

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Desert Canyon Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1642 West Avenue J Lancaster, CA 93534	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the attending physician (MD) and the Responsible Party (RP) for one of five sampled residents (Resident 3) when Resident 3 was noted with a Change of Condition (COC) on 9/29/2025. This deficient practice had the potential for a delay in Resident 3's care and violated the RP's right to be notified. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 4/19/2021 with diagnoses including type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (a condition characterized by partial paralysis or weakness on one side of the body, which can affect the arm, leg, and face) following cerebral infarction (the death of neural [brain] tissue as a result of ischemia), and contracture of muscle (the permanent shortening of a muscle or joint, which causes a deformity and limits movement) in multiple sites. During a review of Resident 3's Order Summary Report, dated 6/14/2024, the Order Summary Report indicated an order for the use of a low air loss mattress with bolsters every shift for skin maintenance. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 3 had the ability to understand and be understood. The MDS indicated Resident 3 was dependent (helper does all the effort) with eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. During a review of Resident 3's Situation, Background, Assessment, Recommendation (SBAR- a structured communication framework used primarily in healthcare to convey critical information quickly and clearly): COC dated 9/9/2025 at 12:24 p.m. the SBAR: COC indicated Resident 3 noted with Moisture-Associated Skin Damage (MASD - is the inflammation or erosion of skin caused by prolonged exposure to moisture and irritants like urine, stool, sweat, wound fluid, or saliva) to left buttocks. Upon assessment, R3 noted with MASD on left buttocks. No open skin noted, no discharge noted, no bleeding noted. Medical Doctor (MD) made aware and ordered treatment as facility protocol and RP made aware. During a review of Resident 3's Wound Weekly Monitoring Assessment, dated 9/9/2025, the Wound Weekly Monitoring Assessment indicated Resident 3 had a wound measuring 3 centimeters (cm- a unit of measurement) in length, 3.5 cm in width, and 0.2 cm in depth in Resident 3's left buttocks. During a review of Resident 3's Wound Weekly Monitoring Assessment, dated 9/16/2025, the Wound Weekly Monitoring Assessment indicated Resident 3 had a wound measuring 3 centimeters (cm- a unit of measurement) in length, 3.5 cm in width and 0.2 cm in depth in Resident 3's left buttocks. During a review of Resident 3's Wound Weekly Monitoring Assessment, dated 9/29/2025, the Wound Weekly Monitoring Assessment indicated Resident 3 had a wound measuring 6 cm in length, 4 cm in width, and depth was unable to determine (UTD) in Residents 3's left buttocks. During a review of Resident 3's Order Summary Report, dated 9/29/2025, the Order Summary Report indicated:- Left buttocks cleanse with normal saline (NS), pat dry, apply dermaseptine (non-prescription over the counter skin protectant ointment used to treat and prevent minor skin irritations), cover with foam dressing everyday shift for MASD.- Left buttocks cleanse with NS, pat (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055307	Facility ID: 055307 If continuation sheet Page 1 of 6

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dry, apply medihoney (a medical grade honey used for dressing wounds like burns, ulcers, and surgical cuts), cover with foam dressing everyday shift for pressure injury for 14 days. During a concurrent interview and record review on 12/1/2025 at 1:32 p.m. of Resident 3's Wound Weekly Monitoring Assessment with Treatment Nurse (TN) 1, TN 1 stated Resident 3 initially had MASD and on 9/29/25 the wound opened up, and it became unstageable. TN 1 stated he (TN 1) was informed about Resident 3's wound getting bigger and he (TN 1) did the wound assessment and treatment. TN 1 reviewed the Wound Weekly Monitoring assessment dated [DATE], TN 1 stated the wound had increased in size and was now 6 cm in length, 4 cm in width and depth was UTD. TN 1 stated this would be considered a COC. TN 1 stated the Registered Nurse (RN) Supervisors are the ones who are responsible for documenting the COC. TN 1 stated he (TN 1) did notify the RN Supervisor that day but cannot recall who it was. TN 1 stated he (TN 1) did not notify the MD and or the RP of Resident 3's COC. TN 1 reviewed COC for 9/29/2025 and stated that COC is not for Resident 3's wound increasing in size. TN 1 stated there is no COC for Resident 3's wound increasing in size, TN 1 stated there is no way to determine if the RP and or MD was notified of Resident 3's COC. During a concurrent interview and record review on 12/1/2025 at 2:45 p.m. of Resident 3's Wound Weekly Monitoring Assessment with the Director of Nursing (DON), the DON stated a COC is created when there is a new wound or if it has increased in size or there is a need for different staging. The DON reviewed Resident 3's Wound Weekly Monitoring Assessment, the DON stated should have had a COC on 9/29/2025 for the wound size increase. The DON stated would require its own COC. The DON stated not having a COC for the increase in Resident 3's wound size means not be able to monitor, potentially not able to treat the wound, and cannot say RP and MD were made aware of Resident 3's COC. The DON stated if the MD is not notified it can also affect the treatment plan and delay in care. During a review of the Facility Policy and Procedure (P&P) titled, Notification of Change, last reviewed on 10/23/2025, the P&P indicated the facility informs the resident, the resident's physician, and the resident's representative when there is an accident resulting in injury, changes involving life-threatening conditions, adverse treatment consequences or transfer or discharge the resident. 1. The facility notifies the physician and resident representative of:b. A significant change in the resident's physical, mental, or psychosocial status.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to maintain a clean and sanitary environment for one of five sampled residents (Resident 4) when on 12/1/2025 Resident 4's bedside fan was noted with thick gray dust. This deficient practice had the potential to negatively impact Resident 3's well-being. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 4/3/2019 with diagnoses including pneumonia (an infection/inflammation in the lungs), bronchiectasis (a chronic lung condition where your airways [bronchi] become permanently damaged, widened, and thickened, like stretched-out tubes, making it hard to clear mucus, which traps germs and causes repeated infections and a chronic cough), and dysphagia (difficulty swallowing). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 8/30/2025, the MDS indicated Resident 4 had the ability to understand and be understood. The MDS indicated Resident 4 was dependent (helper does all of the effort) with eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off shoes, and personal hygiene. During a review of Resident 4's Order Summary Report dated 11/5/2025, the Order Summary Report indicated oxygen at 2 liters per minute (LPM- a unit of measurement) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously. Monitor and document oxygen saturation every shift, maintain oxygen saturations above 91 percent (% - one part in every hundred). During a concurrent observation and interview on 12/1/2025 at 10:37 a.m. with Resident 4, Resident 4 stated the fan at the side of his bed is his and staff are supposed to dust it, but they have not. Resident 4 stated the dust is probably why he (Resident 4) coughs so much. Resident 4 stated the dust from his fan can be a contributing factor to his cough. Resident 4 stated the dust on the fan is thick and grey it is disgusting, and he would like to have someone clean it. During a concurrent observation and interview on 12/1/2025 at 2:45 p.m. with the Director of Nursing (DON), the DON stated residents' rooms should be clutter-free and cleaned by housekeeping daily. The DON observed Resident 4's fan and the DON stated there is accumulation of dust on the fan. The DON stated it should not be like this because it can be a potential for respiratory issues and would not be providing a homelike environment because it is dirty. During a review of the Facility Policy and Procedure (P&P) titled, Homelike Environment, last reviewed on 10/23/2025, the P&P indicated the facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members.9. The facility environment should enhance the quality of life for residents, in accordance with resident preferences.11. It is the responsibility of all facility staff to create a homelike environment and promptly address any cleaning needs. During a review of the Facility P&P titled, Safe Environment, last reviewed on 10/23/2025, the P&P indicated the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely.Environment: refers to any environment in the facility that is frequented by residents, including the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. Sanitary: includes, but not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. 4. Housekeeping and maintenance services are provided.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary treatment and services for one of five samples residents (Resident 3) at risk for developing pressure ulcers (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) to prevent pressure ulcers from developing, by failing to: 1. Perform the Wound Weekly Monitoring Assessment when Resident 4's wound was not assessed on the week of 9/23/2025.2. Wound care orders were not ordered for five (5) days when Resident 4 had a wound from 9/24/2025 to 9/28/2025.3. On 9/29/2025 Resident 4 was noted with a Change in Condition (COC) with wound increased in size and the Medical Doctor (MD) was not informed to provide an updated of treatment. These deficient practices had the potential for Resident 3's wound to worsen. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 4/19/2021 with diagnoses including type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (a condition characterized by partial paralysis or weakness on one side of the body, which can affect the arm, leg, and face) following cerebral infarction (the death of neural [brain] tissue as a result of ischemia), and contracture of muscle (the permanent shortening of a muscle or joint, which causes a deformity and limits movement) in multiple sites. During a review of Resident 3's Order Summary Report dated 6/14/2024, the Order Summary Report indicated an order to use a low air loss mattress with bolsters every shift for skin maintenance. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 9/14/2025, the MDS indicated Resident 3 had the ability to understand and be understood. The MDS indicated Resident 3 was dependent (helper does all the effort) with eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. During a review of Resident 3's Situation, Background, Assessment, Recommendation (SBAR- a structured communication framework used primarily in healthcare to convey critical information quickly and clearly): COC dated 9/9/2025 at 12:24 p.m. the SBAR: COC indicated Resident noted with MASD to left buttocks. Upon assessment, R3 noted with Moisture-Associated Skin Damage (MASD - is the inflammation or erosion of skin caused by prolonged exposure to moisture and irritants like urine, stool, sweat, wound fluid, or saliva) on left buttocks. No open skin noted, no discharge noted, no bleeding noted. Medical Doctor (MD) made aware and ordered treatment as facility protocol, and RP made aware. During a review of Resident 3's Wound Weekly Monitoring Assessment, dated 9/9/2025, the Wound Weekly Monitoring Assessment indicated Resident 3 had a wound measuring 3 centimeters (cm- a unit of measurement) in length, 3.5 cm in width and 0.2 cm in depth in Resident 3's left buttocks. During a review of Resident 3's Wound Weekly Monitoring assessment dated [DATE], the Wound Weekly Monitoring Assessment indicated Resident 3 had a wound measuring 3 cm in length, 3.5 cm in width and 0.2 cm in depth in Resident 3's left buttocks. During a review of Resident 3's Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), indicated that from 9/24/2025 to 9/28/2025 Resident 3 did not receive any wound care treatment. During a review of Resident 3's Wound Weekly Monitoring Assessment, dated 9/29/2025, the Wound Weekly Monitoring Assessment indicated Resident 3 had a wound measuring 6 cm in length, 4 cm in width, and depth was unable to determine (UTD) in Residents 3's left buttocks. During a review of Resident 3's Order Summary Report dated 9/29/2025, the Order Summary Report indicated- Left buttocks cleanse with normal saline (NS), pat dry, apply dermaseptine (non-prescription over the counter skin protectant ointment used to treat and prevent minor skin irritations), cover with foam dressing everyday shift for MASD.- Left buttocks cleanse with NS, pat dry, apply medihoney (a medical grade honey used for dressing wounds like burns, ulcers, and (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surgical cuts), cover with foam dressing everyday shift for pressure injury for 14 days. During a concurrent interview and record review on 12/1/2025 at 1:32 p.m. of Resident 3's Wound Weekly Monitoring Assessment with Treatment Nurse (TN) 1, TN 1 stated Resident 3 initially had MASD and on 9/29/25 the wound opened up, and it became unstageable. TN 1 stated he (TN 1) was informed about Resident 3 wound getting bigger and he (TN 1) did the wound assessment and treatment. TN 1 reviewed the Wound Weekly Monitoring assessment dated [DATE], TN 1 stated the wound had increased in size and was now 6 cm in length, 4 cm in width and depth was UTD. TN 1 stated this would be considered a COC. TN 1 stated the Registered Nurse (RN) Supervisors are the ones who are responsible for documenting the COC. TN 1 stated he (TN 1) notified the RN Supervisor that day but cannot recall who it was. TN 1 stated he (TN 1) did not notify the MD and/or the RP of Resident 3's COC. TN 1 reviewed COC for 9/29/2025 and stated that COC is not for Resident 3's wound increasing in size, TN 1 stated there is no COC for Resident 3's wound increasing in size, TN 1 stated there is no way to determine if the RP and or MD was notified of Resident 3's COC. TN 1 reviewed Wound Weekly Monitoring Assessment for Resident 3 and TN 1 stated there was no Wound Weekly Monitoring Assessment for 9/23/2025 and this could have led to a delay of noting the wound changed in size with a potential for a delay in care. TN 1 reviewed Resident 3's TAR and stated there was a break of five days from 9/24/2025 to 9/28/2025 that Resident 3 did not receive wound care as indicated by the TAR. TN 1 stated on 9/29/2025, that is when TN 1 returned and ordered the wound care for Resident 3's wound. TN 1 stated if the wound treatment is not documented then we cannot say the wound care was done. TN 1 stated there is a potential for the wound to increase in size and worsen. During a concurrent interview and record review on 12/1/2025 at 2:45 p.m. of Resident 3's Wound Weekly Monitoring Assessment with the Director of Nursing (DON), the DON stated a COC is created when there is a new wound or if it has increased in size or there is a need for different staging. The DON reviewed Resident 3's Wound Weekly Monitoring Assessment, the DON stated should have had a COC for 9/29/2025 for the wound increase. The DON stated this would require its own COC. The DON stated not having a COC for the increase in the wound size means not be able to monitor, potentially not be able to treat the wound, and cannot say RP and MD were made aware of Resident 3's COC. The DON stated if the MD is not notified it can also affect the treatment plan and delay the care. During a review of the Facility Policy and Procedure (P&P) titled, Notification of Change, last reviewed on 10/23/2025, the P&P indicated the facility informs the resident, the resident's physician, and the resident's representative when there is an accident resulting in injury, changes involving life-threatening conditions, adverse treatment consequences or transfer or discharge the resident. 1. The facility notifies the physician and resident representative of:b. A significant change in the resident's physical, mental, or psychosocial status. During a review of the Facility P&P titled, Notification of Change, last reviewed on 10/23/2025, the P&P indicated the facility many clinicians utilize a standardized pressure ulcer/injury assessment tool to assess a residents Pressure Ulcer/Pressure Injury risks upon admission, weekly for the first four weeks after admission, then monthly or whenever there is a change in the residents condition. Monitoring: Staff should remain alert to potential changes in the skin condition and should evaluate, report and document changes as soon as identified. Many clinicians recommend evaluating skin condition at least weekly or more.		

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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. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary practices were followed for one of five sampled residents (Resident 4) for food brought from outside of the facility when: 1. Resident 4's food was not properly labeled with use by date. 2. Resident 4's food was not discarded after 48 hours per facility's policy and procedure (P&P). These deficient practices had the potential for Resident 4 to consume food that was unsafe and that can cause foodborne illness (any illness resulting from eating contaminated/spoiled foods). During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 4/3/2019 with diagnoses including pneumonia (an infection/inflammation in the lungs), bronchiectasis (a chronic lung condition where your airways [bronchi] become permanently damaged, widened, and thickened, like stretched-out tubes, making it hard to clear mucus, which traps germs and causes repeated infections and a chronic cough), and dysphagia (difficulty swallowing). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 8/30/2025, the MDS indicated Resident 4 had the ability to understand and be understood. The MDS indicated Resident 4 was dependent (helper does all the effort) with eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off shoes, and personal hygiene. During an interview on 12/1/2025 at 10:37 a.m. with Resident 4, Resident 4 stated he buys food and staff place his food in the refrigerator in the nurses' station 2. Resident 4 stated his food is usually in the refrigerator for one week. During an observation on 12/1/2025 at 11 a.m. of the Station 2 Resident Refrigerator, the Station 2 Resident Refrigerator was noted with Resident 4's identifier on a Ziplock bag with a date of 10/26/2025 and in the bag the following were observed:- Opened sliced pepper jack cheese with no open date, expiration date of 4/6/2026- Opened hard salami with no open date and use by date partially erased unable to determine use by date. During a concurrent observation and record review on 12/1/2025 at 2:45 p.m. of Station 2 Resident Refrigerator with the Director of Nursing (DON), the DON stated a resident's food is stored in Nurses Station 2. The DON stated the desk nurse and supervisor oversee monitoring the Resident Refrigerator with the refrigerator's temperature being checked per shift. The DON stated resident food can be kept until the expiration date unless the item is opened then it must be tossed within 48 hours. The DON stated resident food items must be labeled with received date, opened date, and resident identifier. The DON reviewed Resident 4's food items in the Resident Refrigerator and stated Ziplock was dated 10/26/2025 and since cheese and salami were opened, these items should have been thrown away on 10/29/2025. The DON stated these items must be labeled with open dates. The DON stated if the food items are not properly labeled and not thrown away within 48 hours, they (food items) can become spoiled and cause food borne illness to the residents. During a review of the facility-provided P&P titled, Use and Storage of Food Brought to Resident, last reviewed on 10/23/2025, the P&P indicated to ensure safe food practices and the prevention of foodborne illness, the facility shall provide safe and sanitary storage of food brought to residents by family and visitors for a period not to exceed 48 hours and in accordance with the following guidelines.7. Perishable foods must be stored in the refrigerator, in re-sealable containers with tightly fitting lids. Containers will be labeled with the resident's name, and the manufactures use by, date, as applicable.8. Labeling, dating, and monitoring refrigerator food, including leftovers, so it is used by its use by date, or frozen standards of safe food storage guidelines.		