STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555187	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catalina Island Health	100 Falls Canyon Rd Avalon, CA 90704

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to submit complete and verifiable Payroll-Based Journal ([PBJ] a mandatory, auditable data system used by the Centers for Medicare & Medicaid Services {CMS}) staffing data to CMS for quarter 2 of 2026 (1/1/2026, through 3/31/2026).The facility's failure to submit required staffing information had the potential to affect CMS oversight of nursing staffing levels and the facility's ability to demonstrate compliance with federal staffing reporting requirements, which could impact the care and services provided to residents.Findings:During a review of the facility's PBJ staffing data report dated 06/05/2026, the PBJ staffing data report indicated no staffing data had been submitted to CMS for quarter 2 of 2026 (1/1/2026, through 3/31/2026).During an interview on 06/10/2026, at 8:48 a.m., with the Director of Nursing (DON), the DON stated many of the facility's nursing staff were agency/travel personnel. The DON stated the facility needed to integrate traveler staffing information into the payroll system and upload the information to CMS. The DON stated the facility failed to submit the required PBJ data because the payroll interface was not connected to CMS and that no one had informed her that the systems were not linked. The DON acknowledged she was unaware the staffing reports had not been submitted to CMS as required. The DON stated the facility would work with department heads and responsible staff to ensure staffing information was accurately compiled and submitted on a quarterly basis to prevent future delays.During a review of the facility's policy and procedure (P&P) titled Reporting Direct Care Staffing Information (Payroll-Based Journal) dated 06/05/2023, the P&P indicated Direct care staffing information Is reported electronically to Centers for Medicare & Medicaid Services (CMS) through the payroll- based journal system (PBJ). Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter.

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in a safe and sanitary manner. The facility had four residents receiving an oral diet. The facility failed to:1.Ensure open bags of frozen french fries and frozen ravioli were labeled with open dates.2.Ensure open containers of hot sauce, ground white pepper, dash original seasoning, chili powder, cayenne pepper, corn tortillas, white bread, dry pasta, cheese and garlic croutons, vanilla wafers, and shortbread cookies were labeled with open dates.3.Ensure an open container of liquid whole eggs and a clear plastic tub of peaches stored in the refrigerator were labeled with open dates.These failures had the potential to place residents at risk for developing foodborne illnesses (illnesses resulting from eating contaminated or spoiled foods) and could reduce the quality of food served in the facility.Findings:During a concurrent initial kitchen observation and interview on 6/09/2026 at 9:10 a.m. with the Dietary Supervisor (DS), multiple open food items in the dry storage area, refrigerator, and freezer were observed without open dates. The DS stated he had planned to work with his staff and implement a new system to ensure open dates were placed on food containers once they were opened.During an interview on 6/10/2026 at 10:05 a.m. with Dietary Aide (DA) 1, DA 1 stated any time a food item was opened, an open date needed to be placed on the container to help ensure the food remained fresh when served to residents. DA 1 stated residents' could develop a foodborne illness if they were served spoiled food.During an interview on 6/10/2026 at 10:19 a.m. with the Dietary Supervisor (DS), DS stated any time a food item was opened, it had to be labeled with an open date to ensure the food remained safe to serve. He stated the open date functioned as the quality date for the item. The DS stated improper storage of food items could decrease the flavor and quality of the food. He stated residents with compromised immune systems (weakened defense to infection) could develop a foodborne illness if they were served food that was not fresh.During an interview on 6/11/2026 at 7:21 a.m. with the Director of Nursing (DON), the DON stated open dates were placed on food items to ensure the food was served fresh. The DON stated there was a potential for foodborne illness if a food item did not have an open date after it was opened.During a review of facility's policy and procedure(P&P) titled, Food labeling & Dating of Kitchen Items, the P&P indicated This policy establishes requirements for labeling and dating of all food items stored, prepared or used within the dietary department to ensure food safety, prevent food borne illness, reduce waste, and maintain compliance with federal, state and accreditation standards. The P&P indicated all food items stored or prepared in the kitchen, including refrigerated, frozen and dry storage items, must be properly labeled and dated at the time of preparation, opening or storage.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) was notified for one of four sampled residents (Resident 4) who was hospitalized on [DATE].This failure violated the rights of Resident 4 by not notifying the Ombudsman to ensure Resident 4's discharge was safe and appropriate.Findings:During a review of Resident 4's admission Record, the admission Record indicated, Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4 had a diagnosis including hypertension (high blood pressure), myocardial infarction (heart attack) and angina (chest pain).During a review of Resident 4's History and Physical (H&P), dated 5/17/26, the H&P indicated, Resident 4 did have the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Set (MDS-resident assessment tool) dated 6/9/26, the MDS indicated, Resident 4's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated, Resident 4 was independent (no assistance from helper), with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 4's Discharge Progress Note dated 5/16/26, the Discharge Progress Note indicated, Resident 4 was discharged and admitted to the general acute care hospital (GACH) on 5/16/26 for mastoiditis (infection of the bone behind the ear).During a concurrent interview and record review on 6/11/2026 at 12:05 p.m. with Registered Nurse 1 (RN 1), RN 1 stated she could not find the Ombudsman notification for Resident 1 who was transferred to the GACH on 5/16/26 for mastoiditis. RN 1 stated the Ombudsman should have been notified that the resident was no longer in the care of the facility to ensure the discharge was appropriate. RN 1 stated the Ombudsman served as the advocate for the residents.During an interview on 6/11/2026 at 7:21 a.m. with the Director of Nursing (DON), the DON stated the Ombudsman should have been notified as soon as Resident 4 was transferred to the GACH and no longer in the care of the facility to ensure the discharge was appropriate to meet the needs of the resident.During a review of the facility's policy and procedure (P&P) titled Resident Rights and Responsibilities (undated), the P&P indicated, When a resident requires a transfer or a discharge is initiated by the facility, a written notice must be provided to the resident/representative, and a copy must be sent to the Ombudsman at the same time. This notice is not required if the resident initiates discharge.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure annual performance evaluations were conducted for three sampled staff members Certified Nursing Assistant (CNA 1, CNA 2, CNA 3) and one Licensed Vocational Nurse (LVN 2).This deficient practice had the potential to affect the facility's ability to assess staff performance, identify training needs, and ensure staff competency in providing quality care to residents.Findings:During a concurrent interview and record review on 6/10/2026 at 11:28 a.m., with the Director of Human Resources (DHR), personnel files were reviewed for the following employees:CNA 1 - Hire date: 8/21/2017CNA 2 - Hire date: 12/4/1997CNA 3 - Hire date: 7/2023 and rehired 05/01/2025LVN 2 - Hire date: 4/20/2024Personnel records indicated all four employees lacked documented annual performance evaluations for calendar years 2024 and 2025.The DHR stated she had been in her position for approximately two months and had recently realized the importance of ensuring employee performance evaluations were completed annually.During an interview on 06/10/2026 at 1:12 pm with the Director of Nursing (DON), the DON stated she took her position at the end of 2025. The DON stated she had been working on staff training, in-services, and competency assessments; however, there was no established system left in place from prior leadership to ensure annual performance evaluations were completed. The DON stated annual performance evaluations were important for resident safety, staff development, identifying performance goals, and improving employee performance.During an interview on 06/10/2026, at 4:55 p.m., with CNA 1, CNA 1 stated annual performance evaluations were important because resident needs, equipment, and care practices change over time. CNA 1 stated annual evaluations help ensure resident safety and quality of care. CNA 1 stated she could not recall when her last annual performance evaluation or competency assessment was completed but acknowledged the importance of maintaining and tracking performance reviews.During a follow-up interview on 06/11/2026, at 09:01 a.m., with LVN 1, LVN 1 stated that annual competency assessments and performance evaluations were important to measure staff performance and identify areas for improvement. LVN 1 stated a performance evaluation may have been completed by the Director of Nursing in either 2023 or 2024 but was unable to recall the exact date. LVN 1 stated the importance of conducting annual evaluations to ensure staff competency and ongoing professional development.During a review of facility's policy and procedure(P&P) titled, Performance Evaluation (undated), the P&P indicated The facility endeavors to review each employee performance on an annual basis. The performance evaluations are intended to make you aware of your progress, areas for improvement and objectives or goals for future work performance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications and biologicals (group of medications) were properly labeled and stored in the medication storage rooms. The facility failed to:1.Ensure three open packages of houseˆsupply albuterol sulfate inhalation solution (breathing treatment), not assigned to a specific resident, were labeled with an open date while stored in a cupboard.2.Ensure the medication room refrigerator functioned properly, as ice buildup was observed on the back wall of the refrigerator and multiple boxes of insulin (used to control blood sugar) and tetanus vaccines (used to protect against bacterial infections) were stored in a pool of standing water inside the refrigerator.These failures had the potential to result in decreased medication potency, ineffective treatment, and adverse health outcomes for residents who rely on properly stored medications and biologicals.Findings:During an observation on 6/09/2026 at 3:23 p.m. in the medication storage room, observed three open packages of albuterol sulfate inhalation solution did not have open dates on the packaging.During an observation on 6/09/2026 at 3:23 p.m. in the medication storage room, the medication refrigerator was observed with melting ice buildup on the back wall, and multiple boxes of insulin and tetanus vaccines were stored in a pool of standing water inside the refrigerator.During an interview on 6/09/2026 at 3:28 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the three packages of albuterol sulfate solution did not have open dates and confirmed they should have been labeled with open dates. LVN 1 stated she was not sure what was wrong with the refrigerator. She stated there should not be ice buildup or standing water inside the refrigerator.During an interview on 6/10/2026 at 9:30 a.m. with LVN 1, LVN 1 she stated albuterol sulfate needed an open date because the medication could deteriorate, lose its potency, and become ineffective. LVN 1 stated the issue with the medication refrigerator was related to the coils and the temperature had not been properly regulated. She stated the temperature must be regulated to maintain the integrity of the medications. LVN 1 stated residents could experience adverse reactions due to the possibility of bacteria growing in improperly stored medications.During an interview on 6/11/2026 at 7:41 a.m. with the Director of Nursing (DON), the DON stated open dates were required to ensure medications were not used past a specific date, as medications could lose their potency and may not be as effective. The DON stated the refrigerator needed to be functioning properly to maintain the stability of the medications and to prevent any adverse reactions for the residents.During a review of facility's policy and procedure (P&P) titled, Medication labeling and Storage, (undated), the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature humidity and light controls. The P&P indicated medication, and biologicals are stored in the packaging, container or other dispensing systems in which they are received. The P&P indicated medications in bulk containers contains labels withv medication name, strength, quality, accessory instructions, lot number and expiration date.During a review of facility's policy and procedure (P&P) titled, Medication refrigeration Equipment Failure and Medication Protection, (undated), the P&P indicated, Medications shall be stored within the manufacturer- recommended temperature ranges at all times. The P&P indicated any refrigerator or freezer malfunction, temperature excursion, water intrusion, ice buildup, power interruption, or other condition that may compromise medications integrity shall be treated as a potential medication storage event. The P&P indicated medication stored in a refrigerator or freezer that experiences a malfunction shall immediately evaluated usability. The P&P indicated equipment failure may include but not limited to ice buildup affecting operation, water accumulation inside the unit.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews and record review, the facility's Quality Assessment and Assurance (QAA-ongoing, facility-wide management process used to monitor clinical and administrative services, to ensure resident care meets established standards) Committee failed to provide effective oversight and monitoring to ensure sustained compliance with the facility's Plan of Correction (POC) for deficiencies cited during the previous recertification survey. Specifically, the QAA Committee failed to identify, monitor, and implement corrective actions to prevent the recurrence of deficiencies related to Payroll-Based Journal (PBJ- a mandatory, auditable data system used by the Centers for Medicare & Medicaid Services [CMS]) reporting, nurse aide performance reviews, and food labeling and storage practices.This deficient practice resulted in repeat deficiencies in the same areas during the current recertification survey.Findings:During a review of the facility's Statement of Deficiencies from the 2025 recertification survey revealed citations related to PBJ reporting, nurse aide performance reviews, and food labeling and storage practices.During a concurrent interview and record review on 06/11/ 2026, at 8:51 a.m., with the Director of Nursing (DON), the DON stated the facility had received deficiencies in PBJ reporting, nurse aide performance reviews, and food labeling and storage during the previous recertification survey in 2025. The DON stated she was not employed at the facility during the prior survey but acknowledged the deficiencies had recurred. The DON stated the facility would continue efforts to address these issues and prevent repeat deficiencies in the future.During a review of the facility's policy and procedure (P&P) titled Quality Assurance and Performance improvement (QAPI) revised 03/2020, the P&P indicated The QAPI is implemented and maintained to address identified priorities, and is based on data, resident and staff input and other information that measures performance and focuses on problems and opportunities that reflect processes, functions and services provided to the residents.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and record review, the facility failed to ensure Certified Nurse Assistants (CNAs) completed a minimum of 12 hours of annual in-service education for CNA 1, CNA 2, and CNA 3.This failure to provide the required annual in-service training has the potential to affect the CNAs' knowledge, skills, and competence in providing safe and effective care to residents.Findings:During a review of employee training records conducted on 06/10/2026 at 11:28 a.m., with the Director of Human Resources (DHR) and License Vocational Nurse (LVN 1), the records indicated CNA 1, CNA 2, and CNA 3 had not completed the required 12 hours of annual in-service training for the review period.During a concurrent interview and record review on 06/10/2026 at 1:12 p.m., with the Director of Nursing (DON) reviewed the training records for CNA 1, CNA 2, and CNA 3. The DON stated CNA 1, CNA 2, and CNA 3 had not completed the required 12 hours of annual inˆservice education. The DON stated annual inˆservice training was required to ensure staff maintained competency and provided safe, quality care to residents. She acknowledged the facility failed to ensure compliance with the annual training requirement. She stated although she assisted with CNA inˆservices, most of her inˆservice responsibilities focused on licensed nursing staff. The DON stated the missed training was due to staffing changes but reported she would work to ensure all required inˆservice hours were completed.