

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Poway Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  15632 Pomerado Road Poway, CA 92064	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>51682</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) was accurately coded regarding a feeding tube for 1 (Resident #2) of 2 sampled residents reviewed for tube feeding.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Assessments, revised 10/2023, revealed, 10. Assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline. 11. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 12. Information in the MDS assessment will consistently reflect information in the progress notes, plans of care, and resident observation/interviews.</p> <p>An Admission Record indicated the facility admitted Resident #2 on 01/06/2024. According to the Admission Record, the resident had a medical history that included diagnoses of malignant neoplasm (cancer) of the tongue, irritative hyperplasia (overgrowth of cells due to chronic irritation) of the oral mucosa, moderate protein calorie malnutrition, dysphagia (difficulty swallowing), and gastrostomy (a surgical procedure to create an opening in the stomach, through which food and medication are administered).</p> <p>Resident #2's Order Listing, revealed the resident's enteral feeding order was discontinued on 10/09/2024.</p> <p>Resident #2's medication administration record for the timeframe from 01/01/2025 through 01/31/2025, revealed no evidence to indicate the resident received nutrition by way of a feeding tube.</p> <p>A quarterly MDS, with an Assessment Reference Date (ARD) of 01/11/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition The MDS indicated that the resident had a feeding tube and received 50% or more of their total calories and 500 cubic centimeters per day or less of fluids through a tube feeding.</p> <p>During an interview on 05/06/2025 at 11:14 AM, Resident #2 stated they no longer had a feeding tube. Licensed Vocational Nurse #5 verified Resident #2's feeding tube was removed on 10/02/2024 and since then, the resident received nutrition orally.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/06/2025 at 11:44 AM, the MDS Coordinator reviewed Resident #2's electronic medical record and verified the resident's quarterly MDS with an ARD of 01/11/2025 should not indicate the resident received a tube feeding.</p> <p>During an interview on 05/06/2025 at 11:55 AM, the Registered Dietician stated Resident #2's quarterly MDS should not show the resident received a tube feeding.</p> <p>During an interview on 05/08/2025 at 9:50 AM, the Director of Nursing (DON) stated she expected all staff members who completed sections of the MDS to collect and include all data, to ensure the MDS was completed and accurate. The DON stated Resident #2's feeding tube was pulled out and not replaced, per the resident's request. The DON reviewed Resident #2's MDS with an ARD of 01/11/2025 and stated the MDS should not reflect that the resident received nutrition from a feeding tube.</p> <p>During an interview on 05/08/2025 at 10:31 AM, the Administrator stated he expected MDS to be accurate.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>35314</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to obtain consent for the use of bed rails for 2 (Resident #9 and Resident #24) of 3 sampled residents with bed rails installed; and failed to complete assessments for the continued use of bed rails for 3 (Residents #9, #24, and #54) of 3 sampled residents reviewed for accidents.</p> <p>Findings included:</p> <p>A facility policy titled, Bed Safety and Bed Rails, revised 08/2022, revealed, 3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The policy specified, 8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.</p> <p>1. An Admission Record revealed the facility admitted Resident #9 on 03/13/2021. According to the Admission Record, the resident had a medical history that included diagnoses of senile degeneration of the brain, dementia, history of traumatic brain injury, and a history of falling.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/09/2025, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. According to the MDS, Resident #9 required partial/moderate assistance with rolling from lying on their back to the left and right sides, with moving from sitting on the side of the bed to lying flat on the bed, and with moving from lying on their back to sitting on the side of the bed.</p> <p>Resident #9's Care Plan Report, included a focus area revised 09/20/2024, that indicated the resident was at risk for altered activities of daily living (ADL) related to a decline in functional ADL activity such as bed mobility and transfers. Interventions directed staff to provide bilateral quarter bed rails to assist the resident with bed mobility, getting out of bed, turning and repositioning, supporting themselves during care, and entering/exiting the bed more safely (initiated 06/15/2022).</p> <p>Resident #9's Order Summary Report, revealed an order dated 10/20/2022, for Side/Bed Rail(s) Up x 2 for Bed Mobility (Turning &amp; Positioning).</p> <p>Resident #9's Bed Rail Observation/Assessment forms dated 03/18/2022, 06/14/2022, 06/18/2022, 09/08/2022, 12/08/2022, 03/08/2023, and 06/08/2023, revealed recommendations for bilateral upper quarter bed rails. The section of the assessments titled, Risks, Benefits and Informed Consent was blank on all documents, and there was no evidence that Resident #9 or their representative was informed of the medical necessity to use side rails or the associated risks and benefits. The assessment forms did not include signatures for Resident #9 or their representative to validate informed consent for the use of side rails was obtained.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #9's Progress Notes, for the timeframe from 06/08/2023 through 05/03/2025 revealed no documentation of informed consent or additional assessments for the use of bed rails.</p> <p>An observation on 05/07/2025 at 1:09 PM revealed Resident #9 was in bed with bilateral side rails up.</p> <p>During an interview on 05/07/2025 at 1:29 PM, the Director of Nursing stated the facility was not able to locate the initial consent form for Resident #9's side rails.</p> <p>During an interview on 05/08/2025 at 9:28 AM, Certified Nurse Assistant #4 stated Resident #9 used their side rails for turning and positioning.</p> <p>2. An Admission Record revealed the facility admitted Resident #24 on 09/27/2015. According to the Admission Record, Resident #24 had a medical history that included diagnoses of dementia, osteoarthritis of bilateral knees, and age-related physical debility.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/2025, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. According to the MDS, Resident #24 required substantial/maximal assistance with rolling from lying on their back to the left and right sides, with moving from sitting on the side of the bed to lying flat on the bed, and with moving from lying on their back to sitting on the side of the bed.</p> <p>Resident #24's Care Plan Report, included a focus area initiated 03/15/2022, that indicated the resident was at risk for altered activities of daily living (ADL) related to a decline in functional ADL activity such as bed mobility and transfers. Interventions directed staff to provide bilateral quarter bedside rails for bed mobility and transfers (initiated 03/15/2022).</p> <p>Resident #24's Order Summary Report, revealed an order dated 10/20/2022, for Side/Bed Rail(s) Up x 2 for Bed Mobility (Turning &amp; Positioning).</p> <p>Resident #24's Side/Bed Rail Evaluation/Consent, dated 03/03/2018, revealed an evaluation showed the resident had medical symptoms of generalized weakness and balance deficits, and they required bed rails for bed mobility and boundary identification. The Side/Bed Rail Evaluation/Consent included a recommendation for bilateral quarter side rails at the top of the resident's bed. Further review of the document revealed Resident #24 was informed of the risks and benefits of the side rails, but there was no signature to validate informed consent for the use of side rails was obtained.</p> <p>Resident #24's Bed Rail Observation/Assessment forms dated 03/16/2022, 06/01/2022, 09/05/2022, 12/05/2022, 03/06/2023, 09/06/2023, 12/06/2023, 03/06/2024, and 06/06/2024 revealed recommendations for bilateral upper quarter bed rails. The section of the assessments titled, Risks, Benefits and Informed Consent was blank on all documents, and there was no evidence that Resident #24 or their representative was informed of the medical necessity to use side rails or the associated risks and benefits. The assessment forms did not include signatures for Resident #24 or their representative to validate informed consent was obtained for the use of side rails.</p> <p>Resident #24's Progress Notes, for the timeframe from 12/11/2024 through 05/07/2025 revealed no documentation of informed consent or additional assessments for the use of bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 05/07/2025 at 12:56 PM revealed Resident #24 was in bed with bilateral side rails up.</p> <p>During an interview and observation on 05/08/2025 at 7:44 AM, Resident #24 stated they used the side rails to reposition themselves in bed and demonstrated use of the side rail.</p> <p>3. An Admission Record revealed the facility admitted Resident #54 on 01/12/2022. According to the Admission Record, Resident #54 had a medical history that included diagnoses of osteoarthritis of the right ankle and foot, generalized muscle weakness, and lack of coordination.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/14/2025, revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. According to the MDS, Resident #54 required partial/moderate assistance with rolling from lying on their back to the left and right sides, with moving from sitting on the side of the bed to lying flat on the bed, and with moving from lying on their back to sitting on the side of the bed.</p> <p>Resident #54's Care Plan Report, included a focus area revised 04/24/2022, that indicated the resident was at risk for altered activities of daily living (ADL) related to decline in functional ADL activity such as altered bed mobility and transfers. The focus area specified Resident #54 required quarter side rails for bed mobility, turning, and repositioning. Interventions directed staff to provide bilateral quarter bedside rails to assist with bed mobility (initiated 03/16/2023).</p> <p>Resident #54's Order Summary Report, revealed an order dated 10/20/2022, for Side/Bed Rail(s) Up x 2 for Bed Mobility (Turning &amp; Positioning).</p> <p>A Side/Bed Rail Evaluation/Consent, dated 01/12/2022, revealed Resident #54 was evaluated for the use of side rails and found to have medical symptoms of generalized weakness and balance deficits. The document contained a recommendation for bilateral quarter side rails at the top of the bed. The Side/Bed Rail Evaluation/Consent was signed by Resident #54 to validate they were informed of risks and benefits and gave consent for the use of the side rails.</p> <p>Resident #54's Bed Rail Observation/Assessment forms dated 03/26/2022, 06/26/2022, 07/15/2022, 10/14/2022, 01/01/2023, 04/13/2023, and 07/14/2023 revealed recommendations for bilateral upper quarter bed rails. The section of the assessments titled, Risks, Benefits and Informed Consent was blank on all documents, and there was no evidence that Resident #54 or their representative was informed of the medical necessity to use side rails or the associated risks and benefits. The assessment forms did not include signatures for Resident #54 or their representative to validate informed consent for the use of side rails was obtained.</p> <p>Resident #54's Progress Notes, for the timeframe from 07/12/2023 through 05/07/2025 revealed no documentation of informed consent or additional assessments for the use of bed rails.</p> <p>An observation on 05/05/2025 at 10:10 AM revealed Resident #54 had quarter side rails on their bed.</p> <p>An observation on 05/06/2025 at 1:46 PM revealed Resident #54 was in bed with bilateral side rails up.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/07/2025 at 1:29 PM, the Director of Nursing confirmed Resident #54's last side rail assessment was completed on 07/14/2023.</p> <p>During an interview on 05/07/2025 at 10:03 AM, the Assistant Director of Nursing (ADON) stated the admitting nurse would assess residents to determine if they needed side rails for mobility and obtain consents. The ADON stated residents should have a side rail assessment completed at least quarterly, according to the MDS calendar. The ADON said the MDS Coordinator was responsible for determining if there was continued need for side rails.</p> <p>During an interview on 05/07/2025 at 10:38 AM, the MDS Coordinator stated the admitting nurse completed residents' initial side rail assessments and obtained consent from the residents or their representatives. Per the MDS Coordinator, the facility provided quarter side rails to help with turning and repositioning. She stated nurses must complete annual and quarterly assessments for the continued use of the side rails.</p> <p>During an interview on 05/07/2025 at 1:29 PM, the Director of Nursing confirmed the facility had not completed side rails assessments for Residents #9, #24, and #54. She stated the facility changed electronic medical record systems and the MDS Coordinator informed her the assessments had not been triggered in the current system.</p> <p>During an interview on 05/08/2025 at 9:15 AM, the Medical Director (MD) stated residents used side rails for turning and positioning. The MD stated the residents should be assessed at least quarterly to ensure the continued use of the rails was necessary.</p> <p>During an interview on 05/08/2025 at 10:39 AM, the Administrator stated the residents could use the side rails for repositioning themselves in bed. The Administrator stated his expectations were nurses would ensure consents were completed prior to installing side rails, and staff would complete quarterly assessments related to the continued use of side rails.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35314</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to store continuous positive airway pressure (CPAP) masks in a manner that limited the spread of infection for 2 (Resident #22 and Resident #47) of 2 sampled residents reviewed for respiratory care.</p> <p>Findings included:</p> <p>A facility policy titled, CPAP/BiPAP [bilevel positive airway pressure] Support, revised 03/2015, revealed, General Guidelines for Cleaning, that specified, 9. Storage of equipment: Head gear/mask/nasal pillows when not in use will be stored in a bag labeled with date and changed weekly.</p> <p>1. An Admission Record revealed the facility admitted Resident #22 on 03/05/2025. According to the Admission Record, the resident had a medical history that included diagnoses of cancer of the left bronchus or lung, obstructive sleep apnea, and shortness of breath.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/12/2025, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #22 received intermittent oxygen therapy and utilized a CPAP machine as a non-invasive mechanical ventilator.</p> <p>Resident #22's Care Plan Report, included a focus area initiated 03/06/2025, that indicated the resident was at risk of complications with the respiratory system due to lung cancer with shortness of breath and sleep apnea. Interventions directed staff to provide CPAP as ordered (initiated 03/06/2025).</p> <p>Resident #22's Order Summary Report, revealed an order dated 03/05/2025, for CPAP/BiPAP at bedtime for sleep apnea.</p> <p>An observation on 05/05/2025 at 2:07 PM revealed Resident #22's CPAP mask was on top of the dresser next to the resident's bed. The CPAP mask was not in a bag, and it was in direct contact with the surface of the dresser.</p> <p>An observation on 05/06/2025 at 8:49 AM revealed Resident #22's CPAP equipment, including the CPAP mask and tubing, was on top of the dresser. The CPAP mask was uncovered and was placed directly on the top of the dresser.</p> <p>2. An Admission Record revealed the facility admitted Resident #47 on 03/10/2025. According to the Admission Record, the resident had a medical history that included diagnoses of asthma, obstructive sleep apnea, atelectasis (collapsed lung), and shortness of breath.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2025, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #47 utilized a CPAP machine as a non-invasive mechanical ventilator.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #47's Care Plan Report, included a focus area initiated 03/22/2025, that indicated the resident had CIPAP/BiPAP therapy related to obstructive sleep apnea. Interventions directed staff to provide CPAP at the setting of 7-20 (initiated 03/22/2025).</p> <p>Resident #47's Order Summary Report, revealed an order dated 03/10/2025, for CPAP/BiPAP at bedtime for sleep apnea.</p> <p>An observation on 05/05/2025 at 11:46 AM revealed Resident #47's CPAP machine was on the dresser on the right side of the bed. The mask and tubing were uncovered and rested on the top surface of the dresser.</p> <p>An observation on 05/06/2025 at 8:47 AM revealed the CPAP mask was uncovered, on top of Resident #47's dresser.</p> <p>During an interview on 05/07/2025 at 12:08 PM, Licensed Vocational Nurse (LVN) #2 stated she was currently assigned to Resident #47, and also cared for the resident on 05/06/2025. LVN #2 confirmed the resident's CPAP mask should be stored in a bag. LVN #2 said the night shift nurse was responsible for ensuring CPAP equipment was stored properly.</p> <p>During an interview on 05/07/2025 at 10:00 AM, Certified Nurse Assistant (CNA) #1 stated that when residents finished using their CPAP machines, the equipment should be kept in a bag. CNA #1 stated nurses were responsible for ensuring CPAP masks were placed inside bags.</p> <p>During an interview on 05/07/2025 at 10:11 AM, the Assistant Director of Nursing (ADON) stated nursing staff should ensure CPAP masks and tubing were stored in bags after use. She stated masks should not be left on the top of residents' dressers without being placed in bags related to infection control practice, as they could get dirty or fall to the floor.</p> <p>During an interview on 05/07/2025 at 11:53 AM, the Infection Preventionist (IP) confirmed that a CPAP mask should not be uncovered on a resident's dresser. The IP stated CPAP masks should be placed inside dated bags which were hung on the CPAP machines. The IP stated the date should reflect when the mask was last cleaned. The IP stated she previously had to redirect staff regarding not leaving CPAP masks on dressers to ensure masks did not fall to the floor or get dirt or debris inside them.</p> <p>During an interview on 05/08/2025 at 7:13 AM, LVN #3 stated that after a resident had completed using the CPAP machine, the mask should be cleaned and placed inside a bag.</p> <p>During an interview on 05/08/2025 at 10:07 AM, the Director of Nursing (DON) stated the expectation was nurses would place CPAP masks in bags after use. The DON stated bags should be dated and changed every week and as needed. The DON said if CNAs noticed that a mask was not in a bag, they should place it in a bag for infection control.</p> <p>During an interview on 05/08/2025 at 10:53 AM, the Administrator stated staff thought the respiratory therapist was responsible for placing CPAP equipment into a bag. The Administrator stated the facility staff dropped the ball and did not ensure the CPAP equipment was placed in bags and dated.</p>		