STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055067	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomar Vista Healthcare Center	201 N Fig Street Escondido, CA 92025

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to treat one of two residents (59) with dignity and respect when incontinent care was not provided on a timely basis. This failure resulted in Resident 59 feeling upset towards staff. Findings: Resident 59 was admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of the bladder (loss of control of the bladder due to brain, spinal cord, or nerve condition) and muscle weakness according to the facility's Admission Record. The Minimum Data Set (MDS- a clinical assessment tool) for Resident 59 dated 5/7/24, listed a cognitive score of 14 (a score of 13 to 15 meant cognitively intact) indicated, cognition was intact. Section GG (functional abilities and goals) of the MDS listed Resident 59 as dependent with toileting hygiene. During an observation and interview on 6/24/24, at 9:15 A.M., Resident 59 was in his wheelchair in the room wearing an incontinent brief and a shirt. Resident 59 stated he was upset because he had been waiting since 6:30 AM to be changed. Resident 59 stated his certified nurse assistant (CNA) did not want to change him because the CNA was passing breakfast trays. An interview with CNA 11 was conducted on 7/1/24 at 8:32 A.M. CNA 11 stated Resident 59 was quiet, pleasant, and asked for assistance with toileting as needed. CNA 11 further stated Resident 59 had a daily routine and did not get angry. During an interview with CNA 12 on 7/1/24 at 8:37 A.M., CNA 12 stated Resident 59 was incontinent of bowel and called for assistance if Resident 59 needed to be changed. CNA 12 further stated Resident 59 did not get angry during care. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/24 at 8:47 A.M., Resident 59 was observed sitting on the wheelchair in the lobby. During an interview with Resident 59, Resident 59 stated he was upset again because he was not changed during night shift on 7/1/24. Resident 59 stated he called for assistance at 4 A.M. and the night shift CNA came at 5:25 A.M. Resident 59 stated the night shift CNA told Resident 59 that he would let the morning CNA change Resident 59. Resident 59 stated he was very angry because he was wet and smelled of urine due to the condom catheter that came off. Resident 59 stated the morning CNA arrived and had to change Resident 59. During an interview on 7/1/24 at 9:01 A.M. with CNA 12, CNA 12 confirmed that Resident 59's brief was wet with urine at the beginning of her shift. The Director of Nurses (DON) was interviewed on 7/1/24 at 1:55 P.M. The DON stated residents who were not changed and left wet would feel very uncomfortable and could develop skin problems due to the incontinence. During a review of the facility's undated policy and procedure (P&P) titled, ADL care, the P&P indicated, . Residents who are unable to carry out activities of daily living (ADL) will receive assistance as needed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review Level II (PASRR II - an evaluation of the resident's psychiatric treatment requirements) was followed up and completed for one of one resident reviewed for PASRR. (Resident 10) This failure had the potential for Resident 10 to not receive necessary mental health care services in an appropriate healthcare setting. Findings: Resident 10 was readmitted to the facility on [DATE] according to the facility's Admission Record. A review of Physician's Progress Note (PN), for Resident 10 dated 5/13/24, indicated, .Review of System: unreliable due to cognitive impairment .Schizo-affective d/o (disorder) (a mental health disorder with combination of hallucinations [a perception of having seen, heard, touched, tasted, or ssmelled something that was not actually there] or delusions [a belief or altered reality that is persistently held despite evidence or agreement to the contrary, generally in reference to a mental disorder] and mood disorder symptoms, such as depression or mania). During an observation on 6/25/24 at 7:40 A.M., Resident 10 was observed sitting up on a wheelchair having breakfast. An interview was conducted on 6/26/24 at 10:40 A.M., with certified nurse assistant (CNA) 13. CNA 13 stated Resident 10 had episodes of refusing to shave and had refused wound treatments but did not have agitation. During an interview on 6/26/24 at 3:39 P.M. with licensed nurse (LN) 11, LN 11 stated Resident 10 was taking a medication for visual hallucinations. LN 11 stated she had observed Resident 10 talking to someone when nobody was present. LN 11 stated when she asked who Resident 10 was talking with, Resident 10 replied he was talking to his friend. A review of a document from the State of California-Health and Human Services, Department of Health Care Services dated 3/10/24 for Resident 10 indicated, .Re: Positive Level I Screening Indicates a Level II Mental Health Evaluation is Required .Your facility will be contacted within two to four days . A subsequent document regarding Resident 10 from the State of California-Health and Human Services, Department of Health Care Services dated 3/11/24 indicated, .UNABLE TO COMPLETE LEVEL II EVALUATION .After reviewing the Positive Level I Screening and speaking with staff, a Level II Mental Health Evaluation was not scheduled for the following reason: The individual has no serious mental illness . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 3:49 P.M. with the minimum data set nurse (MDSN- a nurse who assessed and evaluated the quality of care being given to residents), the MDSN stated all residents who were admitted , arrive with a completed Pre-Admission Screening and Resident Review Level I (PASRR I- a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) from the hospital. The MDSN further stated she had not completed any PASARR for residents. During an interview on 6/26/24 at 3:53 P.M., with the Director of Nurses (DON), the DON stated the admissions staff was responsible for PASARRs. On 6/26/24 at 3:54 P.M. the admissions director (AD)was interviewed. The AD stated the hospital sent PASARRs for residents prior to admission to the facility. The AD further stated she was unsure who was responsible for review and follow up of the PASARR Level I. During an interview with the DON on 6/27/24 at 8:06 A.M., the DON stated Resident 10 has been in and out of the facility since 2021 and had the diagnosis of schizoaffective disorder since then. The DON stated there was nobody assigned in the facility to review and follow up the PASARR Level I. The DON further stated the PASARR Level II was not completed because staff provided inaccurate information to the State of California-Health and Human Services, Department of Health Care Services. Another interview on 7/1/24 at 1:55 P.M. was conducted with the DON. The DON stated if the PASARR Level II was not completed, the resident may be placed at a facility that was not appropriate. A review of the undated policy and procedure (P&P) titled, PASRR was conducted. The P&P indicated, .It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility did not develop patient centered care plans for two of eight residents reviewed for care plans (Resident 169 and 170). These failures had the potential for the residents to not receive care and services specific to the residents' needs. Findings: 1. Resident 169 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. The Minimum Data Set (MDS- a clinical assessment tool) for Resident 169 dated 6/20/24, listed a cognitive score of 14 (13 to 15 score meant cognitively intact), indicated cognition was intact. On 6/24/24 at 8:33 A.M., Resident 169 was observed sitting up in bed watching TV with an oxygen cannula (a thin, flexible tube that goes around the head and into the nose to deliver oxygen) on his nose. Resident 169 stated he applied the mask connected to a continuous positive airway pressure machine (CPAP- a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) at night. A review of the physician's orders for Resident 169 with an order date of 6/14/24 indicated, .continue chronic nighttime CPAP at bedtime for CHRONIC HYPOXIA (long term low oxygen content in the blood) . During a concurrent record review and interview on 6/26/24 at 11:54 A.M., with licensed nurse (LN) 12 regarding Resident 169's care plans, LN 12 stated there was no care plan regarding the use of CPAP for Resident 169. LN 12 stated there should have been a care plan developed for staff to monitor Resident 169's breathing at night, monitor for shortness of breath, when to clean the machine and when to add water to the machine. A review of the facility's undated policy and procedure (P&P) titled, Care Planning/Care Conference was conducted. The P&P indicated, .It is the policy of this facility that the interdisciplinary team (IDT- team members with various areas of expertise who work together toward the goals of their residents) shall develop a comprehensive care plan for each resident .A comprehensive care plan is developed within seven (7) days from the completion of the comprehensive assessment (MDS) . 2. Resident 170 was admitted to the facility on [DATE] with diagnoses including sepsis (the body's extreme and life-threatening response to an infection) according to the facility's Admission Record. The Minimum Data Set (MDS- a clinical assessment tool) for Resident 169 dated 6/11/24, listed a cognitive score of 13 (13 to 15 score meant cognitively intact), indicated cognition was intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/24 at 8:52 A.M., Resident 170 was observed lying in bed. An intravenous (IV- into a vein) pole was next to Resident 170's bed with a small plastic IV bag and tubing hanging. Resident 170 stated he was receiving an IV antibiotic and it was administered into an IV line on the left upper arm. A peripherally inserted central catheter (PICC- a type of long catheter inserted through a vein in the arm into a larger vein in the body) was observed on Resident 170's left upper arm. A review of physician's orders dated 6/7/24 for Resident 170 indicated, .PICC .IV SITE CHECK FOR ANY S/S (signs and symptoms) OF COMPLICATIONS .PICC .IV SITE FLUSH: Flush with 10 ml (milliliter) of NS (normal saline) SITE: LUA (left upper arm) every day shift . During a concurrent record review and interview on 6/26/24 at 11:54 A.M., with licensed nurse (LN) 12 regarding Resident 170's care plans, LN 12 stated there was no care plan regarding Resident 170's PICC line. During an interview on 7/1/24 at 1:55 P.M. with the Director of Nurses (DON), the DON stated care plans must be completed within 14 days because it was important to know how to care for the resident. A review of the facility's undated policy and procedure (P&P) titled, Care Planning/Care Conference was conducted. The P&P indicated, .It is the policy of this facility that the interdisciplinary team (IDT- team members with various areas of expertise who work together toward the goals of their residents) shall develop a comprehensive care plan for each resident .A comprehensive care plan is developed within seven (7) days from the completion of the comprehensive assessment (MDS) .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure a CPAP machine was functioning for one of two residents (Resident 169) reviewed for respiratory care. This failure had the potential to adversely affect the health and well-being of the resident. Resident 169 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. The Minimum Data Set (MDS- a clinical assessment tool) for Resident 169 dated 6/20/24, listed a cognitive score of 14 (13 to 15 meant cognitively intact), indicated cognition was intact. During an observation and interview on 6/25/24 at 9:02 A.M., Resident 169 was sitting up in bed watching TV. A continuous positive airway pressure machine (CPAP- a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) was observed on an overbed table next to Resident 169's bed. The mask for the CPAP had a gray tape to keep it together. The tubing also had a large sized gray tape connected to the CPAP machine. Resident 169 stated the CPAP machine was not working well and had asked staff for another machine since he was admitted . A concurrent observation and interview was conducted on 6/25/24 at 9:09 A.M. with licensed nurse (LN) 13. LN 13 stated the CPAP machine for Resident 169 needed to be replaced. LN 13 stated she found out last week that Resident 169 needed a replacement of the CPAP machine. LN 13 stated the CPAP machine should work in order for Resident 169 to receive its functional effect. During an interview on 7/1/24 at 1:55 P.M., with the Director of Nursing (DON), the DON stated she expected licensed nurses to check the CPAP machine before each use to ensure that it was functioning well. The DON further stated the resident may have respiratory problems if the CPAP was not working. During a review of the facility's undated policy and procedure (P&P) titled, CPAP/BiPAP Monitoring and Management, the P&P indicated .interventions are implemented to minimize risks .Ensure mask fits well with minimal air leak around the nose . The P&P did not provide guidance for staff to check the machine's function.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observations, interviews, and record reviews, the facility failed to consistently provide dialysis (a procedure to remove waste products from the body when the kidneys stop working properly) access site care and assessment for one of three sampled residents (Resident 13) reviewed for dialysis. As a result, there was the potential for the resident to have complications after receiving dialysis treatment. Findings: 1. Resident 13 was admitted to the facility on [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis per the facility's Admission Record. A review of Resident 13's MDS (an assessment tool) indicated, the resident's BIMS (Brief Interview of Mental Status) score was 7, indicating mild cognitive impairment. On Monday 6/24/24 at 9:24 A.M., an observation and interview of Resident 13 was conducted. Resident 13 was in bed, wearing a hospital gown. Resident 13 showed his dialysis access site on the right upper arm with a dressing intact. Resident 13 stated his last appointment to dialysis was Saturday, 6/22/24. Resident 13 stated he left for dialysis .around 10 A.M . and returns .around 6 P.M . Resident 13 stated he often removes the dialysis dressing himself. A review of Resident 13's physician's orders indicated, dialysis treatments were scheduled for Tuesdays, Thursdays, and Saturdays. Resident 13's physician's orders further indicated Dialysis Treatment: Post Dialysis (right arm) .Remove Pressure Dressing After 3 Hours. A review of Resident 13's Treatment Administration Record indicated, Resident 13's last dialysis appointment was Saturday 6/22/24. On 6/26/24 at 4:23 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated .if [the dialysis access site] is covered for a long time, we won't be able to assess it . She further stated it was important to remove the dressing .to prevent infection. With the same dressing, infection could occur, and bleeding. On 7/1/24 at 10:55 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated her expectation was a resident's dialysis dressing .should be removed 3 hours after dialysis. The DON stated if it was not removed, the site cannot be assessed and it could lead to complications. A review of the facility's undated Policy and Procedure titled Renal Dialysis, Care of Resident indicated Vascular Access site care will be provided by licensed nurse, with physician's orders.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47466 Based on interview and record review, the facility failed to provide a registered nurse (RN) coverage eight consecutive hours a day, seven days a week. As a result, there was not consistent oversight by an RN for the coordination, management, and overall delivery of care to the residents. Findings: During a record review of the facility's payroll-based journal (PBJ- report that provides data on staffing levels) data report indicated the facility triggered for low weekend staffing and a 1-star rating (quality of healthcare service) both in 2024. A record review of the facility's daily census (a facility form used to track facility daily census, licensed nurse hours, and certified nursing assistant hours) dated April 2024, May 2024 and June 2024 indicated: 1. Less than eight hours of RN coverage in the facility on 4/11/24, 2. No RN in the facility for eight consecutive hours on 4/11/24, 4/13/24, 4/14/24, 4/27/24,4/28/24 5/11/24, 5/19/24, 6/8/24 and 6/9/24. An interview on 7/1/24 at 3 P.M., with the Staffing Coordinator (SC) was conducted. The SC stated the weekends are challenging, she would asked the DON to act as a charge nurse, provide assistance on the floor, start and hang intravenous (way of giving drugs or other substance through a needle or tube into a vein) lines. On 7/1/24 at 9:15 A.M., a concurrent record review of the facility's schedule for the months of April, May and June 2024 and an interview with the Director of Nursing (DON) was conducted. The DON stated there was no RN on duty for eight hours a day, seven days a week. DON stated she did not know the required hours for a RN since the facility census is below 74. The DON stated there are times she would come on weekends to the facility and helped on the floor. The DON stated a RN was an important role in the facility to ensure oversight of assessments. The DON indicated that the facility did not have a staffing policy.

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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** 46235 Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary environment that mitigated the risk for foodborne illness and cross contamination when: 1. The kitchen walk in refrigerator contained ketchup, soy sauce, and Italian dressing that did not have a use by date, staff's plastic water bottle, and beverage were also in the kitchen refrigerator. In addition, shredded carrots in a plastic bag, pack of hot dogs, tortilla in an opened plastic bag containers and two onions in plastic wrap were not identified and labeled in the refrigerator, 2. A coil above the food shelf in the refrigerator had gray debris covering the entire coil attached to a light fixture. These failures exposed residents to contaminated food and unsanitary practices, which had the potential to place them at risk of developing a foodborne illness. Findings: 1. During a concurrent observation and interview on [DATE] at 8 A.M. with the cook, the cook stated a label with OD was the date a food item was opened and a label with UB was the use by date. Inside the kitchen walk in refrigerator, the cook observed on a shelf ketchup, soy sauce and Italian dressing which did not have a use by date. The cook then removed a water bottle and a beverage from the refrigerator shelf. The cook identified the water bottle and the beverage belonged to staff and should not have been in the refrigerator. On another shelf of the refrigerator, the cook observed carrots in a plastic bag, a pack of hot dogs, tortilla in an opened plastic bag and two onions in plastic wrap that were not identified and labeled in the refrigerator. According the 2022 US FDA Food Code, Section ,d+[DATE].11 titled Food Labels, .(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement . 2. During a concurrent observation and interview on [DATE] at 11:02 A.M. with the registered dietician (RD), the RD observed a coil above the food shelf filled with gray debris with some gray debris hanging off the coil. The RD stated she will notify maintenance to check the coils. During a follow up kitchen observation on [DATE] at 4:23 P.M. with the RD, the RD stated the refrigerator coils were old and dirt from the coils could get into foods and cause illness to the residents. The RD further stated it was also important for food items to be labeled and have a use by date to prevent residents from consuming expired food. A review of the facility's undated policy and procedure (P&P) titled, Storage of Food and Supplies was conducted. The P&P indicated, .Food and supplies will be stored properly and in a safe manner .Routine cleaning and pest control procedures should be developed and followed .All food will be dated .All food products will be used per the times specified in the Dry Food Storage Guideline . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled, Facility environmental Condition, the P&P indicated, .It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents . The P&P did not provide specific guidance pertaining to the maintenance of the kitchen refrigerator. According to the 2022 US FDA Food Code, Section ,d+[DATE].11 Good Repair and Proper Adjustment. (Equipment) Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk.

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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** 46235 Based on observation, interview, and record review, the facility failed to ensure current infection control practices were followed for three of three residents reviewed for infection control when: 1. Resident 169's continuous positive airway pressure (CPAP- a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) mask was left on top of the machine open to air, 2. Resident 170's IV (intravenous- into the vein) tubing did not have a date used and the peripherally inserted central catheter (PICC- a type of long catheter inserted through a vein in the arm into a larger vein in the body) line site did not have a date when the dressing was last changed, 3. Resident 126's CPAP mask and tubing were not stored in sanitary manner. Failure to follow current infection control practices had the potential for the equipment to be contaminated and cause illness to the residents. 1. Resident 169 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. On 6/24/24 at 8:33 A.M., Resident 169 was observed sitting up in bed watching TV with an oxygen cannula (a thin, flexible tube that goes around the head and into the nose to deliver oxygen) on his nose. Resident 169 stated he applied the CPAP mask at night. The CPAP mask was observed on top of the CPAP machine open to air. A concurrent observation and interview on 6/25/24 at 9:09 A.M. was conducted with licensed nurse (LN) 3. LN 3 observed Resident 169's CPAP mask on top of the CPAP machine. LN 3 stated the CPAP mask should be stored in a plastic bag for infection control. 2. On 6/24/24 at 8:52 A.M., Resident 170 was observed lying in bed. An IV pole was next to Resident 170's bed with a small plastic IV bag and tubing hanging without a date. Resident 170 stated he was receiving an IV antibiotic and it was administered into an IV line on the left upper arm. A peripherally inserted central catheter (PICC- a type of long catheter inserted through a vein in the arm into a larger vein in the body) was observed on Resident 170's left upper arm. The PICC had an undated transparent dressing with worn out tape. Resident 170 stated he did not remember when the dressing was last changed and the IV bag was from yesterday, 6/23/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055067	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomar Vista Healthcare Center	201 N Fig Street Escondido, CA 92025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/24/24 at 12:12 P.M. with licensed nurse (LN) 3. LN 3 stated Resident 170's PICC line dressing was just changed and acknowledged the dressing that was removed was dirty and did not have a date labeled on it. LN 3 further stated she administered Resident 170's IV antibiotic at around 9 A. M. and removed the bag and tubing that was hanging on the pole from yesterday, 6/23/24. During an interview on 7/1/24 at 1:55 P.M. with the Director of Nurses (DON), the DON stated IV tubings and PICC lines were possible route of infection for residents. The DON stated she expected the nurses to verify physician's orders for IV antibiotics, label the tubing with the date administered and discard the bag and tubing upon completion of dose. The DON further stated PICC line dressings must be changed once a week or as needed. A review of the facility's undated policy and procedure (P&P) titled, CPAP/BIPAP Monitoring and Management was conducted. The P&P did not provided guidance regarding proper storage of the CPAP mask. During a review of the facility's undated P&P titled, IV-PICC,CVC (central venous catheter), the P&P indicated, .Apply appropriate label to tubing. Include: A. Date B. Time C. Nurse's initials . The P&P did not provide guidance to staff regarding labeling of PICC line dressing after changing. 49330 3. Resident 126 was admitted to the facility on [DATE] with diagnoses that include OSA, and morbid obesity, per the facility's Admission Record. On 6/24/24 at 8:35 A.M., Resident 126's CPAP mask was observed on the resident's bed, uncovered. On 6/25/24 at 10:59 A.M., a concurrent observation and interview was conducted with Resident 126. Resident 126 stated he left the CPAP mask uncovered because he used it throughout the day when he is in bed, not just at night. Resident 126 stated the CPAP mask .has a bag that it came in . but he typically left the mask on the bed uncovered. Resident 126 stated he cleaned the CPAP machine .every couple months . and that he prefers to clean it himself. On 6/26/24 at 8:19 A.M., Resident 126's CPAP mask was observed on the resident's pillow, uncovered. On 6/26/24 at 11:13 A.M., an interview was conducted with the Infection Preventionist Nurse (IPN). The IPN stated that CPAP masks should be stored in a plastic bag when not in use. The IPN stated staff should provide a plastic bag that was replaced weekly. The IPN stated it was important to store a CPAP mask when not in use because it could be exposed to microorganisms, and to prevent dust or particles from entering the tubing. The IPN further stated CPAP machines should be cleaned daily, after every use. On 7/1/24 at 10:55 A.M., an interview was conducted with the Director Of Nursing (DON). The DON stated if Resident 126 preferred to clean the CPAP machine himself, .staff should have educated the resident about the risks and benefits of not cleaning the CPAP daily. The DON further stated the CPAP mask should be in a bag, labeled with the date it was changed, the resident's name, and room number. The DON stated that it was important to clean the CPAP mask/machine daily to prevent any respiratory problems for Resident 126. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated Policy and Procedure titled CPAP/BIPAP Monitoring and Management indicated .The mask adapter and tubing will be cleansed with soap and water daily, clean with soap and water PRN if visibly soiled The Policy and Procedure did not provide guidance regarding CPAP mask storage.