cheese sauce after the red bucket, it had the potential for the white sauce to be contaminated, which could have made resident's receiving pureed diets ill from cross contamination. An interview was conducted with the Director of Nursing (DON) on 12/4/25 at 9:50 A.M. The DON stated she expected all food service workers to perform safe food handling practices, so resident did not become ill. Per the facility's Policy titled, Nutrition Services Infection Control, dated August 2024, .R. Service Standards: .i. During service and handling, employees shall avoid touching the food contact surfaces of dishes and serving utensils.w. Use convenient and suitable utensils such as forks, knives, spoons, scoops to handle food during preparation and service.		

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to properly store and label Resident 54's pain medication. As a result, the facility could not ensure medications were safely stored. Findings: On 9/28/20 Resident 54 was admitted to the facility per the facility Records of Admission. On 5/8/25 Resident 54 had a physician order for Diclofenac gel to apply topically to both knees every shift routinely for pain. On 12/1/25 at 1:06 P.M., concurrent observation and interview were conducted with Resident 54, Resident 54 was in bed. There was an unlabeled, undated and unpackaged topical gel medication on top of Resident 54's bedside drawer. Resident 54 stated this was his topical pain medication for his shoulder and knee joints. Resident 54 stated he was supposed to administer the unlabeled, undated and unpackaged topical gel medication this morning after shower but he was in a hurry because his family was already here to pick him up. Resident 54 stated he just came back from an out on pass with his relative today and will administer the unlabeled, undated and unpackaged topical gel medication by himself now. Resident 54 stated either Resident 54 or a Licensed Nurse (LN) administer his medication. On 12/1/25 1:10 P.M., at a concurrent observation and interview were conducted with LN 8 and Resident 54. LN 8 stated she did not leave the unlabeled, undated and unpackaged medication at Resident 54's bedside. On 12/1/25 at 1:17 P.M., an concurrent observation and interview were conducted with LN 9 and Resident 54. LN 9 stated she was supposed to administer the unlabeled, undated and unpackaged topical gel medication after Resident 54's shower this morning. LN 9 stated she should not leave the unlabeled, undated and unpackaged topical gel medication at Resident 54's bedside. LN 9 stated the unlabeled, undated and unpackaged topical gel medication was Resident 54's diclofenac topical gel. On 12/3/25 at 10: 56 A.M., an interview was conducted with LN 10. LN 10 stated LN s should not leave medications at bedside for safety and another resident might take it. ON 12/4/25 at 2:26 P.M., an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) was conducted. The DON stated LNs should not leave medications at bedside for safety. The ADON stated LNs should not leave medications at bedside because it could pick up by another resident. According to the facility policy entitled Self-Administered Medications, dated 5/22/2024, indicated .No medications is to be stored at resident's bedside, without a physician ?s order.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food brought in from the outside and stored in the designated resident refrigerator was discarded in a timely manner, for two of five resident refrigerators (Santa [NAME] and [NAME]), when reviewed for safe food storage, This failure had the potential for resident's personal food to be unsafe if consumed after the expiration date. Findings: 1. An observation was conducted of the resident refrigerator in Sanat [NAME] on 12/4/5 at 9:02 A.M. Inside the refrigerator on the bottom shelf was a white plastic grocery bag which was labeled with Resident 114's name. Inside the grocery bag, was a store-bought container of sour cream and shredded cheese. Also inside the grocery bag was an opened, but sealed clear plastic bag of flour tortillas. All the products were labeled with Resident 114's name and each had a different discard date. The package of flour tortillas contained a sticker with a discard date of 12/3/25. An observation, interview, and record review was conducted with Licensed Nurse 1 (LN 1), of the resident refrigerator on 12/4/25 at 9:07 A.M. LN 1 stated the nurses on the day shift (7 A.M. through 3:30 P.M.) were responsible for checking and documenting the temperature within the refrigerators. LN 1 stated the nurses on the previous night shift (11 P.M. through 7:30 A.M.) were responsible for inspecting and discarding foods labeled with discard dates and documenting the inspection was completed. LN 1 reviewed the refrigerator log and confirmed it was checked and signed off last night, and all the old food had been discarded. LN 1 viewed the package of tortillas with the discard date of 12/3/25, and stated, those should have been thrown away. LN 1 stated if the resident ingested the tortillas, they could get sick because the tortillas were old. 2. An observation was conducted of the resident refrigerator in [NAME] on 12/4/25 at 9:30 A.M. The temperature log clipped to the outside refrigerator was reviewed. The temperature had not yet been documented for the morning of 12/4/25, and the food checked for discarding had been initialed by the night staff for 12/3/25 through 12/4/25. The refrigerator section was unlocked. Inside the door was a clear plastic cup with a clear plastic straw, which appeared half consumed of a dark brown substance. The cup was labeled as Vietnamese coffee with a preparation date of 11/29/25. The cup was inside a clear sealed plastic zip lock bag, labeled with Resident 24's name and a discard date of 12/2/25. An observation, interview, and record review of the resident refrigerator was conducted with LN 2 on 12/4/25 at 9:38 A.M. LN 2 stated all refrigerators should be locked when not in use, to prevent other residents from accessing. LN 2 reviewed the temperature log and stated the temperature on the refrigerator had not been checked yet, but the food had been inspected last night by the night shift and signed off. LN 2 review the clear plastic bag that contained the 1/2 consumed Vietnamese coffee. LN 2 stated the coffee should have been discarded on 12/2/25, since the discard label indicated 12/2/25. LN 2 stated resident food was only stored for 48 hours and then thrown away, in order to prevent residents from becoming ill. An interview was conducted with the Director of Nursing (DON) on 12/4/25 at 9:50 A.M. The DON stated all resident food brought in from the outside needed to be discarded after 48 hours, in order to prevent residents from getting a foodborne illness. An interview was conducted with Chief Nutritional Services (CNS) regarding the resident refrigerators on 12/4/25 at 10:30 A.M. The CNS stated resident refrigerators should always be locked when not in use, to prevent unauthorized personas from accessing. The CNS stated it was important for staff to check the refrigerator temperature to ensure the food was safe to consume and stored properly. The CNS stated resident food brought in from the outside should always be discarded after 48 hours, in order to ensure the food was safe and did not contain any bacteria that could make the resident's sick. According to facility's policy, titled Outside Personal Food Storage-Reheating, dated August 2024, .Procedures:.D. After inspection, the nursing staff will label food items with the resident's name, date and time stored and expiration date.G. Personal food is visually inspected for any signs of spoilage, infestation, and expired or best buy dates. Food maybe discarded without notice to resdietrn if it is past the expiration date, best buy date, or if there are signed of spoilage.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent possible cross contamination (where microorganisms are unintentionally transferred from one object to another) when a urinary catheter (a bag that contained urine which is draining from the bladder via a tube) was in contact with the floor for one of seven residents (Resident 159), reviewed for urinary catheter care. This failure had the potential for Resident 159 to obtain a transmitted urinary infection from the dirty floor. Findings: An observation was conducted during initial tour of Resident 159, asleep in his room on 12/1/2025 at 9:50 A.M. Resident 159 had a urinary collection bag, clipped to the left side of the bed, with a blue/black dignity bag covering the collection bag. The dignity bag was in contact with the floor. An observation and interview was conducted with Licensed Nurse 3 (LN 3), of Resident 159 on 12/1/25 at 9:51 A.M. LN 3 observed the urinary collection bag and stated the bag should not be on the floor, because the floor was dirty and bacteria could travel up to the catheter, causing an infection. Resident 159's clinical record was reviewed on 12/1/25. Resident 159 was admitted on [DATE] with a urinary catheter, due to malignant neoplasm of the bladder (cancer of the bladder), per the facility's Record of Admission. An observation was conducted of Resident 159 in bed on 12/2/25 at 2:59 P.M. Resident 159 was awake sitting up in bed with the bed in a low position and a wheelchair next to the bed. The urine collection bag and the dignity bag was on the left side of the bed. The dignity bag was in contact with the floor, leaning sideways. An observation and interview of Resident 159's urinary collection bag was conducted with certified nursing assistant (CNA 1) on 12/2/25 at 3:01 A.M. CNA 1 stated Resident 159's urinary collection bag should not be on the floor, because the floor was dirty and could cause an infection to the resident. An interview was conducted with Infection Control Preventionist (ICP) on 12/3/25 at 4:18 P.M. The ICP stated urinary collection bags should never touch the floor, because the floors were dirty and it could cause cross contamination. An interview was conducted with the Director of Nursing (DON) on 12/4/25 at 9:50 A.M. The DON stated urinary collection bags and the tubing should never be in contact with the floor. According to the facility's policy, titled Catheter Indwelling Care, dated November 2024, .D. Licensed nurses utilize best practices as outlined in the CDC references including: .h. Keeping bags below the level of the bladder, but not on the floor.		