STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555326	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Mountain Rehabilitation & Healthcare Center	11895 Avenue of Industry San Diego, CA 92128

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to ensure dignity was maintained for one out of six residents (Resident 320) when Resident 320's urine collection bag was not concealed from public view. This failure had the potential to negatively affect the resident's psychosocial well-being. Findings: Resident 320's clinical record was reviewed and indicated he was admitted to the facility on [DATE] with muscle weakness, urinary retention (inability to eliminate urine completely) per the facility's Admission Record. During an observation conducted on 5/7/24 at 11:08 A.M. in the facility hallway, Resident 320's urine bag was observed hanging on the wheelchair. The collection bag was not covered, and the content was visible. A concurrent observation and interview were conducted with Licensed Nurse (LN) 31 on 5/7/24 at 11:15 A.M. LN 31 stated, Resident 320's urine collection bag was seen by the people passing in the hallway and further stated, the urine collection bag must be covered to provide dignity and respect to the resident. During an interview with the Director of Nursing (DON) on 5/10/24 at 11:15 A.M., the DON stated urine collection bags must be placed inside a privacy bag to prevent other people from seeing the contents and to provide respect to the resident. Review of the facility's policy, Quality of Care, Catheter Care, Indwelling, [undated], the policy stated 13. Cover drainage bag with privacy bag.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to ensure their policies on medication self-administration (resident takes medication without staff assistance) were implemented for one of one sampled resident (Resident 101) when the facility did not determine the resident was clinically appropriate and safe to self-administer a medication. This failure had the potential to result in unsafe medication administration. Findings: Review of Resident 101's clinical record indicated she was admitted on [DATE] with diagnoses which included hypertension (elevated blood pressure), diabetes mellitus (DM - elevated blood sugar) per the facility's Admission Record. An observation and interview were conducted with Resident 101's son on 5/7/24 at 10:05 A.M. inside Resident 101's room. A tube of triamcinolone cream (medication to treat skin condition) was on the bedside table. Resident 101's son stated he applied the medication to Resident 101's itching skin. A joint interview and record review were conducted with Licensed Nurse (LN) 32 on 5/7/24 at 10:15 A.M. LN 32 stated Resident 101's physician order record did not indicate a triamcinolone order. LN 32 further stated if a resident wants to self-administer medications, the facility should do an assessment, obtain a physician's order, and develop a care plan. LN 32 stated the triamcinolone medication should have not been inside the room to prevent misuse of the medication. An interview conducted with the Director of Nursing (DON) on 5/10/24 at 2:04 P.M. The DON stated residents should have been assessed for self-administration and the medication should not be left inside the resident's room to prevent inappropriate use. Review of the facility's policy Self Administration of Medications [undated] indicated, .2. If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in resident's status .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to address resident's needs for one of 29 sampled residents (Resident 316) when the resident's call light (device used to call staff's assistance) was not placed within reach. This failure had the potential for Resident 316's needs not being met. Findings: Review of Resident 316's clinical record indicated he was admitted to the facility on [DATE] with displaced fracture (break in the bone) of right femur (leg), history of falling, difficultly in walking. Resident 316's minimum data set (MDS, an assessment tool), dated 5/9/24 indicated Resident 316 was cognitively intact. During an observation and interview on 5/7/24 at 9:20 A.M. inside Resident 316's room. Resident 316's call light was observed dangling on the headboard. Resident 316 stated I need help and I can't reach my button. Resident 316's son was inside the room and pressed the button for Resident 316. An interview was conducted on 5/7/24 at 11:05 A.M. with Licensed Nurse (LN) 32. LN 32 stated, residents call lights should be placed within their reach to call for staff's assistance. During an interview with the Director of Nursing (DON) on 5/10/24 at 1:30 P.M., the DON stated call lights should be placed within residents' reach to alert staff of residents' needs. Review of the facility's policy and procedure (P&P) titled Routine Procedure Call Light/bell [undated], the P&P indicated 5. Leave the resident comfortable. Place the call device within resident's reach before leaving the room .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38542 Based on interview and record review, the facility failed to ensure the Physician Order for Life-Sustaining Treatment (POLST- a written medical order from a healthcare provider based on patient preferences on the type of medical treatment they want to receive during serious illness) was signed by the physician in a timely manner for one of two sampled residents reviewed for advance directives (Resident 62). As a result, the POLST was not valid for a patient who wished to be on Do Not Attempt Resuscitation (DNR-allow natural death) in case of a serious illness. Findings: Resident 62 was admitted to the facility on [DATE] with diagnoses which included heart failure per the facility's Admission Record. On 5/8/24 a review of records was conducted. The POLST indicated Resident 62 wanted to be DNR. There was no physician signature on the document. On 5/9/24 at 3:50 P.M., an interview with the Social Services Director (SSD) was conducted. The SSD stated for new admission residents, the nurse, physician and social worker would discuss and verify the POLST with the resident. The SSD stated the physician should have signed the document within 48 hours of the physician's visit and discussion with the resident. The SSD stated if the POLST was not completed, including the physician's signature, then the document was not valid and the default code status would be full code (includes intubation, medication and cardio-pulmonary resuscitation). On 5/10/24 at 9:43 A.M., an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated if the POLST did not have a physician's signature, the document was not valid and no matter what the resident's wishes were during a code, the resident will be a full code. LN 1 stated the physician had to sign the POLST within three days. On 5/10/24 at 3:25 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the POLST had to be completed in all areas. The DON stated if the document was not signed by the physician or the resident/responsible party, then the patient would be automatic full code. Per the original POLST document, .Completing the POLST .To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and the (2) patient or decision maker. Per the facility's undated policy and procedure titled Resident Assessment Advance Directives/POLST, POLICY: The facility recognizes and respects the resident's right to choose his/her treatment and make decisions about care to be received at the end of his/her life.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview and record review, the facility failed to ensure the staff protected the confidential information of two of 29 sampled residents (Resident 216 and Resident 215) when the computer monitors were left open and unattended. This failure had the potential for the residents' personal and confidential medical information to be visible to unauthorized persons. Findings: Resident 216 was admitted to the facility on [DATE] with a diagnoses which included fracture of sacrum (a large triangular bone at the bottom of the spine) per the facility's Admission Record. Resident 215 was admitted to the facility on [DATE] with a diagnoses which included right supracondylar and humeral fracture (right shoulder fracture) per the facility's Admission Record. An observation was conducted on 5/7/24 at 9:56 A.M. on the Medication Cart #1's computer monitor in the hallway outside of room [ROOM NUMBER]. The unattended computer monitor was observed open with Resident 216's medical record. An interview was conducted on 5/7/24 at 10:03 A.M. with Licensed Nurse (LN) 11. LN 11 stated the computer monitor with Resident 216's medical record was open and patient information was left unattended. LN 11 stated the resident's medical information should have been protected from any unauthorized persons. LN 11 stated it was important to close the computer monitor with Resident 216's medical information to provide confidentiality. An observation was conducted on 5/8/24 at 8:40 A.M. on Medication Cart #1's computer monitor in the hallway outside of room [ROOM NUMBER]. The unattended computer monitor was observed with Resident 215's medical record. An interview was conducted on 5/8/24 at 8:45 A.M. with LN 4. LN 4 stated the computer monitor with Resident 215's medical record and patient information was open and left unattended. LN 4 stated she should have closed the computer monitor with Resident 215's medical information. An interview was conducted on 5/10/24 at 8:29 A.M. with the Director of Nursing (DON). The DON stated the computer monitor with resident's information should have been closed when unattended. The DON stated it was important to ensure resident's medical records were protected and treated with confidentiality. A review of facility's policy and procedure titled Resident - Medical Information (undated) indicated POLICY: It is the policy of this facility that our facility treats all resident information on a confidential basis. PROCEDURES: 1. Resident records .will be safeguarded to protect the confidentiality of the information. 2. Access to resident medical records will be limited to the staff and consultants providing services to the resident .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview, and record review the facility failed to ensure a homelike environment was provided for two of 29 sampled residents (Resident 50 and Resident 216) when the bedrails' black foam was ripped, torn and in disrepair condition. This failure had the potential to negatively impact the resident's comfort, well-being, and quality of life. Findings: 1. Resident 216 was admitted to the facility on [DATE] with diagnoses which included fracture of sacrum (a large triangular bone at the bottom of the spine) per the facility's Admission Record. An observation was conducted on 5/7/24 at 10 A.M. in the room of Resident 216. Resident 216's bedrail was observed with a wrapped black foam on both sides of the bed. Both the right and left bedrails' black foam had multiple ripped and torn areas. An interview was conducted on 5/7/24 at 10:05 A.M. with Resident 216. Resident 216 stated she does not feel being cared for because her bedrail foam coverings were broken. An interview was conducted on 5/7/24 at 1:10 P.M. with Resident 216's daughter. Resident 216's daughter stated she was concerned with the ripped and broken foam of Resident 216's bedrail. Resident 216's daughter further stated the torn foam coverings were disrespectful to the resident. 2. Resident 50 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis of one side of body) following cerebral infarction (damage of brain tissue due to loss of oxygen on the brain) per the facility's Admission Record. An observation was conducted on 5/7/24 at 4:15 P.M. in the room of Resident 50. Resident 50's left side bedrail was observed with a wrapped black foam. Resident 50's left siderails' black foam was falling apart and was wrapped with a black tape and had multiple ripped and torn areas. An interview was conducted on 5/10/24 at 11 A.M. with Resident 50's spouse. Resident 50's spouse stated, it would make him feel better if the facility would fix the ripped and torn black foam. A joint observation and interview was conducted on 5/9/24 at 11:57 A.M. with the House Keeping Supervisor (HKS). The HKS stated the bedrail's black foams were ripped and broken. The HKS stated the black foams condition should have been reported to maintenance and should have been fixed or replaced. An interview was conducted on 5/10/24 at 8:41 A.M. with the Director of Nursing (DON). The DON stated the ripped and broken black foam should have been replaced or removed. The DON stated that it was important that resident's equipment and items were in good working condition as it would make the resident feel at home. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled Environmental Conditions/ Environmental Rounds (undated) indicated .POLICY: It is the policy of this facility that the facility must provide a safe, functional, sanitary, comfortable and home-like environment for residents .

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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** 38542 Based on interview and record review, the facility failed to ensure care plans were developed for: 1) psychotropic (drugs that affect mood, behavior, thoughts and perception) medications and 2) code status (an instruction on what the medical team should do if a resident had a cardiac or respiratory arrest) for two of two sampled residents (Resident 6 and Resident 62): As a result, there was a potential for 1) Resident 6's psychotropic medications were not managed appropriately and 2) Resident 62's code status was not followed. Findings: 1) Resident 6 was readmitted to the facility on [DATE] with diagnoses which included major depressive disorder (a type of mood disorder) and anxiety disorder (a type of mental health disorder characterized by feelings of worry or fear) per the facility's Admission Record. On 5/10/24 a review of records was conducted. The Order Summary Report dated 4/5/24 indicated the physician ordered to administer psychotropic drugs to Resident 6. On 5/10/24 at 3:43 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated psychotropic drugs for Resident 6 had to be addressed and a care plan should have been developed. 2) Resident 62 was admitted to the facility on [DATE] with diagnoses which included heart failure per the facility's Admission Record. On 5/8/24 a review of records was conducted. The Physician Order for Life-Sustaining Treatment (POLST- a written medical order from a healthcare provider based on patient preferences on the type of medical treatment they want to receive during serious illness) indicated Resident 62 wanted her code status to be Do Not Resuscitate (DNR - allow natural death). On 5/10/24 at 3:40 P.M., an interview with the DON was conducted. The DON stated Resident 62's code status had to be incorporated into the plan of care and a care plan should have been developed. Per the facility's undated policy and procedure titled Care Planning/Care Conference, POLICY: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.

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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** 45909 Based on observation, interview and record review, the facility failed to ensure personal care was provided for one of three sampled residents (Resident 319) when Resident 319 had white, crusty substance on the inner side of her eyes. This failure had the potential to result in poor personal hygiene and decreased psychosocial well-being. Findings: Review of Resident 319's clinical record indicated she was admitted to the facility on [DATE] with diagnoses which included difficulty in walking, traumatic subdural hemorrhage (injury to the brain) per the facility's Admission Record. Resident 319's Minimum Data Set (MDS, an assessment tool) indicated she required maximum assistance with shower/bathing. During an observation on 5/7/24 at 9:35 A.M., inside Resident 319's room, Resident 319's inner eyes were observed with white, crusted substance. A joint observation and interview were conducted with Licensed nurse (LN) 2 on 5/07/24 at 12:05 P.M. LN 2 stated Resident 319 had a white, crusty substance on the inner side of her eyes. LN 2 stated Resident 319's eyes should have been cleaned and attended to within two hours of the shift by the nursing staff. An interview was conducted with the Director of Nursing (DON) on 5/10/24 at 2:14 P.M. The DON stated residents who were dependent on staff with their personal care should be cared for promptly to provide comfort and respect. Review of the facility's policy, Routine Procedure Morning Care revised 5/2007 indicated, Give resident moist cloth and towel for cleaning hands and face, assisting if necessary.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38542 45063 Based on observation, interview and record review, the facility did not ensure staff followed physician's orders when : Resident on daily weight was not weighed daily on 1 of 2 residents (Resident 41) These failures had the potential to result in decreased physical and psychosocial well being for the residents. Resident 41 was admitted to the facility on [DATE] with diagnoses which included Morbid (severe) obesity due to excess calories and Chronic Kidney disease Stage 3 per facility's Admission Record. On 5/7/24 at 10:34 A.M. a concurrent observation and interview with Resident 41 was conducted in Resident 41's room. Resident 41 was on a wheelchair waiting for his lunch. Resident 41 stated the facility was supposed to weigh him daily to monitor his weight. Resident 41 stated the facility sometimes were not weighing him everyday. On 5/7/24 at 10:49 A.M. , a review of records was conducted. The physician's order dated 1/11/2022 indicated Daily Weights to be completed, everyday shift. On 5/10/24 at 10:05 A.M. an interview and record review with Restorative Nursing Assistant (RNA) 1 was conducted. RNA 1 stated he was responsible for weighing residents in the facility. RNA 1 stated he gives report to Licensed Nurses (LN) of resident' s weight and document residents's weight in the Electronic Medical Record (EMR). RNA 1 stated there were no weights recorded for Resident 41 on dates : 5/1/24. 5/2/24. 5/3/24 and 5/4/24. RNA 21 stated if there were no weights recorded , Resident 41 was not weighed. On 5/10/24 at 10:45 A.M.an interview and record review with Charge Nurse (CN) 21 was conducted. Resident 41 orders included Daily Weights to be completed, everyday shift dated 1/11/22. CN 21 stated there were no weight recorded on dates: 5/1/24, 5/2/24,5/3/24 and 5/4/24. CN 21 stated Resident 41 should have been weighed daily as ordered. CN 21 stated weighing Resident 41 daily was important to monitor weight gain and water retention. On 5/10/24 at 3:20 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 41 should had been weighed daily as ordered. The DON stated it was important to weigh Resident 41 daily to monitor weight accurately and possible water retention. A review of the facility's policy titled, Nursing Services, Physician Orders, (undated), indicated , It is the policy of this facility to accurately transcribe and implement orders A review of the facility's policy titled , Routine Procedures, Weight, (undated), indicated It is the policy of this facility to obtain an accurate weight as part of the resident's assessment . .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38542 Based on observation, interview and record review, the facility failed to ensure Restorative Nursing Assistance (RNA- care to improve or maintain functional ability) was conducted per the physician's order for one of two sampled residents reviewed for limited range of motion (Resident 6). As a result, there was a potential for development of further contractures (chronic loss of joint mobility) for Resident 6. Findings: Resident 6 was readmitted to the facility on [DATE] with diagnoses which included contracture of muscle, left upper arm and quadriplegia (paralysis of all four extremities) per the facility's Admission Record. On 5/9/24 at 9:49 A.M., an observation of Resident 6 was conducted. Resident 6 was in bed, both upper arms were noted to be contracted. On 5/10/24, a review of records was conducted. The physician order dated 4/5/24 indicated to begin RNA program three times per week for three months on both upper and lower extremities. Resident 6's RNA flowsheet for the month of April 2024 indicated: Week of 4/8, Resident 6 had RNA two times per week Week of 4/15, Resident 6 had RNA one time per week Week of 4/22, Resident 6 did not have RNA On 5/10/24 at 2:29 P.M., an interview with Restorative Nursing Assistant (RNA) 1 was conducted. RNA 1 stated Resident 6 was in RNA program because Resident 6 had contractures on both upper and lower extremities. On 5/10/24 at 3:09 P.M., an interview with Minimum Data Set Coordinator (MDS) 1 was conducted. MDS 1 stated Resident 6's RNA program should have started when the physician order for it was written. MDS 1 stated there would be a risk for contractures when the staff did not perform the RNA for Resident 6. On 5/10/24 at 3:57 P.M., a joint interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated based on the staff's documentation, RNA was not conducted three times a week for Resident 6. Per the facility's undated policy and procedure titled Restorative Care, POLICY: 2. The resident will receive services to attain and maintain the highest possible mental/physical functional status .defined by the comprehensive assessment and plan of care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38542 Based on observation, interview and record review, the facility failed to ensure tube feeding (TF-nutrition in liquid form through a tube) was labeled appropriately per the facility's policy for two of three residents reviewed for TF (Resident 6 and Resident 106). As a result, there was a potential the residents may not receive the adequate amount of TF per physician order. Findings: Resident 6 was readmitted to the facility on [DATE] with diagnoses which included encounter for attention to gastrostomy (opening in the stomach created surgically) per the facility's Admission Record. On 5/9/24 at 9:49 A.M., an observation of Resident 6 in the room was conducted. A TF bag was noted to be dated 5/8/24 and running at 55 milliliters (mls) per hour. There was no time on the TF bag when it was started to be administered to Resident 6. On 5/9/24 at 9:54 A.M., a joint interview and record review with Licensed Nurse (LN) 2 was conducted. The physician order for TF for Resident 6 indicated Resident 6 was to be administered TF at 55 mls/hour for 20 hours until dose was completed. LN 2 stated the TF bag should have been labeled with the time it was administered to make sure when the TF needed to be completed. LN 2 stated she forgot to label the TF bag the day before when she connected the TF to Resident 6. On 5/9/24 at 12:26 P.M., an interview with the Director Of Nursing (DON) was conducted. The DON stated the paper sticker/label that was on the TF bag needed the resident's name, date, time and initials of the LN administering the TF. The DON stated the right documentation was part of the six rights of medication administration. Per the facility's undated policy and procedure titled Enteral Feeding Administration, .PROCEDURES: 2. Label bag with .time . 43674 Resident 106 was admitted to the facility on [DATE] with diagnoses which included pneumonitis (inflammation of the lungs) per the facility's Admission Record. An observation was conducted on 5/7/24 at 9:35 A.M. in Resident 106's room. Resident 106's Intravenous (IV) pole was observed with a hanging TF pump set connected to a water bag and TF formula bag .The TF formula and water bolus bags were not labeled with the time the TF was started, the amount to be infused and the staff initials. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint interview and record review was conducted on 5/9/24 at 2:30 P.M. with the Director of Nursing (DON). The DON stated the facility's policy for TF administration was to administer the TF formula with a label that indicated the resident's name, the amount to infuse, the date and time it was administered, and initial of the administering staff. An interview was conducted on 5/10/24 at 8:29 A.M. with the Director of Nursing (DON). The DON stated it was important for the TF to be labeled per policy to ensure TF orders were followed. An interview was conducted on 5/10/24 at 9:06 A.M. with Licensed Nurse (LN) 13. LN 13 stated the TF formula and water bags should be labeled with resident's name, date, and time the TF was started, the rate of the infusion, and initial of the staff. Per the facility's undated policy and procedure titled Enteral Feeding Administration, .PROCEDURES: . 2. Label bag with formula, resident's name, amount, date, time, and initials.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45063 Based on observation, interview and record review, the facility failed to ensure the staff was able to verbalize the accurate steps in administering a tube feeding (TF - nutrition in liquid form through a tube) for one of three residents (Resident 20). This failure had the potential to negatively affect Resident 20's health. Findings: Resident 20 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory (lung) failure, with tracheostomy (an incision in the windpipe made to relieve obstruction to breathing),connected to a ventilator (a device used medically to support the breathing) per Facility's Admission Record. On 5/9/24 at 9:25 A.M., a joint observation, interview and record review with Licensed Nurse (LN) 13 was conducted. Resident 20 was in his room with TF through gastrostomy (an opening into the stomach from the abdominal wall made surgically for introduction of food). The physician order for Resident 20 indicated TF at 50 milliliters (ml) per hour for 20 hours. LN 13 stated the process for administering a TF bag. LN 13 was not able to verbalize the need to verify the physician's order as part of the process of administering a TF bag. LN 13 stated verifying physician's orders was important for resident's safety. On 5/10/24 at 10:19 A.M. an interview with the Charge Nurse (CN) 22 was conducted. CN 22 stated it was important to verify physician's orders first before administering a TF bag to a resident to make sure a resident gets the right formula, right rate, and had no allergic reactions with the formula. On 5/10/24 at 3:30 P.M. an interview with the Director of Nursing (DON) was conducted. The DON stated LNs should verify the physician's orders first to make sure the right formula, right rate were followed. Per the facility's undated policy and procedure titled Enteral Feeding Administration, .PROCEDURES: . 1. Verify physician's orders .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview, and record review the facility failed to ensure medication was administered accurately to one of 29 sampled residents (Resident 17) when the Licensed Nurse (LN) administered a medication without properly identifying the resident. This failure had the potential for residents to be administered with wrong medications. Findings: Resident 17 was admitted to the facility on [DATE] with diagnoses which included diverticulitis (inflammation) of large intestine with perforation (rupture) and abscess (pus) per the facility's Admission Record. An observation was conducted during medication administration on 5/10/24 at 8:19 A.M. with LN 14. LN 14 verbalized that she was ready to administer the medication to Resident 17. LN 14 was observed walking to the bedside of Resident 17 with a medication. Resident 17 was observed without a wristband identification (ID). LN 14 did not check for Resident 17's wristband ID and did not ask for Resident 17's identifiers (name and date of birth). LN 14 administered the medication without checking for Resident 17's identifiers. An interview was conducted on 5/10/24 at 8:25 A.M. with LN 14. LN 14 stated she was aware that Resident 17 did not have an ID wristband. LN 14 stated she did not ask and confirm Resident 17's identifier prior to the medication administration. LN 14 stated she identified Resident 17 prior to administration of medication by checking the posted room number and resident's name outside the room. LN 14 further stated she shoud have identified the resident prior to the administration of medication by checking the resident's wristband ID and confirming the resident's identification. An interview was conducted on 5/10/24 at 8:29 A.M. with the Director of Nursing (DON). The DON stated the LN should identify the resident prior to administration of the medication. The DON stated identifying the resident was one of the Rights in medication administration. The DON stated if the resident does not have a wristband identification, the resident should have been identified using the photo in the patient profile, when available and confirm with another licensed staff the resident's identification. The DON stated the LN cannot use as identifier the resident's room number and name posted outside the room as it may not be accurate. The DON stated it was important to identify the patient prior to the administration of medication for patient safety. A review of facility's policy and procedure titled Medication Administration (undated) indicated .POLICY: It is the policy of this facility to accurately prepare and administer medications as ordered .2. Identify Resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview and record review, the facility failed to ensure all medications were locked for one of seven medication carts (Medication Cart # 1). This failure had the potential for Medication Cart # 1 to be accessed by unauthorized personnel. Findings: An observation was conducted on 5/7/24 at 9:56 A.M. in the hallway outside of room [ROOM NUMBER]. A Medication Cart (#1) was noted to be unlocked and unattended by a Licensed Nurse (LN). A joint observation and interview were conducted on 5/7/24 at 10:03 A.M. with LN 11. LN 11 was observed in room [ROOM NUMBER] with a resident. LN 11 later exited the resident's room and went to Medication Cart # 1. LN 11 stated the medication cart was left unlocked and unattended when she went inside room [ROOM NUMBER]. LN 11 opened the drawers of Medication Cart # 1 without unlocking it with a key. LN 11 stated the key lock button should have been pushed to lock the medication cart. LN 11 stated she should have locked the Medication Cart # 1, when she went inside the resident's room. An interview was conducted on 5/10/24 at 8:29 A.M. with the Director of Nursing (DON). The DON stated the medication cart should be locked when unattended. The DON stated it was important to ensure that medication carts were locked to prevent unauthorized access to the medication, for patient safety and for prevention of drug diversion (illegal distribution of medication). A review of facility's policy and procedure titled Medication Access and Storage (undated) indicated . PROCEDURES: 2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications .are allowed access to medications .Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38542 Based on observation, interview and record review, the facility failed to ensure the staff followed policy and procedure when: 1) opened food items were not labeled and dated properly 2) opened food item was not discarded by use by date and 3) a. knife had food debris on it and b. a kitchen staff did not change gloves after washing a used blender during food preparation. As a result, there was a potential for foodborne illness (illness caused by food contaminated by microorganisms and toxin) and cross-contamination (physical transfer of harmful bacteria). Findings: 1) On [DATE] at 7:50 A.M., a tour of the facility's kitchen was conducted. Inside a refrigerator, a plastic container with leftover pineapple slices was noted. There was no date on the container when the pineapple was first opened/prepared or needed to be used by. On [DATE] at 8:04 A.M., an observation of a shelf with bread in it was conducted. An opened package of bread buns and an opened package of hot dog rolls had no dates when they were opened or needed to be used by. One of the hot dog rolls was noted to have a greenish discoloration on it. On [DATE] at 3:27 P.M., a joint observation and interview with the Nutrition Service Director (NSD) was conducted. The opened container of pineapple slices was noted to be still in the refrigerator. The NSD stated a label with an opened by date and use by date should have been placed on the container because we do not know when it was opened. In addition, the NSD stated the opened package of bread should have been labeled with the opened by and use by date. The NSD stated the bread was good for seven days and should have been disposed of in the trash by then. On [DATE] at 3:57 P.M., a joint observation of the dry storage room was conducted with the NSD. A plastic container of powdered milk and a plastic container of breadcrumbs had no label when it was opened and had no use by date. The NSD stated the containers should have been labeled. On [DATE] at 4 P.M., an interview with the NSD was conducted. The NSD stated the best practice was to dispose of the unlabeled bread. On [DATE] at 2:57 P.M., an interview with Registered Dietitian (RD) 1 was conducted. RD 1 stated food should have been labeled with the received date, opened date and use by date. RD 1 stated the opened bread package should have been labeled and dated. RD 1 stated in general, bread and tortilla were good for five to seven days when not stored inside the refrigerator or freezer. RD 1 stated the bread should have been thrown away when it got moldy. RD 1 stated there was a potential for food poisoning if moldy bread was consumed or if food was expired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's policy and procedure titled Labeling and Dating of Foods dated 2023, POLICY: All food items in the storeroom, refrigerator and freezer need to be labeled and dated . Per the facility's policy and procedure titled Storage of Food and Supplies dated 2023, .PROCEDURES FOR DRY STORAGE: 6 . Bins/containers are to be labeled, covered and dated. 2) On [DATE] at 8:04 A.M., a joint observation of the kitchen preparation counter and interview with Cook 1 was conducted. There was an opened package of flour tortilla on the counter labeled with an opened by date of [DATE] and a use by date of [DATE]. The manufacturer's best by date indicated on the package was [DATE]. Cook 1 was not able to answer why the tortilla was on the kitchen counter. On [DATE] at 2:57 P.M., an interview with RD 1 was conducted. RD 1 stated in general, bread and tortilla were good for five to seven days when not stored inside the refrigerator or freezer. Per the facility's policy and procedure titled Dry Good Storage Guidelines dated 2023, .Food item .Tortillas, corn and flour .Unopened on Shelf 1 month Opened on Shelf Refrigerate Opened, Refrigerated 2 months. 3) a. On [DATE] at 7:50 A.M., a tour of the facility's kitchen was conducted. One of the knives on a magnetic knife holder was noted to have debris on it. On [DATE] at 3:33 P.M., an interview with the NSD was conducted. The NSD stated the knife should have been washed after use. On [DATE] at 2:57 P.M., an interview with RD 1 was conducted. RD 1 stated the knife should have gone through the dish machine and checked if there was still food debris. RD 1 stated there was a potential for foodborne illness if the knife was used to prepare food. Per the facility's policy and procedure titled Sanitation dated 2023, .PROCEDURE: 11. All utensils .shall be kept clean . b. On [DATE] at 10:30 A.M., a joint observation of pureed (cooked food that was blended to a creamy paste or liquid consistency) food preparation was conducted with the NSD and Food Services Consultant (FSC) 1. Cook 1 had gloves on when she pureed vegetables in a blender. Cook 1 washed the blender wearing the same gloves, and then prepared the pureed meat without performing hand hygiene and using new gloves. On [DATE] at 10:40 A.M., Cook 1 stated she should have changed her gloves after washing the blender to prevent cross-contamination of the food. On [DATE] at 10:45 A.M., an interview with the NSD was conducted. The NSD stated the staff should have removed her gloves, washed hands and used new gloves after washing the used blender before preparing another pureed food. On [DATE] at 2:57 P.M., an interview with RD 1 was conducted. RD 1 stated the staff should have changed gloves after washing the used blender before preparing the pureed food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's policy and procedure titled Sanitation dated 2023, .PROCEDURE: 17. All Food & Nutrition Services shall know the proper hand washing technique .19. Note that hands must be thoroughly washed and clean before handling clean dishes .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45063 Based on observation, interview and record review, the facility failed to ensure staff adhered to proper infection control practices when : 1. a resident's urinary catheter (a tube inserted into the bladder to aide in urine flow) bag and dignity bag (a bag used to cover and conceal contents inside), were laying on the floor on 1 of two residents (Resident 81). 2. the staff did not perform hand hygiene (HH- washing hands with soap and water or use of hand sanitizer to kill microorganisms a) after exit from resident's room and b) before entry to residents' room. 3. the staff did not perform HH in between glove changes a) during wound care and b) after glove removal and before putting on new glove. 4. the staff did not remove personal protective equipment (PPE) before exiting a resident's room on an Enhanced Barrier Precautions (EBP- precautions to prevent spread of infection that require the use of PPE during high-contact resident care activities); placed the basket of phlebotomy (blood draw) supplies on the clean phlebotomy cart and touched the cart with used gloves on. 5. facility staff did not clean and replace Resident 216 and Resident 50's bedrail (device to prevent resident from falling) foam covering. 6. Resident 87's bipap mask (device worn around the nose to deliver oxygen) was not stored inside a clean bag. These failures had the potential for cross contamination (spread of germs and bacteria) and infection to residents, staff and vsitors. Findings : 1. Resident 81 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection and sepsis (a serious infection in which the body responds improperly to an infection) per facility's Admission Record. On 5/7/24 at 11:08 A.M., an observation was conducted in Resident 81's room. Resident 81 had a urine drainage bag and it was resting on the floor. On 5/9/24 at 8:54 A.M., a joint observation and interview was conducted with Licensed Nurse (LN) 13. Part of resident 81's urine drainage bag surface was observed resting on the floor. LN 13 stated Resident 81's urine drainage bag should have not been been touching the floor because of cross contamination risk. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/9/24 at 10:30 A.M., an interview was conducted with the Infection Preventionist (IP). The IP stated Resident 81's urine drainage bag should not have been touching the floor because of the potential for cross contamination. On 5/10/24 at 3:15 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 81's urine drainage bag should not have been resting on the floor to prevent infection. According to Center for Disease Control and Prevention (CDC) Guidelines titled, Guideline for Prevention of Catheter Associated Urinary Tract Infections, dated 2009, indicated, .III.B.2.Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. 38542 2. a. On 5/9/24 at 8:20 A.M., an observation of Resident 62 in the room was conducted. Certified Nurse Assistant (CNA) 1 was observed assisting Resident 62 in setting up her meal. CNA 1 exited the room and put away the plate cover in the meal cart. CNA 1 did not perform HH after contact with Resident 62 and after exiting the resident's room. On 5/9/24 at 8:24 A.M., an interview with CNA 1 was conducted. CNA 1 stated she should have performed HH after exiting Resident 62's room. b. On 5/10/24 at 9:02 A.M., an observation of Resident 71 in the room was conducted. CNA 2 was observed setting up Resident 71's meal. CNA 2 exited the room and put away the plate cover in the meal cart. CNA 2 grabbed a straw and went back inside Resident 71's room. CNA 2 did not perform hand hygiene after exit and before entry to Resident 71's room. On 5/10/24 at 9:24 A.M., an interview with CNA 2 was conducted. CNA 2 stated she should have performed HH after putting away the plate cover. CNA 2 stated it was important to perform HH after contact with residents to stop germs from spreading. Per the facility's undated policy and procedure titled Hand Hygiene, .Procedure .Use alcohol-based hand rub .or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents .Before and after assisting a resident with meals . 3. a. On 5/9/24 at 9:27 A.M., an observation during wound care for Resident 97 was conducted. LN 3 performed wound care on Resident 97's heels with gloves on. After multiple glove changes, LN 3 ran out of clean gloves, removed the used gloves, did not perform HH and got more new gloves. b. On 5/10/24 at 9:06 A.M., an observation of Resident 71 in the room was conducted. LN 4 was observed administering medications to Resident 71. LN 4 removed a glove from one hand, did not perform HH and put on a new glove and went back to give medications to Resident 71. On 5/10/24 at 9:28 A.M., an interview with LN 4 was conducted. LN 4 stated she should have performed HH after glove removal to prevent infection from spreading. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's undated policy and procedure titled Hand Hygiene, .Procedure .Use alcohol-based hand rub .or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents .f. before donning sterile gloves .m. After removing gloves . 4. On 5/10/24 at 8:53 A.M., an observation outside of resident room [ROOM NUMBER] was conducted. There was an EHB sign by the resident's door. Certified Phlebotomy Technician (CPT) 1 was observed exiting the room with gown and gloves on. CPT 1 then placed the basket of phlebotomy supplies on the clean phlebotomy cart and touched the cart while still wearing the used gloves. On 5/10/24 at 8:56 A.M., an interview with CPT 1 was conducted. CPT 1 stated she performed blood draw for a resident in room [ROOM NUMBER] who was on EBP. CPT 1 stated she should have removed her PPE before exiting the resident's room. CPT 1 stated she was supposed to clean the phlebotomy supply basket before putting it on the clean cart. On 5/10/24 at 3:35 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the staff should have removed her gown and gloves before exiting the resident's room. The DON stated the phlebotomy cart was considered clean. Per the facility's provided document from the Centers for Disease Control and Prevention (CDC) titled How to Safely Remove Personal Protective Equipment (PPE), undated, .Remove all PPE before exiting the patient room . Per the facility's policy and procedure titled IPCP Standard and Transmission-Based Precautions dated 3/24, .Procedure 1. Standard Precautions are infection prevention practices that apply to the care of all residents, . e. Environmental cleaning and disinfection . Per the facility's undated policy and procedure titled Hand Hygiene, .Procedure .Use alcohol-based hand rub .or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents .r. After removing and disposing of personal protective equipment . 43674 5. Resident 216 was admitted to the facility on [DATE] with a diagnoses which included fracture of sacrum (a large triangular bone at the bottom of the spine) per facility's Admission Record. Resident 50 was admitted to the facility on [DATE] for diagnoses which included hemiplegia and hemiparesis (weakness and paralysis of one side of body) following cerebral infarction (damage of brain tissue due to loss of oxygen on the brain) per facility's Admission Record. An observation was conducted on 5/7/24 at 10 A.M. in the room of Resident 216. Resident 216's bedrail was observed with a wrapped black foam on both sides of the bed. Both the right and left bedrails' black foam had multiple ripped and torn areas. An observation was conducted on 5/7/24 at 4:15 P.M. in the room of Resident 50. Resident 50's left side bedrail was observed with a wrapped black foam. Resident 50's left bedrail's black foam was falling apart and was wrapped with a black tape and had multiple ripped and torn areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/7/24 at 1:10 P.M. with Resident 216's daughter. Resident 216's daughter stated she was concerned with the ripped and broken foam of Resident 216's bedrail. Resident 216's daughter stated looks dirty and unsanitary. An observation was conducted on 5/8/24 at 4:30 P.M in the room of Resident 216. Resident 216 was discharged home. The room was later observed unoccupied with clean bed and linens. The bed's bedrails with black foam was not fixed or removed. An observation was conducted on 5/9/24 at 10 A.M. in the room of Resident 216. Resident 216's room was occupied by another resident. Both the right and left bedrails' black foam were the same and had multiple ripped and torn areas. An interview was conducted on 5/9/24 at 11:57 A.M. with House Keeping Supervisor (HKS). HKS stated the bedrails' black foam's conditions were ripped and broken. HKS stated the black foam's condition should have been reported to maintenance and maintenance should have fixed or replaced the black foam. HKS stated the housekeeping would clean the room including the bedrails black foam with cloth wet with bleach regularly and terminally when the patient was discharged . HKS stated the black foam's condition could not be cleaned with the wet cloth with bleach and should have been removed. HKS stated the bed's bedrail was not properly cleaned and sterilized as it was ripped and torn, and it would only absorb the bleach. An interview was conducted on 5/9/24 at 4:37 P.M. with the Infection Preventionist (IP). The IP stated the expectation was for the bed's bedrails black foam to be removed after the patient was discharged or if the new admitted patient does not need them. The IP stated if the bedrail's black foam were ripped and torn, it should be removed as it could not be cleaned and sanitized. The IP further stated it was important to ensure the bedrail's black foam were intact so it could be cleaned and sanitized, to prevent the spread of bacteria. A review of facility's policy and procedure titled Environmental Conditions/ Environmental Rounds (undated) indicated .POLICY: It is the policy of this facility that the facility must provide a . sanitary . environment for residents . 45909 6. Review of Resident 87's clinical record indicated he was admitted to the facility on [DATE] with diagnoses which included chronic respiratory (lung) failure per the facility's Admission Record. A physician order dated 3/29/24 indicated bipap mask use at night. An observation was conducted on 5/7/24 at 9:15 A.M. inside Resident 87's room. A bipap mask was placed on a bedside table next to Resident 87's urinal. A joint observation and interview were conducted with Licensed Nurse (LN) 32 on 5/7/24 at 11:22 A.M. Resident 87's bipap mask was still observed on the bedside table next to Resident 87's urinal. LN 32 stated the bipap mask should have been placed inside a bag and should be away from the urinal to avoid cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555326	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Mountain Rehabilitation & Healthcare Center	11895 Avenue of Industry San Diego, CA 92128

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 - Some	An interview was conducted with the infection preventionist (IP) on 5/9/24 at 1:18 P.M. The IP stated bipap mask when not in use, should be stored inside a dated clean bag to prevent cross contamination. Review of the facility's policy, CPAP/BIPAP Use, revised 3/20/2019 indicated, Tubing and mask are to be stored into a designated bag/container after each use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555326	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38542 Based on observation, interview and record review, the facility failed to ensure fire extinguishers in the kitchen were inspected in a timely manner. As a result, there was a potential the fire extinguishers were not safe to be used. Findings: On 5/7/24 at 7:50 A.M., a tour of the facility's kitchen was conducted. There were three fire extinguishers noted with March 2024 as the last documented inspection date on the tags. On 5/7/24 at 3:48 P.M., an interview with Maintenance Assistant (MA) 1 was conducted. MA 1 stated he did not record the months of April and May 2024 inspection dates of the fire extinguishers on the tags. On 5/9/24 at 9:15 A.M., an interview with MA 1 was conducted. MA 1 stated the fire extinguishers should be checked monthly. On 5/9/24 at 9:56 A.M., an interview with MA 1 was conducted. MA 1 stated it was important to check the fire extinguishers to make sure they work. MA 1 stated when he checked the fire extinguishers, he would write it down on his notebook and rips the page and put it on the boss' computer or desk. MA 1 stated his boss would log it on an application (computer program). MA 1 stated there was no documentation on the application the fire extinguishers were inspected. On 5/9/24 at 12:11 P.M., an interview with the Maintenance Supervisor (MS) was conducted. The MS stated the fire extinguishers should be checked monthly to make sure they were in good operating condition. The MS stated the inspection was recorded on the application but was not able to show the actual documentation the fire extinguishers were inspected timely. On 5/9/24 at 12:16 P.M., an interview with the Maintenance Director (MD) was conducted. The MD stated the fire extinguishers' tags had to be marked on the first day of the month to make sure they were in good shape and ready to be used in case of a fire. The MD stated MA 1 needed proper education and training. Per the facility's provided document titled NFPA 10 Standard for Portable Fire Extinguishers, undated, PORTABLE FIRE EXTINGUISHERS 7.2.4 Inspection Record Keeping .7.2.4.3 At least monthly where manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.