

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/29/2024
NAME OF PROVIDER OR SUPPLIER  Santa Monica Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1320 20th Street Santa Monica, CA 90404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43497</p> <p>Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity, respect, and individuality for one of four sampled residents (Resident 208). On 3/26/2024 at 8 AM, the facility staff was observed standing over Resident 208 while assisting the resident during breakfast.</p> <p>This deficient practice had the potential to negatively affect Resident 208's self-esteem and self-worth.</p> <p>Findings:</p> <p>A review of Resident 208's Admission Record indicated the resident was admitted to the facility on [DATE], with medical diagnoses including hyperlipidemia (elevated cholesterol), hypertension (high blood pressure), peripheral vascular disease (the reduced circulation of blood to a body part), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), acute pulmonary edema (a condition caused by too much fluid in the lungs), and of left femur fracture (broken thigh bone).</p> <p>A review of Resident 208's History and Physical dated 3/21/2024, indicated the resident had the capacity to understand and make decisions.</p> <p>During a breakfast observation in Resident 208's room on 3/26/2024 at 8 AM., Certified Nursing Assistant 8 (CNA 8) was feeding Resident 208 by standing over the resident, who was sitting up in bed with head of bed elevated. CNA 8 continued to feed Resident 208 while standing.</p> <p>During an interview on 3/26/2024, at 8:58 AM, CNA 8 stated CNA 8 should have obtained a chair to feed the resident to provide dignity and respect to the resident.</p> <p>During an interview with Director of Nursing (DON) on 3/29/2024 at 3 PM, DON stated staff must be at eye level with the residents while feeding them to provide the residents with dignity and respect.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review facility's policy and procedures titled Assistance the Resident to Eat, undated, indicated, to assist the resident to eat and provide nutrition for residents needing assistance with eating. Assist the resident as necessary. If the resident needs to be fed: sit at eye level in front of the resident. Offer a sip of beverage first to moisten the throat. Ask for resident's preference about the order in which he or she would like to eat the food.</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>46843</p> <p>Based on observation, interview, and record review, the facility failed to investigate lost belongings promptly and thoroughly for one of eight sampled residents (Resident 27).</p> <p>This failure resulted in delay in investigating and replacing Resident 27's personal property/belongings.</p> <p>Findings:</p> <p>A review of Resident 27' s Admission Record dated 3/29/2024, indicated the facility initially admitted Resident 27 on 4/6/2022 with diagnoses including abnormal gait (Gait is the pattern or way a person walks) and mobility, pneumonia (an infection in the lungs that may be caused by bacteria, or viruses), gastro-esophageal reflux disease (GERD - a common condition in which the stomach contents move up into the esophagus, chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), cellulitis (a potentially serious bacterial skin infection) of left lower limb, and asthma (a condition that makes it harder to breath and may cause cough).</p> <p>A review of Resident 27's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 2/10/2024, indicated Resident 27 was cognitively intact (able to make decisions concerning care, alert to situation and oriented to place and time). Resident 27 required maximal assistance (helper does more than half the effort needed to complete activities of daily living (ADL - shower, toileting hygiene, upper and lower body dressing).</p> <p>During an interview with Resident 27 on 3/26/2024 at 10:26 AM, Resident 27 stated Resident 27 was missing two bags of clothes that were not transferred with Resident 27 when the facility moved Resident 27 to another room. Resident 27 stated Resident 27 had five pairs of pants, and five shirts, with one pair of orthopedic shoes. Resident 27 stated Resident 27 told a facility staff that Resident 27's clothes were missing. Resident 27 stated that after mentioning the missing clothes, no other staff had spoken to Resident 27 again about the missing clothes.</p> <p>During an interview with Social Worker (SW)on 3/29/2024 at 11:31 AM, SW stated SW had written down the information about Resident 27's missing property, and SW had notified the Administrator (ADM) about the next course of action to be taken. SW stated ADM decided to replace the lost property for Resident 27.</p> <p>During an interview with ADM on 3/29/2024 at 11:31 AM., ADM stated ADM will replace Resident 27's lost property.</p> <p>A review of Resident 27's Inventory of Personal Effects list, undated and untimed, indicated no property/belongings listed.</p> <p>A review of Grievance/Complaint Report, undated and untimed, indicated Resident 27 had reported missing wheelchair, five pants, five shirts, and one pair of orthopedic shoes.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 27's Resolution of Grievance/Complaint, undated and untimed, indicated, Spoke to [Resident 27] that facility will replace his missing belongings. Resident is happy and agrees with the Resolution and appreciates the SW's visit.</p> <p>A review of the facility's policy and procedures (P&amp;P) titled, Misappropriation of Resident Property, dated 9/11/2023, indicated, Purpose Reports of misappropriation of resident property shall be promptly and thoroughly investigated. Background Reports of misappropriation or mistreatment of resident property are to be investigated through the resident grievance process (OP2 0306.00) and documented in the progress notes or through the grievance process.</p> <p>A review of the facility's P&amp;P titled, Grievances and Complaints, dated 7/14/2023, indicated, Purpose To support each resident's right to voice grievances and to ensure that after a grievance has been received, the Company will actively resolve the issue and communicate the resolution's progress to the resident and or resident's family in a timely manner. Background The Administrator (Grievance Official) is responsible for the resolution of all grievances and/or complaints.</p>

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497</b></p> <p>Based on interview and record review, the facility failed to provide information about State Long-Term care Ombudsman (representative appointed by the government who assists residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) to three of four sampled residents (Resident 15, 45, and 53).</p> <p>This deficient practice had the potential to deprive the residents of assistance from resident advocacy groups of unresolved issues in the facility.</p> <p>Findings:</p> <p>A review of Resident 15's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hypokalemia (low potassium), unspecified fall, hypertension (HTN - elevated blood pressure), hyperlipidemia (elevated cholesterol), muscle weakness, and left hip fracture.</p> <p>A review of Resident 45's Admission Record indicated the resident was admitted on [DATE] with diagnoses including fracture of right patella, fracture of nasal bones, unspecified fall, hypothyroidism (low thyroid levels), muscle weakness, Raynaud's syndrome (a condition in which some areas of the body feel numb), iron deficiency anemia (low red blood cells), and right hip fracture (right hip fracture).</p> <p>A review of Resident 53's Admission Record indicated the resident was admitted on [DATE] with diagnoses including Parkinson's disease (neurodegenerative disease, of the brain), hyperlipidemia (elevated cholesterol), acute respiratory failure (inability to breathe), hypothyroidism (low thyroid), dementia (memory loss), anxiety (a feeling of dread, and uneasiness), HTN, unsteadiness on feet, and dysphagia (inability to swallow).</p> <p>During Resident Council Meeting (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care, and quality of life) on 3/28/24 at 9:58 AM., Resident 15, 45, and 53 who were alert and oriented, stated they were not aware of what Ombudsman's program is about, and how the residents can contact the Ombudsman's office.</p> <p>During an interview with Social Service Director (SSD) on 3/28/2024 at 3:35 PM., SSD stated residents were notified of the Ombudsman Program on admission and during resident council meetings. The SSD stated the facility would ensure all the residents were informed of the Ombudsman Program.</p> <p>During an interview with Activities Assistant (AA) on 3/28/2024 at 3:40 PM., AA stated it is important for the residents to know the role and contact information of the ombudsman so the residents will be able to inform the ombudsman of the residents' concerns in the facility.</p> <p>During an interview with Director of Nursing (DON) on 3/28/2024 at 4 PM., DON stated the Activities Director was responsible for informing residents where they could locate information about how to contact the ombudsman. DON stated the Activities Director would be informing all the residents about where to obtain the information.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review facility's policy and procedures titled, Resident Rights dated 7/14/2023, indicated, The company protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43497</p> <p>Based on interview and record review, the facility failed to document that Advance Directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was discussed, and written information was provided to the residents and/or responsible parties for two of five sampled residents (Residents 8 and 22).</p> <p>This deficient practice had the potential to violate the rights of Residents 8 and 22 and/or the representatives' right to be fully informed of the option to formulate advance directives and to cause conflict with the residents' health care wishes.</p> <p>Findings:</p> <p>A review of Resident 8's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including bilateral knee osteoarthritis (degenerative joint disease), pain in left shoulder, pain in right knee, anxiety disorder (a mood disorder), hypertension (elevated blood pressure), major depressive disorder (persistent low mood), and muscle weakness.</p> <p>A review of Resident 8's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 2/26/2024, indicated Resident 8 was moderately cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impaired. The MDS indicated Resident 8 required maximal assistant with toilet hygiene, and personal hygiene.</p> <p>During an interview with Social Worker (SW) on 3/28/2024 at 8:54 AM, SW stated SW could not locate the acknowledgement for advance directive forms in the Resident 8's medical record. SW stated SW will contact the resident's representative and provide information on the choice to develop an advance directive.</p> <p>A review of Resident 22's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including orthostatic hypotension (sudden drop in blood pressure when standing up), anemia (low red blood cells), protein-calorie malnutrition (decreased food intake), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), and familial dysautonomia (a rare inherited condition affecting the nervous system), and atrial fibrillation (an irregular heart rate).</p> <p>A review of Resident 22's MDS, dated [DATE], indicated Resident 22 was cognitively intact and was dependent on staff with for personal hygiene, and dressing.</p> <p>During an interview with SW on 3/28/2024 at 8:56 AM, SW stated SW provided information to Residents 8 and 22 about formulating an advance directive. However, SW did not have any notes or documentation to indicate that Residents 8 and 22 were provided with an Advance Directive Acknowledgment form or information.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Director of Nursing (DON) on 3/29/2024 at 12 PM, DON stated DON was not aware of advance acknowledgment form for Residents 8 and 22. DON stated, the facility asks residents' family members about advance directives, and conducts Interdisciplinary Team (IDT - involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) meetings regarding advanced directive. DON stated DON will inquire about the advance acknowledgment form for Residents 8 and 22.</p> <p>A review of facility's policy and procedures titled, Advance Directive dated 8/16/2021, indicated, the resident has a right to accept or refuse medical or surgical treatment an Advance Directive in accordance with state and federal law. Upon admission the Company will provide a resident or resident's representative with written information regarding the company's policies on Advance Directives and a copy of this policy. The company must document in a prominent part of the resident's clinical record whether the resident has issued an Advance directive.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43497</p> <p>Based on observation, interview, and record review, the facility failed to obtain a physician's order for low air loss mattress (LALM - is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) for one of five sampled residents (Resident 43).</p> <p>This deficient practice had a potential to result in inappropriate care and treatment for Resident 43.</p> <p>Findings:</p> <p>A review of Resident 43's Admission Record, indicated the resident was admitted on [DATE] with diagnoses including cellulitis (common infection of the skin) of right lower limb, tremor (an involuntary muscle contraction), depression (persistent low mood), hypothyroidism (low thyroid ), hyperlipidemia (elevated cholesterol), manic episode (a state of mind characterized by high energy), anxiety disorder (mood disorder), obstructive sleep apnea (intermittent airflow blockage during sleep), and hypertension (elevated blood pressure).</p> <p>A review of Resident 43's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 2/ 25/2024, indicated Resident 43 was cognitively (relating to mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and required moderate assistance with toilet hygiene and personal hygiene.</p> <p>During an observation on 3/26/2024 at 8 AM, Resident 43 was on a LALM. The LALM was set at 320 pounds of body weight.</p> <p>During an interview with Treatment Nurse (TN) on 3/26/2024 at 10 AM, TN stated Resident 43, is using an air loss mattress for comfort and the prevention of any pressure injuries (bed sore). TN stated, Resident 43's LALM was set at 320 pounds, but Resident 43 weighed 187 pounds. TN stated, TN could not find an order for the LALM for Resident 43. TN stated TN will call the physician to obtain an order for the LALM.</p> <p>During an interview with Director of Nurses (DON) on 3/29/2024 at 3 PM, DON stated, Resident 43 was using the air LALM to provide comfort, and it is important to obtain a physician's so that the nurses know and provide appropriate treatment for the resident.</p> <p>A review of the facility's policy and procedures titled, Physician Orders dated 7/13/2023, indicated, physician orders are obtained to provide a clear direction in the care of the resident.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>46843</p> <p>Based on observation, interview and record review, the facility failed to provide effective pain management to maintain the highest practical level of well-being for one (1) of eight (8) sampled residents (Residents 9) by failing to:</p> <ol style="list-style-type: none"> <li>1. Assess, recognize, develop, and implement an individualized pain management care plan for Resident 9 with initiation date, stop date and reevaluation date to determine the effectiveness of the care plan.</li> <li>2. Respond to Resident 9's continual plea for help due to severe pain to the left leg, hip, and back by notifying a MD (Medical Doctor) concerning the resident's uncontrolled pain.</li> </ol> <p>These deficient practices resulted in Resident 9 suffering severe pain to the left leg, hip, back, and nerve pain at a level 8 out of 10 (where 10 is the worst severe pain that can be experienced).</p> <p>Findings:</p> <p>A review of Resident 9's Admission Record dated 3/29/2024, indicated the facility initially admitted Resident 9 on 1/5/2024 with diagnoses that included, fracture of the left femur (Fracture: a partial or complete break in the bone. Femur: is the thigh bone), seizures (a sudden, uncontrolled burst of electrical activity in the brain), anxiety disorder (restlessness, worried, tense, or afraid of what may happen in the future), depression (a constant feeling of sadness and loss of interest), hypertension (high blood pressure).</p> <p>A review of Resident 9's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 1/9/2024, indicated Resident 9 was cognitively intact (able to make decisions concerning care, alert to situation and oriented to place and time). Resident 9 required maximal assistance (helper does more than half the effort needed to complete activities of daily living (ADL-such as shower, toileting hygiene, upper and lower body dressing).</p> <p>During an interview on 3/26/24 at 7:58 AM, Resident 9 stated Resident 9 was in pain and the pain medications the nurses gave Resident 9 did not relieve the pain for very long. Resident 9 stated the nurses gave Resident 9 three different medications for pain and even if Resident 9 took them all at once, the pain had not been relieved for more than three hours. Resident 9 stated Resident 9 asked for something stronger, however, the nurses had not given Resident 9 anything stronger to help with the pain.</p> <p>A review of Resident 9's SBAR (situation, background, assessment, recommendation, a method of communication across different professional personnel concerning care and treatment of a Resident) Communication Form, dated 3/17/2024 at 5:45 AM, indicated the resident had mild pain and itchy left eye. No other information was listed in the form regarding pain, or any other conditions for Resident 9.</p> <p>A review of Resident 9's Physician's orders, dated 1/5/2024 at 8:30 AM, indicated orders for pain medications as follows:</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Tylenol two tablets 500mg (milligrams) every 6 hours as needed for mild pain,</p> <p>Gabapentin Capsule (medication for nerve pain)100 mg three times a day as needed for nerve pain; and</p> <p>Oxycodone HCL (controlled pain medication) oral tablet 5 mg by mouth every 6 hours as needed for mild pain.</p> <p>A review of Resident 9's Medication Administration Record (MAR-a record of medications that have been given, in addition to medications that have been refused by the Resident) from 3/1/2024 to 3/28/2024, indicated that Resident 9 had taken Gabapentin capsules 100mg three times a day as needed for nerve pain. Resident 9 had only two dates listed as receiving Tylenol for mild pain. MAR also indicated Resident 9 had received Oxycodone tablet 5mg three to four times a day as needed, for mild pain; however, the pain assessment scored documented as reported by Resident 9 had been between 7 to 8 out of 10 on the pain scale (a numerical pain assessment tool where pain level zero is no pain and 10 is severe pain).</p> <p>A review of Resident 9's care plan titled Pain with initiation date 1/6/2024 indicated the identified problem as Resident expressed alteration in comfort and Daily Activity due to presence of pain. Due to Surgery to left hip, for fracture, with goals including Resident will be pain free or relieved from pain. Resident's functional ability will be maintained/enhanced, and quality of life will improve with interventions. The care plan approaches included Administer pain medication as ordered: Oxycodone - Schedule II tablet; 5 mg; amount 1 tablet; oral Special instructions: Take 1 tablet by mouth every 6 hours as needed for Moderate pain. However, the care plan did not address the interventions for Resident 9's severe pain.</p> <p>During an interview with certified nursing assistant 1(CNA 1) on 3/29/24 at 8:46 AM, CNA 1 stated Resident 9 complains of pain, every ten minutes when she is awake. CNA 1 stated Resident 9 slept for about two to three hours after licensed vocational nurse (LVN) had given the resident medication, but started complaining pain when the resident woke up. CNA 1 stated Resident 9 continually complained of pain and asked for something stronger than what the nurses had given Resident 9. CNA 1 stated sometimes Resident 9 refused the medication offered by the nurses and would say the medication did not help.</p> <p>During an interview with LVN 2 on 3/29/24 at 9:08 AM, LVN 2 stated Resident 9 complains of pain when she is awake. LVN 2 stated Resident 9 received pain medication at 6 AM and at 8 AM but the resident stated Resident 9 still was in pain. LVN 2 stated Resident 9 refused the offer for Tylenol and would say Tylenol did not help. LVN 2 informed the RN (Registered Nurse) supervisor that Resident 9 was still complaining of pain after taking pain medication.</p> <p>During an interview with Registered Nurse Supervisor 1 (RNS 1) on 3/29/24 at 9:22 AM, RNS 1 stated RNS 1 was informed by LVN 2 that Resident 9 still complained of pain after receiving all available pain medications. RNS 1 assessed Resident 9 who informed RNS 1 that Resident 9 had been in pain and the current medications did not work. RNS 1 stated RNS 1 called the doctor to request pain medication to treat the continued pain of Resident 9.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Santa Monica Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1320 20th Street Santa Monica, CA 90404	
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Medical Doctor 1 (MD 1) on 3/29/24 at 9:35 AM, MD 1 stated MD 1 could not just increase the medication because Resident 9 complained Resident 9 was in pain. MD 1 acknowledged that pain is subjective and there is a need to treat the pain immediately instead of waiting until the underlying cause of the pain is identified. MD 1 initially stated MD 1 was not willing to increase or give an alternative pain medication to Resident 9 until MD 1 determined the underlying cause. However, MD 1 reconsidered the decision and ordered pain medication to be given every four hours instead of every six hours. In addition, MD 1 ordered a series of tests to help determine the underlying cause of pain in Resident 9.</p> <p>During an interview with Director of Nursing (DON) on 3/29/24 at 10:34 AM. DON stated Resident 9 had complained of pain. DON stated Resident 9 has the right to be free of pain, in as much as is possible for her condition, and the facility should seek to do all it can to help Resident 9 gain relief from pain, including asking the doctor for an increase or change in Resident 9's medications for pain.</p> <p>A review of facility policy and procedures titled Pain Management, dated 3/29/2024, indicated, Purpose To identify patients experiencing pain and develop, implement, and evaluate care plans for the management of pain, and monitor and document the patient's response to pain management interventions. Procedure Pain screening, evaluation and care management is conducted upon admission, quarterly, annually, and with significant change in condition utilizing the Pain Evaluation Form (Attachment A). Patients are also screened for pain regularly through asking a patient if they have pain, observing patient during daily care and/or observing for signs and symptoms of pain. Regular Screening and Observation of Pain 1Ask patients regularly if they are experiencing any new onset of pain. Evaluate the patient with and without movement. Record the finding on the Pain Management Flow Sheet (Attachment B). 2. Observe both verbal and non-verbal patients for signs and symptoms of pain and notify a nurse immediately. Notify the physician. 3. Administer a therapeutic intervention for pain if ordered.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>38740</p> <p>Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 3/26/2024 when:</p> <ol style="list-style-type: none"> <li>Cook used small scoop size to serve chicken Dijon for 16 residents on mechanical soft diet and finely chopped diet (consists of foods that are moist, ground, chopped or easily mashed required little chewing.) Residents on both mechanical soft and finely chopped diet received 4 oz (ounces) of chicken instead of 5 oz per menu.</li> <li>Facility failed to ensure 13 residents on mechanical soft finely chopped diet (food that are easily chewed, for resident with chewing problems and minor swallowing problems food should be chopped to 1/8-1/4-inch pieces) received rice in texture and form to meet their needs when they received regular parsley rice instead of pureed parsley rice according to the menu and spreadsheet (food portion and serving guide).</li> <li>Cook added long strips of sliced red bell pepper garnish to residents on mechanical soft diet. Nine out of 16 residents on mechanical soft and finely chopped diet received bell pepper garnish that was long strips and not chopped per mechanical soft diet policy.</li> </ol> <p>These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake and choking in 16 out of 51 residents on mechanical soft and finely chopped diet who received food from the facility kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>According to the facility lunch menu for mechanical soft and finely chopped diet on 3/26/2024, the following items would be served on mechanical soft diet: Chicken Dijon Ground (5 ounces) (oz), gravy, parsley rice 1/2 cup; spinach 1/2 cup; white roll/margarine, fruit cobbler, coffee tea. Finely chopped diet: Chicken Dijon Ground (5 ounces) (oz), gravy, pureed parsley rice 3.5 ounces, spinach chopped 1/2 cup, white roll slurry, fruit cobbler, coffee/tea.</li> </ol> <p>During an observation of the tray line service for lunch on 3/26/2024, at 11:40AM, for the residents who were on mechanical soft diet and finely chopped diet, the cook served chopped Dijon chicken using the #8 scoop yielding 4 oz instead of 5 oz per menu.</p> <p>During an interview with Cook 1 on 3/26/2024, at 12:30 PM, Cook 1 stated Cook 1 made a mistake with the scoop sizes and served less chicken to residents on mechanical soft and finely chopped diet. Cook 1 stated serving less food to the residents might make them hungry and wanting more food.</p> <ol style="list-style-type: none"> <li>During an observation of the tray line service for lunch on 3/26/2024, at 11:40AM, for the residents on finely chopped diet, cook 1 served regular parsley rice instead of the pureed rice.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Cook 1 and kitchen supervisor (KS) on 3/26/2024, at 12:30 PM, Cook 1 stated Cook1 did not notice the menu to serve pureed rice to residents. Cook 1 stated some residents complain when they get pureed food. Cook 1 stated it is important to follow the menu to serve the right portion and right texture. Cook 1 also stated some people can choke if they receive wrong diet. KS stated the spinach should be finely chopped for the resident on finely chopped diet. KS stated the spinach is stringy and can cause problem in swallowing.</p> <p>3. During an observation of the tray line service for lunch on 3/26/2024, at 11:40 AM, Cook 1 used long and thick slices of red pepper for garnish. Residents on mechanical soft and finely chopped diet received long and thick slices bell pepper for garnish.</p> <p>During a concurrent interview with RD and KS on 3/26/2024, at 11:40 AM, RD stated Cook 1 should have chopped the bell peppers into 1/4 size pieces and used the pieces for garnish. RD stated long thick slices is not right for the mechanical soft diet. KS stated long strips of bell pepper can cause choking in residents who have hard time chewing and swallowing. KS removed the garnishes and chopped them into small pieces.</p> <p>A review of facility menu and diet spreadsheet for mechanical soft (L3/Advanced) and finely chopped (L2/Mech Alt) diet indicated to serve 5 ounces of ground chicken Dijon. The menu also indicated to serve pureed rice to residents on finely chopped diet.</p> <p>A review of facility policy and procedures (P&amp;P) titled Menu (undated) indicated, Menus are written and approved by Registered Dietitian to meet the nutritional needs of the residents . Menu must meet the nutritional needs of residents . and be followed.</p> <p>A review of facility P&amp;P titled Mechanical soft (dated 2018), indicated, The foods are modified in texture by chopping, dicing, and grinding. For menu planning purposes the diet should be planed using ground meats and diced fruits and vegetables. Chopped is 1/4- 1/2 inch pieces; chopped fine/diced/minced:1/8-1/4-inch pieces, ground is 1/8-inch pieces consistency of ground meat.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38740</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when:</p> <ol style="list-style-type: none"> <li>1. Cooked eggs in a bowl were stored on the same shelf and on top of cartons of raw liquid eggs. A large piece of raw pork loin with thaw dates of [DATE]-[DATE] stored on top of imitation crab (frozen ready to eat seafood product) with use by date of [DATE].</li> <li>2. One kitchen staff working in the dish machine area did not wash hands before removing the clean and sanitized dishes from the dish machine.</li> <li>3. Ice machine was not maintained in a sanitary manner and the inside compartment of ice machine was stained with red color residue.</li> <li>4. Food brought to resident from outside of the facility including leftovers stored in the resident food refrigerator were not dated. There was no monitoring system for the refrigerator temperatures while expired and blue color moldy food were not discarded.</li> </ol> <p>These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another that could lead to food borne illness) in 51 of 54 residents who received food and ice from the facility and in the residents who had food stored in the resident refrigerator.</p> <p>Findings:</p> <p>During an observation in the kitchen on [DATE] at 8:45 AM, there was a container of hard-boiled eggs stored on same shelf as raw shelled eggs and cartons of liquid eggs in the reach in refrigerator.</p> <p>During a concurrent observation and interview with cook (Cook 1), Cook 1 stated the hard-boiled eggs were left over from breakfast. Cook 1 stated cooked food should be stored separately to prevent cross contamination. Cook 1 also stated both the refrigerator and its space are small and food was stored on top of each other accidentally.</p> <p>During an observation of the same reach in refrigerator on [DATE] at 8:50 AM, there was a large raw pork loin in a pan thawing. The pan was placed on top of imitation crab meat (ready to eat seafood product).</p> <p>During a concurrent interview with cook 1 on [DATE] at 8:50 AM, Cook 1 stated because the space of the refrigerator is small so sometimes food is placed on top of each other. Cook 1 stated someone had made a mistake because raw food should not be placed on same shelf as cooked food.</p> <p>During an interview with Registered Dietitian (RD) on [DATE] at 9:00AM, RD stated raw food should be separated from cooked food to prevent cross contamination.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the 2022 U.S. Food and Drug Administration (FDA) Food Code titled Packaged and Unpackaged Food - Separation, Packaging, and Segregation Code ,d+[DATE].11 indicated, (A) Food shall be protected from cross contamination by: separating raw animal foods during storage, preparation, holding and display from (b) Cooked ready-to-eat food.</p> <p>2. During an observation in the dishwashing area on [DATE] at 9:15AM, Dietary Aide 1 (DA 1) was rinsing soiled dishes and loading the dirty dishes in the dish machine. DA 1 then dipped DA 1's hands in a bucket filled with soapy water located inside the manual dishwashing sink next to the dishwashing machine, shook the excess water off DA 1's hands and proceeded to remove the clean and sanitized dishes from the dish machine.</p> <p>During an interview with DA 1 on [DATE] at 9:45AM, DA 1 stated the bucket was filled with soapy water and sanitizer, and DA 1 washed DA 1's hands inside the bucket. DA 1 stated DA 1 made a mistake because DA 1 did not wash hands in the hand washing sink to prevent cross contamination of germs from dirty dishes to clean dishes.</p> <p>A review of facility's policy and procedures (P&amp;P) titled, Dishwashing Procedures (Dish machine) dated 2018, indicated, If only one employee is available to wash and handle clean and soiled dishes, the employee must wash hands thoroughly before handling clean dishes, trays and carts.</p> <p>A review of facility's P&amp;P titled, Handwashing dated 2018, indicated, follow the following steps to effectively wash hands: turn on water slowly to a warm, comfortable temperature, wet hands ., Apply soap. Wash and scrub for 20 seconds or more. Rub your hands together briskly .rinse hands thoroughly, dry hands and arms with a paper towel.</p> <p>3. During an observation of the facility ice machine in the kitchen on [DATE] at 10:15AM, a clean paper towel swiping of ceiling and sides in the ice storage bin produced red color residue. The residue was observed on the ceiling of the bin and sides.</p> <p>During a concurrent interview with kitchen supervisor (KS) and Cook 1, KS stated the maintenance supervisor cleans the ice machine every month. KS and Cook 1 verified there were residues that looked like splashes of colorful substance inside the bin. KS stated KS will contact the Maintenance Supervisor (MS) for the cleaning log.</p> <p>During an interview with MS on [DATE] at 10:30AM, MS stated MS cleans the ice machine and the ice storage bin every month. MS said the residue looked like splashes of juice. MS said kitchen staff had kept the ice storage bin open while filling up beverage containers with ice.</p> <p>During an interview with RD on [DATE] at 11:40AM, RD verified and stated staff had brought the pitchers with juice close to the ice machine to add ice to juice and some juice spilled.</p> <p>A review of facility policy and procedures titled Cleaning and maintaining ice machines policy no. IC0615 (undated) indicated, keep access door closed at all times except when in use.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the 2022 U.S. FDA Food Code titled Equipment Food-Contact Surfaces and Utensils Code# , d+[DATE].11, indicated, Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.</p> <p>4. During an observation in the resident refrigerator located outside in a courtyard on [DATE] at 3 PM, there were seven plastic bags with resident leftover food in boxes. There was one bag with a resident's room number and undated; there were two bags that had no label or date; there were four ready to eat launchable packages dated ,d+[DATE] that were expired ; there was one cheese sandwich with blue colored mold covering the bread; there were one half of a leftover sandwich with no covering in the refrigerator drawer, four (4) open bottles of soda and one container of fruit cup that spilled inside the refrigerator covering the refrigerator with sticky residue while plastic bags containing resident food were stuck in the shelf covered with sticky fruit cup residue. The freezer was full of frozen food with no label and date. The temperature log was not completed, and there was no indication of that the temperature of the refrigerator was monitored.</p> <p>During a concurrent interview with Director of staff development (DSD) on [DATE] at 3 PM, DSD stated that the resident refrigerator is open and sometimes residents' family and visitors put their own food in there. DSD stated the family should bring food to nursing staff to check before taking the food to resident's room. DSD stated nursing staff should label and date the food before storing the food in the refrigerator for later. DSD stated the food is stored for three days and then the food will be discarded. DSD stated the maintenance staff checks and monitors the temperature of the resident refrigerator. DSD also stated the temperature log was missing and the temperature of the resident refrigerator had not been monitored.</p> <p>During a concurrent interview with DSD and MS on [DATE] at 3:15PM, MS stated MS is not allowed to throw away food per 3-day policy because some residents complained that their food was discarded. MS acknowledged and stated the refrigerator for residents had not been cleaned. DSD stated all the food in the refrigerator will be discarded because the food is not safe for residents as some food had no dates, and some food had expired.</p> <p>During an interview with facility Administrator (ADM) on [DATE] at 4:00PM, ADM stated the food in the refrigerator for residents will be discarded because some food was not dated and had expired, and the refrigerator will be cleaned.</p> <p>A review of facility's policy and procedures titled Food Brought from outside the facility, dated ,d+[DATE], indicated, instruct visitor to bring all foods to the nurse's station prior to delivery to resident .Perishable foods must be stored in resealable containers with tightly fitting lids. Containers will be labeled with the resident's name, the item and the 'use by' date .the nursing staff will discard perishable foods on or before the 'use by date.'</p>		