STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Plaza Regency Post Acute Rehab	6021 W. Cheyenne Ave. Las Vegas, NV 89108

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR- a federally mandated process which screens individuals seeking admission to a nursing facility (NF) to identify those with serious mental illnesses (SMI) or intellectual/developmental disabilities (ID/DD) to ensure individuals with these conditions receive the most appropriate placement) level II was completed for 1 of 40 sampled residents (Resident 155). The deficient practice had potential for not ensuring a resident with behavioral symptoms still fits within the resident population and for additional behavioral needs would be provided. Findings include: Resident 155 (R155) was admitted on [DATE], with diagnoses including bipolar disorder and hallucinations. Resident 155 was discharged on 05/12/2025.On 08/12/2025 at 11:00 AM, R155 was reported to have kicked a roommate twice on the lower leg and kicked the dietary person in the leg. R155 continued to exhibit behavioral issues as exhibited by trying to hit staff members and residents. R155 was transferred to a geriatric-psychiatric facility where the patient was admitted . Review of R155's nursing Behavior Complex Care Progress Notes from 03/09/2025 to 05/12/2025, revealed the following documented behaviors: Behaviors: Potential indicators of psychosis: Delusions - Resident stated people were trying to kidnap the resident. Resident believed that someone was trying to kill the resident. At one point the resident went back into the resident's room and blocked the door not allowing people to get into the room because the resident feared someone was trying to hurt the resident. The resident rummaged through the roommate's belongings and was found to be wearing the roommate's earrings which the resident claimed belonged to R155 and not the roommate. The resident claimed R155 owned the facility and could do whatever the resident wanted. The resident pulled the fire alarm when R155 did not get the attention the resident wanted.Physical behavior: Hitting others and kicking others. The resident kicked a roommate twice in the right lower leg and kicked the dietary person in the leg, The resident was hitting staff and other residents. Throwing objects at others. Grabbing others. Throwing the resident's shoe towards the certified nursing assistant (CNA) who attempted to stop the resident from harassing another resident. R155 hit the glass window at the day room with a folded walker. Splashed water at care providers.Verbal behavior: Cursing at others. R155 was frequently yelling, screaming, and cursing at staff, and other residents. The resident would scream inappropriate comments at others and use offensive foul language. R155 would ask repetitive questions/statements to disturb a roommate's rest after bedside care and stealing property of roommate like clothes, dress or any items the resident wanted to pick up. R155 would enter the roommate's persona space. Yelling and screaming on and off almost the entire shift. Behavior not exhibited toward others: R155 pulled the fire alarm one time. A nurse saw the resident trying to induce vomiting by inserting finger to throat. The resident claimed the resident was going on a car ride later and was worried about vomiting inside the car if the resident did not vomit now.Rejection of care: Medications were spit out. The resident would get upset when offered care. Resident had spit out the morning medications because the resident believed the medications could kill the resident. The resident refused a brief change from CNA. The resident purposely raised voice to get attention and (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disrupt others.Other behaviors: Behavior of disrupting others. The resident could be loud screaming especially at the nurse's station. R155 disrupts other residents' sleep during bedtime and disrupts staff while charting at the station. Multiple entries of behaviors were entered by nursing staff which demonstrates R155 was experiencing symptoms or indicators of significant mental illness.R155 had numerous documented routine Psychiatry Evaluations. The progress notes documented the following assessments: Initial Psychiatry Evaluation dated 05/30/2024 at 8:30AM, to the most recent Psychiatry visit dated 04/25/2025 at 11:15AM, consistently documented under Complexity/Medical Decision Making:1. Bipolar disorder with psychotic features - Continue Seroquel (anti-psychotic) 75 milligram (mg) three times a day (TID) to help address delusions associated with (a/w) bipolar disorder. Continue Fluoxetine (anti-depressant) 40 mg daily for depression a/w bipolar disorder.2. Generalized anxiety disorder - Continue Alprazolam (anti-anxiety) 0.5 mg TID for anxiety/restlessness. Continue Hydroxyzine 25 mg TID for restlessness.The Initial PASRR level I Screening form dated 07/05/2023, documented Determination: No mental illness, mental retardation, related condition or dementia. The PASRR deemed the resident was appropriate for nursing facility placement.R155 lacked documented evidence a PASRR level II assessment was completed even with R155 demonstrated behaviors of a serious mental illness (SMI) or the actual diagnosis from the psychiatric evaluations.On 09/11/2025 in the morning, two Registered Nurses (RNs) indicated behavioral incidents were documented on the progress notes. The RNs indicated the Resident Care Managers (RCM) would be informed of the behaviors as well. Any further directives would be received from the physicians or RCM.On 09/11/2025 at 2:14 PM, two RCMs indicated nurses would report any resident behaviors and would be discussed during interdisciplinary team (IDT) meetings. The RCM reviewed R155?s EHR and confirmed the resident did not have a PASRR level II. On 09/11/2025 at 3:03 PM, a social worker (SW) confirmed the assigned SW to the specific resident attends the IDT meeting and would be informed of behavioral changes exhibited by a resident. The need for a Level II PASRR assessment would be determined at the IDT meeting. The SW acknowledged the purpose of the PASRR was to assess if the current facility was appropriate for the level of care or additional recommendations needed for a resident's behavioral needs. The SW acknowledged a level II PASRR was needed for R155. The facility policy titled PASRR Protocol - Nevada (Undated), documented when to complete the PASRR Level II Request: 1. When the resident is determined to have serios mental illness (SMI), mental retardation (MR) or related concerns (RC). 2. At any point if a person with SMI, MR or RC has an exacerbation of behaviors or indications of worsening mental health indicators.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a baseline care plan was developed and implemented for residents who were admitted with a peripherally inserted central catheter (PICC) line for 2 of 40 sample residents (Residents 159 and 164). The deficient practice had the potential to place the residents at risk of receiving inadequate PICC line care which could have resulted in complications such as infection and line occlusion. Findings include:1) Resident 159 (R159) was admitted on [DATE], with diagnoses including congestive heart failure and diabetes mellitus.On 09/09/2025 at 9:35 AM, R159 had a single lumen intravenous (IV) access in the right upper arm with dressing dated 08/29/2025. R159 indicated the PICC line was placed in the hospital for Insulin infusion to treat R159's diabetic ketoacidosis (a complication of diabetes resulting in elevated blood sugar and accumulation of ketones). R159 indicated the line was not used during the resident's first few days in the facility and almost became occluded but was successfully flushed by staff when the physician ordered IV Lasix (an anti-diuretic).On 09/09/2025 at 9:39 AM, a Registered Nurse (RN) confirmed R159 had a right upper arm PICC line which was dated 08/29/2025 and described black matter which appeared to be dried blood surrounding the insertion site. The RN explained the facility protocol was to replace the PICC line dressing every seven days or as needed when soiled or loose. The RN indicated being floated to the unit and was new to the resident. The RN indicated that the nurses who have been administering IV Lasix should have identified the dressing was outdated and soiled and performed a dressing change. A Nursing admission assessment dated [DATE], revealed R159 was admitted with a right upper arm PICC line. R159's baseline care plan initiated 09/03/2025, documented R159 had a PICC line with a goal to prevent complications and an intervention to follow physician order for dressing changes.The medical record lacked documented evidence that R159's dressing changes were followed in accordance with the care plan and failed to include other appropriate interventions such as flushing and site assessment. 2) Resident 164 (R164) was admitted [DATE], with diagnoses including cellulitis of left lower limb.On 09/09/2025 at 10:24 AM, R164 had a single lumen IV access in left upper arm dated 08/17/2025. A white reinforcement tape was observed on the top and bottom edges of the transparent dressing. R164 explained the line was inserted in the hospital for antibiotics and had not been used at this facility since admission. R164 indicated staff do not routinely flush the line and no one changed the dressing. On 09/09/2025 at 10:23 AM, the Resident Case Manager (RCM) indicated R164 had a left upper arm PICC line which was not in use. The RCM confirmed the dressing was dated 08/17/2025 and there was reinforcement tape on the top end and bottom end of the dressing. The RCM explained PICC line dressing changes were performed every seven days which was an overdue task for R164's PICC line. The RCM indicated that any nurse could have contacted a physician to determine whether the PICC line would be removed and if the physician ordered the PICC line to remain, maintenance orders to include flushing and site assessment every shift and weekly dressing change should have been entered and carried out.The medical record lacked documented evidence that the resident's PICC line was included in the baseline care plan. On 09/10/2025 at 4:26 PM, the Director of Nursing (DON) indicated R159's baseline care plan was not implemented specifically with regards to dressing changes and interventions were lacking flushing and site assessment protocols. The DON conveyed R164's baseline care plan failed to include care and management for the resident's PICC line which was an immediate care need.The Interdisciplinary Team Care Planning policy revised November 2017, documented care planning begins on the day of admission, and the baseline care plan was developed with the first 48 hours of admission and would include the resident's immediate care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure fingernail care was provided for 1 of 40 sampled residents (Resident 147). The deficient practice had the potential for residents not to receive nail care.Findings include:Resident 146 (R146) was admitted on [DATE], with diagnoses including need for assistance for personal care and cognitive communication deficit.On 09/10/2025 at 9:45 AM, R146 was observed to have bilateral arms lying on the chest. The fingernails on both hands were approximately more than a quarter of an inch long with dark brown to black accumulations of dry substances embedded between the tip of the hand and nailbed. On 09/11/2025 at 9:30 AM, R146 was awake, conversive and just had finished eating breakfast. The resident was not sure why the fingernails were not trimmed. R146 indicated receiving showers from staff once to twice per week and no trimming of fingernails was provided.On 09/11/2025 at 10:34 AM, the Registered Nurse (RN) caring for R146 went to the bedside to inspect the fingernails and agreed the fingernails should have been trimmed. The RN indicated the certified nursing assistants (CNAs) should be inspecting and trimming fingernails during shower days. If a resident refused the care the assigned nurse should be informed.On 09/11/2025 at 12:35 PM, an RN indicated nurses and CNAs could trim a resident's fingernails. Nails should be assessed routinely during care, more so during shower days. Nailcare refusals from a resident should be communicated to nursing staff to be addressed accordingly.On 09/11/2025 at 2:00 PM, two Resident Care Managers (RCM) indicated finger and toenail assessments should be looked at during every care of a resident. The RCMs confirmed fingernails should be trimmed by the CNAs or nurses. Long fingernails could be an infection control concern as well as skin tears or scratches.The facility policy titled Assisting the Nurse in Examining and Assessing the Resident revised 08/2017, documented the procedure is to assist the nurse in gathering information about the overall condition of the resident and performance of activities of daily living. Grooming and Dressing: Assistance with bathing, hair and nailcare.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure care orders were transcribed and carried out for a peripherally inserted central catheter (PICC) line for 2 of 40 sampled residents (Residents 159 and 164) and a short peripheral line was dated, and maintenance protocols were followed during non-use for 1 of 40 sampled residents (Resident 162). The deficient practice had the potential to place residents at risk of infection. Findings include: 1) Resident 159 (R159) was admitted on [DATE], with diagnoses including congestive heart failure and diabetes mellitus.On 09/09/2025 at 9:35 AM, R159 had single lumen intravenous (IV) access in the right upper arm with a dressing dated 08/29/2025. R159 indicated the PICC line was placed in the hospital for Insulin infusion to treat R159's diabetic ketoacidosis (a complication of diabetes resulting in elevated blood sugar and accumulation of ketones). R159 indicated the line was not used during the resident's first few days in the facility and almost became occluded but was successfully flushed by staff when the physician ordered IV Lasix (an anti-diuretic).On 09/09/2025 at 9:39 AM, a Registered Nurse (RN) confirmed R159 had a right upper arm PICC line which was dated 08/29/2025 and described black matter which appeared to be dried blood surrounding the insertion site. The RN explained the facility protocol was to replace PICC line dressings every seven days or as needed when soiled or loose. The RN indicated being floated to the unit and was new to the resident. The RN indicated that the nurses who have been administering IV Lasix should have identified the dressing was outdated and soiled and performed a dressing change. A Nursing admission assessment dated [DATE], revealed R159 was admitted with a right upper arm PICC line. The medical record lacked documented evidence maintenance orders for flushing, site assessment and dressing changes were entered on admission. A Physician Order dated 09/07/2025, documented to change PICC line dressing every seven days by night shift for maintenance. The Medication Administration Record (MAR) for September 2025, reflected PICC line dressing change had not been performed since R159's admission on [DATE].The medical record lacked documented evidence flushing and site assessment orders were transcribed and carried out in accordance with facility policy.A Physician Order dated 09/07/2025, documented to give Furosemide Injection Solution, use 20 milligrams (mg) intravenously two times a day for edema.2) Resident 164 (R164) was admitted [DATE], with diagnoses including cellulitis of left lower limb.On 09/09/2025 at 10:24 AM, R164 had a single lumen IV access in the left upper arm dated 08/17/2025. A white reinforcement tape was observed on the top and bottom edges of the transparent dressing. R164 explained the line was inserted in the hospital for antibiotics and had not been used at this facility since admission. R164 indicated staff did not routinely flush the line and no one had changed the IV dressing. On 09/09/2025 at 10:23 AM, the Resident Case Manager (RCM) indicated R164 had a left upper arm PICC line which was not in use. The RCM confirmed the dressing was dated 08/17/2025 and there was reinforcement tape on the top end and bottom end of the dressing. The RCM explained PICC line dressing changes were performed every seven days which was an overdue task for R164's PICC line. The RCM indicated that any nurse could have contacted a physician to determine whether the PICC line would be removed and if the physician ordered the PICC line to remain, maintenance orders to include flushing and site assessment every shift and weekly dressing change should have been entered and carried out.On 09/09/2025 at 10:32 AM, the RCM indicated staff did not follow maintenance protocols for R164's PICC line which placed the resident at risk for infection, occlusion and unnecessary reinsertion if a line was determined to be needed. A Nursing admission assessment dated [DATE], revealed R164 was admitted with a left antecubital (in front of the elbow) PICC line. A Physician Order dated 08/22/2025, documented IV PICC line dressing change by night shift every Sunday for IV maintenance and as needed if wet, soiled, dislodged or compromised.The medical record lacked documented evidence R164's PICC line dressing had been changed since admission. A Physician Order dated 08/22/2025, documented to administer Normal (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Saline flush solution 0.9 percent (%), use 10 milliliters (ml) intravenously every shift for clinical standard.Review of R164's medication administration record (MAR) revealed the PICC line was flushed on four shifts from 08/22/2025 to 09/09/2025.A Physician Order dated 08/24/2025, documented to remove the PICC line due to the resident not having IV medications.The MAR revealed a nurse signed off on R164's PICC line removal on 08/24/2025 which did not align with direct observation.On 09/10/2025 at 4:05 PM, the Director of Nursing (DON) indicated R159 and R164 were admitted with a PICC line in the absence of IV medication orders. The DON confirmed the medical record did not reflect the admitting nurse clarifying whether the residents' PICC lines were to be removed or maintained. If the physician ordered to keep the PICC line, maintenance orders to include flushing and site assessments every shift and weekly dressing change should have been transcribed and carried out. The DON explained that dressing changes were performed on Sundays by night shift staff, but the tasks were missed for R159 and R164 which placed the residents at risk of infection and line occlusion. The DON indicated the facility policy for midlines was provided because care and management of midlines were identical to care and management of PICC lines.The facility policy Midline Dressing Changes revised May 2017, documented the purpose of catheter dressing changes were to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. Documentation requirements included date and time dressing were changed, type of dressing placed, and signature of person who performed procedure. The facility policy Flushing Midline and Central Line IV Catheters dated May 2010, documented catheters were flushed at regular intervals to maintain patency and required a physician order. Documentation requirements included date and time of procedure, condition of IV site and notification of physician of any complications and signature of staff member who performed procedure. 3) Resident 162 (R162) was admitted on [DATE], with diagnoses including abnormality in blood chemistry and myopathy. On 09/09/2025 at 9:50 AM, R162 had an undated peripheral IV line in the left hand with plastic tape coming loose at the ends. R162 indicated the line was inserted for fluids to treat the resident's dehydration. An IV pump was stored by the resident's doorway. The resident verbalized the IV line had not been used since the nurse practitioner informed the resident lab results came back good.On 09/09/2025 at 10:00 AM, an RN confirmed R162's left-hand peripheral IV was inserted at the facility, and the dressing should have been signed and dated by the nurse who performed the insertion. The RN verbalized the line was no longer in use because the resident's dehydration had been resolved, and someone should have contacted the provider to obtain an order for removal since peripheral lines were meant for short term use. The RN described R162's IV line as covered with plastic tape which was coming loose at the edges.A Physician Order dated 09/03/2025, documented to insert hep lock (a short peripheral line typically flushed with Heparin instead of Saline) for IV infusion one time only for IV fluids.A Physician Order dated 09/03/2025, documented to give Sodium Chloride Solution 0.9 % at 75 ml per hour intravenously every shift for hydration for two days.The medical record lacked documented evidence an order for peripheral line removal was obtained or clarified with the provider after the fluids order was completed on 09/04/2025, and maintenance orders for flushing and site assessments were transcribed and carried out.On 09/10/2025 at 4:34 PM, the DON confirmed R162's fluids were started through a hep lock on 09/03/2025 for fluids times two days. The DON verbalized the laboratory results dated [DATE] revealed resolution of dehydration and a nurse could have obtained an order to remove the IV line.The facility policy titled The Insertion of a Peripheral Catheter revised August 2017, defined a peripheral short catheter was less than or equal to three inches in length and was not a steel-infusion set which was used for administration of IV fluids and/or medications. Once inserted, the label is affixed, which reflects the date and time of catheter insertion with initials. Documentation requirements include date and time of the procedure, type and length of catheter, location or site, signature and title of person who performed procedure. The facility policy titled The Removal of a Peripheral Catheter revised August 2017, documented a peripheral IV line was to be removed every 96 hours (4 days), immediately after suspected contamination, when rotating the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	site or when therapy was discontinued. Documentation requirements include date, time of procedure, reason for removal, any communication with the physician and any changes to treatment orders.

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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** Based on observation, interview, record review and document review the facility failed to ensure physician orders with therapy settings were obtained and a comprehensive care plan developed for 1 of 40 sampled residents (R172) receiving Continuous Positive Airway Pressure (CPAP- a medical device used to help people breathe more easily during sleep) treatment. The deficient practice had the potential to result in inappropriate or ineffective treatment for residents receiving CPAP therapy. Findings include:Resident 172 (R172) was admitted to the facility on [DATE] with diagnoses including displaced comminuted fracture of shaft of right femur, type 2 diabetes mellitus, and gastro-esophageal reflux disease.A Physician Order dated 08/28/2025 documented to use CPAP every night.R172's medical record lacked a care plan for CPAP use. On 09/11/2025 at 11:29 AM, a Registered Nurse (RN) explained the Respiratory Therapist (RT) managed CPAPs for the residents. On 09/11/2025 at 11:31 AM, the RT Director explained the RT department was responsible for equipment changes and the initial setup of CPAP equipment for residents.On 09/11/2025 at 11:38 AM, the RT Director explained being unaware R172 had a CPAP. The RT Director explained that if a resident brought a CPAP device from home the settings would have been preset in the device, and the physician order would denote the settings needed. On 09/12/2025 at 9:00 AM, the Resident Care Manger (RCM) explained when a resident required the use of a CPAP the RCM would coordinate with RT services to establish setup of the equipment. The RCM explained residents using CPAP would have a care plan developed by the case manager. On 09/12/2025 at 10:17 AM, the RCM verbalized R172 was not admitted to the facility with orders for CPAP. The family brought the CPAP machine to the facility after the resident was admitted . The RCM verbalized R172's physician order was entered by the charge nurse when the family delivered the device on 08/28/2025. The RCM confirmed that R172 lacked a care plan for the use of CPAP.On 09/12/2025 at 10:21 AM, the Director of Nursing (DON), explained the expectation for a resident using CPAP therapy would be for the physician order to include the specific settings required for use and for the resident to have a care plan in place for the use of the device. The DON confirmed R172's physician order lacked the specific settings required for use of the CPAP and R172's medical record lacked a care plan for use of the CPAP. The facility policy titled CPAP/BiPAP (bilevel positive airway pressure) Support- Level III, revised 06/2018, documented review the physician orders to determine the oxygen concentration and flow, and the PEEP (positive end-expiratory pressure) pressure for the machine and set CPAP settings on the machine, as prescribed. The facility policy titled Care Plans- Person Centered Comprehensive, revised 10/2024, documented assessments of residents were ongoing, and care plans are revised as information about the resident and the resident's condition change.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure the temperature in a resident's personal refrigerator was monitored for two unsampled residents (Residents 63 and 94). The deficient practice had the potential for foods to be stored at temperatures which could lead to food borne illness.Findings include: Resident's (R63) was admitted on [DATE], with diagnoses including hyperlipidemia, atherosclerotic health disease and heart Failure.Resident's R94 was admitted on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder, hyperlipidemia, and gastro-esophageal reflux disease.On 09/09/2025 at 9:30 AM, the two unsampled resident's personal refrigerator contained undated food items and there was no temperature log.On 09/12/2025 at 10:00 AM, R63 mentioned family members regularly checked the refrigerator and disposed of any expired food. R63 checked the dates on the food to make sure it was not expired. R63 stated family members helped by checking the temperature of the refrigerator.On 09/12/2025 at 10:06 AM, R94 checked the expiration dates on food items and discarded anything expired. R94 had asked the housekeeper to clean out the refrigerator and throw away any expired food. R94 explained that the housekeeper checked the refrigerator temperature.On 09/12/2025 at 10:20 AM, a housekeeper explained the inside of residents' personal refrigerators were cleaned upon resident request, and expired food were thrown away at those times. The housekeeper explained the outside of the refrigerator was cleaned regularly during routine room cleaning.On 09/12/2025 at 10:35 AM, a maintenance staff member indicated monitored the temperatures of the facility refrigerators, not resident's personal refrigerator. The maintenance staff member verbalized checking a personal refrigerator if a Certified Nursing Assistance (CNA) or nurses reported an issue, such as a water leak, or if a resident reported the refrigerator was working properly.On 09/12/2025 at 10:45 AM, CNA1shared personal refrigerators were checked daily for leftover or expired food, but not for temperature.On 09/12/2025 at 10:56 AM, CNA2 checked the resident's refrigerator to see if it was clean or not. If a resident informed the CNA the freezer was too icy, the CNA would adjust the temperature. The CNA did not take the actual temperature.On 09/12/2025 at 11:57 AM, the Director of Nursing (DON) explained CNAs were responsible for checking residents' personal refrigerators daily and discarding any expired food. The DON noted within the medical task documentation system, CNAs could mark yes or no to indicate whether the temperature was checked. There was no recorded temperature log available. The DON checked the temperature of R94 and R63 personal refrigerator, which read 50 degrees Fahrenheit. The DON acknowledged the refrigerators for R94 and R63 were too warm and needed to be cooler than 40 degrees Fahrenheit. The DON indicated when family members bring in food which did not have a manufacturer's expiration date, it must be labeled with a date. The DON mentioned that the resident's food was permitted to remain in the refrigerator for up to 72 hours (3 days) before CNAs were required to discard it.The DON confirmed a temperature log should be maintained for personal refrigerators but was unable to provide any documented temperature log for residents R94 and R63 personal refrigeratorsThe facility policy titled Resident/Patient Food from Outside Sources, effective 4/2018 documented designated staff would monitor resident's room and refrigeration units for food and beverage disposal. Any unlabeled, expired or undated food would be discarded. Food items without a manufacturer's expiration date would be discarded after 3 days. Refrigerator and freezers temperature would be recorded daily on a temperature log. All units must maintain safe internal temperatures in accordance with the state and federal standards for safe food storage temperatures.