STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555163	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Care Center	5225 South J Street Oxnard, CA 93033

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 2) was protected from physical and verbal abuse from a fellow resident (Resident 1) who was having undirected behavioral symptoms and outbursts. This facility failure resulted in Resident 2 being slapped by Resident 1 and sustaining bruises (purplish/reddish skin discoloration) to the left arm and hand. Findings: During a review of Resident 2's admission Record (AR), the AR indicated, Resident 2 had diagnoses including, chronic obstructive pulmonary disease (lung disease that makes breathing difficult), acute and chronic respiratory failure with hypoxia (low oxygen levels in the blood), anxiety disorder (excessive feelings of worry, fear, and unease that significantly interfere with daily life), and depression (feeling of sadness, hopelessness, and loss of interest in activities previously enjoyed). During a review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR), dated 5/24/25, the SBAR indicated, around 1 a.m. Resident 2 was slapped by another resident (Resident 1), staff intervened and separated both residents. The SBAR further indicated, on 5/24/25 evening shift 3-11 p.m., Resident 2 was observed with physical signs of injury described as bruising to the right arm and hand. The SBAR with evening nursing notes dated 5/26/25 indicated dark red colored bruise on left shoulder, arm, and hand. Further review of the SBAR which was started on 5/24/25 by night shift - 5/27/25, the bruises found on Resident 2 were identified not on the right hand and arm but on the left shoulder, arm, and hand. During a review of Resident 2's Care Plan (CP), dated 5/26/25, the CP indicated, bruising (purplish/reddish skin discoloration) on the resident's left arm and shoulder. During a concurrent observation and interview on 6/2/25 at 5:18 p.m. with Resident 2, Resident 2 was observed with a large bruise on the left forearm. Resident 2 stated that Resident 1 had accused her of stealing cigarettes and shampoo and then slapped her on the left arm. Resident 2 stated, A Certified Nursing Assistant (CNA) had to pull Resident 1 off of me. Resident 2 further stated not feeling safe being in the same room with Resident 1 and did not want to move to another room unless the other roommate (Resident 3) changed rooms too. In addition, Resident 2 stated the police had been at the facility at least six to seven times that week because of Resident 1's behavior. (continued on next page)

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

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Clinical Record, the Clinical Record indicated, Resident 1 had multiple mental and behavioral undirected outbursts secondary to existing behavioral diagnoses including, psychosis (loss of contact with reality, symptoms of hallucinations, delusions and disorganized thinking) and unspecified schizophrenia (mental disorder characterized by disruptions in thinking, perception, emotions, and social interactions). Further review of Resident 1's Clinical Record, indicated, on 5/24/25, Resident 1 had a verbal and physical altercation with a roommate (Resident 2), resulting in Resident 2 sustaining bruises on the left arm. Resident 1's clinical record further indicated, from 5/9/ through 5/29/25 the facility had numerous documentation regarding the resident having undirected aggressive behaviors towards staff and other residents. The crisis team and law enforcement were also called in to the facility due to the escalation of behaviors. The psychiatrist plan was to provide 1:1 staff for Resident 1. During an observation and record review on 6/2/25 at 5:52 p.m. in the facility's smoking patio, Resident 2 was smoking in the same area as Resident 1 with no visible 1:1 staff. During a review of Resident 1's Physician Progress Notes, dated 5/29/25 at 12:10, the Notes indicated, PLAN: facility will continue 1:1 staffing. During an interview on 6/2/25 at 6 p.m. with the Director of Nurses (DON), the DON acknowledged that it is the facility's responsibility to protect the residents. During a review of the facility's policy and procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting, dated 10/2022, the P&P indicated in part, Each resident has the right to be free from abuse . Resident to Resident abuse means the willful infliction of injury .with resulting physical injury, pain or mental anguish by one resident towards another.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's Interdisciplinary Team (IDT - a group of medical staff that work together to provide care of residents) failed to initiate a Significant Change in Status Assessment (SCSA - a comprehensive assessment) for one of four sampled residents (Resident 1) when: 1. Resident 1 refused to take schizophrenia (mental disorder that affects how a person thinks, feels, and behaves), depression (persistent feelings of sadness that interfere with daily life) and other medications. As a result, Resident 1 developed severe symptoms of distress including psychosis (loss of touched with reality), delusions, hallucinations, and paranoia. 2. Resident 1 showed physical and verbal aggression towards other residents and staff, and refused to follow the facility's smoking rules. These failures resulted in Resident 1's escalating behavior becoming more erratic, with increased aggressiveness toward others. No appropriate clinical interventions were implemented, which placed residents and staff at risk for danger and harm when Resident 1 started a fire in the facility. Findings: Review of Centers for Medicare & Medicaid Services (CMS), version 1.20.1 dated October 2025, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, page 45, in the section titled, Significant Change, in Status Assessment (SCSA) the Manual indicated, The SCSA .must be completed when the IDT has determined that a resident had a major decline .in status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. 1. During a review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including, fracture of right and left calcaneus (breaks in both heel bones), psychosis (loss of contact with reality, symptoms of hallucinations, delusions and disorganized thinking), schizophrenia, chronic pain, opioid (controlled pain medication) dependence, anxiety (feeling of apprehension, tension, and uneasiness) disorder, and depression. Resident 1 was admitted with orders for Physical Therapy (PT) to address admitting condition of right and left heel bone fractures. 1. During a review of Resident 1's Medication Administration Record (MAR), dated 5/1/25 to 5/31/25, the MAR indicated on: 5/8/25 - Resident 1 began refusing the Pro-Stat supplement and incentive spirometer treatments (use of a handheld device to help take slow, deep breaths and expand lungs). The refusal continued the month of May. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/18/25 - Resident 1 began refusing to take aripiprazole (medication used to manage and treat mental conditions such as schizophrenia, and depression) and sertraline (medication used to treat depression, anxiety, and improve mood). The refusal of Resident 1 to take the medications (aripiprazole and sertraline) continued 5/20, 5/21, 5/24, 5/25, 5/26, 5/27, and 5/28/25. According to Talkspace.com-Abrupt discontinuation of Aripiprazole (Abilify) can lead to a range of withdrawal symptoms, which may include: Neuropsychiatric: Anxiety, restlessness, agitation, irritability, decreased concentration, and mood changes, cause neuroadaptation in the brain, where the brain adjusts to having a new level of dopamine. Suddenly stopping the medication can disrupt this balance, potentially leading to withdrawal symptom and can also increase the risk of a relapse or return of the symptoms that the medication was intended to treat. It's crucial to consult with a doctor before stopping Abilify to ensure a safe and effective tapering plan. There was no evidence in Resident 1's clinic record of an IDT review or determination to initiate a SCSA from 5/18/25 to 5/28/25 when the resident started refusing the regular ordered dose of aripiprazole and sertraline. 2. During a review of Resident 1's PNR dated 5/24/25, the PNR indicated, Resident 1 left facility without signing self out per facility's policy. During a review of Resident 1's Change in Condition Nurse's Notes (CIC), dated 5/25/25, the CIC indicated, the evaluation was due to behavioral symptoms (e.g. agitation, psychosis). The physical assessment outcome indicated, new or worsened delusions or hallucinations and other symptoms or signs of delirium (e. g. inability to pay attention, disorganized thinking) for mental status and physical and verbal aggression, danger to self or others, other behavioral symptoms for behavioral status. There was no evidence in Resident 1's clinic record of an IDT review or determination to initiate a SCSA in reference to the CIC for behavioral symptoms dated 5/25/25. During further review of Resident 1's clinical record, the PNR indicated on: 5/9/25 - Resident 1 began displaying symptoms of agitation (restlessness, inability to stay calm, paranoia, suspiciousness, irritability, hostility, confusion, disorientation, inability to communicate, and violent behavior) starting on 5/9/25 and continued 5/13, 5/21, 5/24, and 5/26/25. 5/21/25 - Resident 1 started displaying increased symptoms of verbal aggression towards others. 5/24/25 - Resident 1 had a verbal and physical altercation with a roommate (Resident 2) on 5/24/25, resulting in Resident 2 sustaining bruises on the left arm. 5/25/25 - Resident 1 became verbally and physically aggressive towards a licensed staff (LN 8). 5/25/25 - The crisis team was called to address the physical aggression of Resident 1 in the facility. The facility was informed the crisis team can't respond to any physical aggression secondary to a hands-off approach. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/27/25 - The crisis team was called again regarding Resident 1's behavior, history of slapping another resident, refusing medication administration, and for being verbally and physically aggressive. The crisis team arrived at the facility, talked to Resident 1 and offered to take the resident to the hospital. Resident 1 refused and claimed not wanting to go back to the psychiatric hospital and will sue the psychiatric hospital. Resident stated her cigarettes and medications were poisoned including that people were being raped. The crisis team stated they can't do anything for the resident or the facility but if the resident continued to refuse medications and meals to call them again to reassess. 5/28/25 - Resident 1 became verbally and physically aggressive towards LN 6. 5/28/25 - Resident 1 took the one-on-one caregiver s notes away, tore several pages from the notebook and started a fire with the torn pages in the patio smoking area. 5/28/25 - The crisis team was called again regarding Resident 1's behavior outside the facility (referring to the fire started in the facility patio area). The crisis team responded, Since there is no suicidal ideation or homicidal ideation, we can't do anything about her behavior. 5/28/25 - The police were called regarding resident's behavior of lighting a fire in the facility's smoking area. LN 1 asked Resident 1 for her lighter, Resident 1 attempted to hit LN 1's arm but the police stopped the resident. The police indicated they can't take the resident out of the facility due to a mental health condition and that the resident had to be moved to a different facility by social services or administration. 5/29/25 - The police were called back to the facility again in regard to Resident 1 starting a fire in the room. While waiting for the police to arrive, Resident 1 took a cell phone from nearby, LN 7 asked the resident to give the cell phone back and Resident 1 threatened to kill LN 7. The resident refused to return the cell phone until the police showed up. The police were able to retrieve the lighter that was used to start a fire inside the Resident 1's room. 5/29/25 - A resident informed LN 7 of being assaulted when Resident 1 ran into his wheelchair. 5/29/25 - Resident 1 threatened the Administrator (ADM) by throwing coffee at the ADM when resident was asked to surrender her lighter for safe keeping. Resident 1 refused to turn in the lighter. 5/29/25 - MD notes indicated a visit to see Resident 1 in the facility. The police and crisis team had been at the facility numerous times over the past four days. Resident 1 stopped taking ordered behavioral medications, is psychotic, paranoid, and delusional, has assaulted several staff and residents, last night started a fire in her room. The police had confiscated her lighter last night, but the resident was able to obtain more this morning. The police were not able to arrest the resident despite the arson and assault on staff and residents due to mental health. Resident was admitted from a psychiatric facility secondary to jumping off a table and breaking both feet. Resident is now refusing to eat and take medications. The crisis team in the building with MD to assess the resident but the crisis team will not take the resident on a 5150 (involuntary 72-hour psychiatric hold) due to resident not posing a threat to self or others. The plan indicated the facility will continue 1:1 staffing, call 911 as needed, and file an APS (Adult Protective Services) report. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/1/25, Resident 1 left the facility again (first episode on 5/24/25) without signing self out as per facility's policy. There was no evidence in Resident 1's clinic record of an IDT review or determination to initiate a SCSA in reference to behavioral changes/escalation which began on 5/9/25. During an interview on 6/2/25 at 5 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had an altercation with Resident 2 one week prior. The DON stated that Resident 1 slapped Resident 2. Resident 1 was having behavioral issues. During a concurrent observation and interview on 6/2/25 at 5:18 p.m. with Resident 2, Resident 2 was observed with a large bruise on left forearm (purplish/reddish skin discoloration). Resident 2 stated that Resident 1 had accused her of stealing cigarettes and shampoo and then slapped her on the left arm. A Certified Nursing Assistant (CNA) pulled Resident 1 off of Resident 2. Resident 2 further stated not feeling safe being in the same room with Resident 1 and did not want to move to another room unless the other roommate (Resident 3) changed rooms too. During an observation on 6/2/25 at 5:52 p.m. in the facility's smoking area, Resident 1 was smoking in the same area a few steps away from Resident 2. No facility staff/supervision was visible within the perimeter smoking area. R 1 was observed to be heading towards the unlocked smoking area gate leading to the facility parking lot. Resident 1 then stopped and laid down on the grassy area near the gate. During an interview on 6/2/25 at 6:05 p.m. with Resident 4, who was within the smoking area with other residents also smoking, Resident 4 stated that Resident 1 went bonkers when she stopped taking meds, would push other residents with the wheelchair, would make other residents spill their coffee on themselves, and was verbally abusive to residents and staff. Resident 4 further stated that Resident 1 started a fire with a lighter and was concerned she will burn the whole place down. A review of the facility's initial admission assessment dated [DATE] indicated Resident 1 had no behavioral symptoms, including physical (hitting, grabbing), and verbal. The MDS assessment additionally indicated Resident 1 did not have behavioral symptoms that impacted any other residents. During an interview on 6/2/25 at 10 p.m. with the Minimum Data Set Registered Nurse (MDS-RN), and the DON, the MDS RN stated that an MDS assessment was performed on Resident 1 upon admission, but no other assessments were done. The DON confirmed that no SCSA or other additional MDS assessments were completed when Resident 1 had changes in behavior. The DON indicated no assessments had been performed since Resident 1's admission. During a review of the facility's policy & procedure (P&P) titled, Psychoactive Medication Management, dated August 2014, the P&P indicated, in part, When a resident presents with symptoms or behavior that causes impairment in function, alteration in emotional well-being, or a danger to the resident or others, it is the responsibility of the IDT to determine if the emotional or behavioral symptoms may be caused by a transient medical condition, or reversible environmental and/or psychological stressor. This can be assessed through the MDS/CAA process or by a team evaluation documented in the IDT notes.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), had their health status accurately documented on the admission Minimum Data Set (MDS: a comprehensive assessment that helps nursing home staff identify health problems and track the improvement or decline of those problems). This failure had the potential to result in an inaccurate plan of care, compromising the resident's quality of life and leading to unmet needs, inappropriate interventions, and negative health outcomes. Findings: During a review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was admitted on [DATE] with diagnoses that included, fracture of right and left calcaneus (breaks in both heel bones), psychosis (loss of contact with reality, symptoms of hallucinations delusions and disorganized thinking), unspecified schizophrenia (psychotic symptoms that do not meet the criteria for a more specific schizophrenia spectrum or other psychotic disorder), chronic pain, opioid (moderate to severe pain medication) dependence, anxiety (feeling of apprehension, tension, and uneasiness) disorder, and depression (persistent sadness or loss of interest that interferes with daily life). During a review of Resident 1's MDS, dated [DATE], the MDS sections (I) Active Diagnoses and (J) Fall History on Admission/Entry or Reentry did not accurately reflect Resident 1's health status when questions J1700A, J1700B, and J1700C were marked no which indicated, Resident 1 did not have a fall any time in the last month, in the last 2-6 months, or had sustained a fracture related to a fall in the 6 months prior to admission/entry or reentry. During review of Resident 1's Psych (psychiatric) Discharge Note (PDN), dated 3/06/25, and Health and Physical (H&P), dated 3/7/25, the PDN and H&P did not indicate a diagnosis of schizophrenia. The PDN indicated, Resident 1 was discharged with diagnoses of, anxiety disorder, opiate dependency, and psychosis. The H&P indicated, Resident 1 had diagnoses of, left and right calcaneus fractures, anxiety, and opiate dependency. During review of Resident 1's Order Summary Report (OSR), dated 6/5/2025, the OSR indicated, Resident 1 was prescribed aripiprazole (medication used to manage and treat mental conditions) for psychosis and sertraline (medication used to treat depression, anxiety, and improve mood) for depression. During a concurrent interview and record review on 6/12/25 at 3:18 p.m., with the Minimum Data Set Coordinator (MDS-C), Resident 1's Medication Administration Record (MAR) and MDS were reviewed. MDS-C stated questions J1700A, J1700B, and J1700C in section J of the MDS were incorrectly answered as no and should have been answered as yes. MDS-C acknowledged the MAR indicated Resident 1 was prescribed aripiprazole for psychosis and that the H&P did not include a diagnosis of schizophrenia. MDS-C stated schizophrenia was selected as an active diagnosis in section I of the MDS because the PDN indicated Resident 1 had a history of schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/13/25 at 11:13 a.m. with the MDS-C and the Director of Nursing (DON), the CMS manual titled, Long-Term Care Facility Resident Assessment Instrument 3.0 (a manual that provides guidance on completing the MDS), dated 10/2025, section I for Active Diagnoses was reviewed. DON and MDS-C acknowledged the absence of a comprehensive psychiatric evaluation and documentation of currently treating Resident 1 for the diagnosis of schizophrenia. Review of the CMS manual titled, Long-Term Care Facility Resident Assessment Instrument 3.0, dated 10/25, the Manual indicated, on page 341, in the section titled, Steps for Assessment, Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current .medical treatments .during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses .Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an active diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan (a plan that includes clear goals to meet a resident's needs) when: 1. Female staff were not consistently assigned to Resident 1 as care planned. This failure had the potential to cause emotional distress and compromise Resident 1's psychosocial well-being. 2. Resident 1's cam boot (foot/ankle brace) was replaced with a non-weight-bearing immobilizer cast (a stiff wrap that keeps an injured area stable) on the left foot with no protocol in place for care. This failure had the potential to result in poor circulatory function and delayed healing of Resident 1's left foot fracture. Findings: During a review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including, psychosis (loss of contact with reality, hallucinations, delusions and disorganized thinking) and unspecified schizophrenia (mental disorder characterized by disruptions in thinking, perception, emotions, and social interactions) and fracture of right and left calcaneus (breaks in both heel bones). Resident 1's primary purpose for admission was for physical therapy. 1. During a review of Resident 1's Care Plan (CP), dated 5/26/25, the CP indicated, risk for decline in psychosocial well-being. CP interventions included, Assign a female staff to do 1:1 (one-to-one; one staff member to provide direct, continuous supervision and/or care) CNA (certified nursing assistant) to help with ADL's (activities of daily living). During a review of Resident 1's Interdisciplinary Team (IDT) notes, dated 5/26/25, the IDT indicated, continue 1:1 supervision with female staff. During a review of the facility's Daily Assignment Sheets (DAS), dated 5/24/25 through 6/2/25, the DAS indicated, male staff were assigned as 1:1 caregivers for Resident 1 on 5/29/25 and 5/30/25. During an interview on 6/13/25 at 11:13 a.m. with the Director of Nursing (DON), the DON acknowledged male staff were assigned to provide 1:1 care for Resident 1 on 5/29/25 and 5/30/25, contrary to the formulated care plan dated 5/26/25 specifying that only female staff should be assigned. 2. During a review of Resident 1's Orthopedic Progress Note (OPN), dated 4/11/25, the OPN indicated, a non-weight bearing immobilizer cast to left foot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Care Plan (CP), dated 3/5/25, the CP titled, Alteration in musculoskeletal status r/t (related to) fracture of left and right calcaneus had no update for the 4/11/25 order of non-weight bearing immobilizer cast to left foot. Further review of the care plan indicated, no interventions in relation to the circulatory function of the left foot while wearing an immobilizer cast. During an interview on 6/13/25 at 11:13 a.m. with the Director of Nursing (DON), DON acknowledged Resident 1's cam boot was changed to a non-weight bearing immobilizer cast on left foot. DON confirmed Resident 1's care plan was not updated to reflect the current immobilizer cast in use/care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Care Center	5225 South J Street Oxnard, CA 93033

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain infection control practices in one of two sampled residents (Resident 2) when Resident 2's respiratory care equipment was not stored in a manner to prevent cross-contamination (accidentally transferring harmful bacteria) or labeled/dated. These facility failures had the potential to result in cross-contamination that could negatively impact Resident 2's health and safety and cause preventable HAIs (Healthcare Associated Infections). Findings: During a review of Resident 2's admission Record (AR), the AR indicated, Resident 2 had diagnoses including, chronic obstructive pulmonary disease (lung disease that makes breathing difficult), acute and chronic respiratory failure with hypoxia (low oxygen levels in the blood), anxiety disorder (excessive feelings of worry, fear, and unease that significantly interfere with daily life), and depression (feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). During an observation on 6/2/25 at 5:18 p.m. inside Resident 2's room, a nebulizer (a device that produces a fine spray of liquid for inhaling a medicinal drug) that was not being used was on the bedside table without any dates on the tubing and not stored in a bag/enclosed container. Resident 2's nasal cannula oxygen tubing (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) had no date indicating when the oxygen tubing was last changed. During a concurrent observation and interview on 6/2/25 at 5:40 p.m. with Licensed Nurse (LN1), LN1 observed Resident 2's nebulizer was not stored in a plastic bag and the oxygen tubing was not dated. LN1 acknowledged the nebulizer tubing and oxygen tubing must be dated so staff know when to change them, and the nebulizer should be stored inside a plastic bag when not in use. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated August 2014, the P&P indicated, g. Label humidifier with date and time opened. During a review of the facility's P&P titled, Nebulized Medication/Hand-Held Nebulizer, dated 2008, the P&P indicated in part, .store in a plastic bag that is labeled with the resident name and room number.