

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Victoria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5445 Everglades Street Ventura, CA 93003	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure the observance of proper sanitation and food handling practices when dietary aid (DA 1) failed to use a beard net during food handling. This failure had the potential to result in foodborne illnesses among the residents. During an observation, on 6/22/26, at 9 a.m., in the kitchen, a dietary aid (DA 1), was observed sporting a goatee (a style of facial hair defined by a small, pointed, or tufted beard grown entirely on the chin). The goatee measured approximately 1 to 2 inches in length. Additionally, DA 1 had noticeable stubble on both cheeks and upper lip. DA 1 was not wearing a beard net. When asked why he was not wearing a beard net, DA 1 stated, I forgot. This exchange was witnessed by the registered dietician (RD). The RD acknowledged the observation and deficient practice. During tray line observation, on 6/22/26, at 12:20 p.m., DA 1 was observed in the tray line/food preparation area, standing over the steam table pans/trays containing food. DA 1 was scooping food into the individual resident trays. DA 1's beard net was observed positioned under his chin. DA 1's facial hair was unsecured by a beard net. Facial hairs shed and can potentially fall into the food being served to the residents. When asked why his beard net was under his chin and not covering his beard, DA 1 stated, I forgot. The RD was present and acknowledged the observation and interview with DA 1. During a review of the facility's policy and procedure (P&P) titled, Workplace Hygiene: Who Needs a Hair Restraint?, dated 1/20/25, indicated, Under FDA Food Code, all employees who enter the kitchen or food preparation area must wear a hair restraint, including anyone with a beard who must wear a beard net. Everyone entering a kitchen must wear a hair restraint to prevent contamination, and anyone with a beard must wear a beard net - answering the common question: are beard nets mandatory in food handling? Yes, in areas where food is prepared.		

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the plan of care (POC) for respiratory (breathing) condition and a wound infection isolation protocols were accurately reflected for two (2) of 35 sampled residents (Resident 1 & 146) when: Resident 1 use of suction machine to remove excess oral secretions (fluids). Resident 146 was placed both for contact isolation precautions and enhanced barrier precautions. This failure had the potential to hinder continuity of care, insufficient management of residents' needs and not to address all aspects of residents' condition including the infection control protocols without the updated and accurate information of the care plan. Findings: 1. During an observation and Resident 1's caregiver interview on 6/23/26, at 1:58 p.m. Resident 1 was observed to have occasional coughs while resting in bed. There was several medical equipment in the room including an oxygen concentrator, suction machine, tube feeding machine and Resident 1's head of the bed was observed to be elevated. According to Resident 1's caregiver, Resident 1 required oral suctioning to remove phlegm (thick, sticky mucus) and oral (mouth) secretions and had seen nursing staff using the suctioning machine. During a review of Resident 1's clinical record (CR), Resident 1's CR indicated that Resident 1 was re-admitted to the facility, arrived via stretcher, without signs of difficulty breathing, and no cough and had the following medical diagnosis Urinary Tract Infection (UTI - infection in urine), hypoxia (body not enough oxygen), COPD (Chronic Obstructive Pulmonary Disease - lung disease), and AKI (Acute Kidney Injury - kidney disease). Further review of the CR, Resident 1's plan of care for respiratory condition did not address the need for a suction machine. During a concurrent observation, interview and record review on 6/25/26, at 9:49 a.m. with the Assistant Director of Nursing (ADON), Resident 1's CR was reviewed. Resident 1 was visited in room [ROOM NUMBER], Resident 1 coughed; the suction machine by the bedside contained one-fourth filled whitish mucus-like contents. Resident 1's caregiver verified the use of the suction machine by the nursing staff to remove excessive secretions in Resident 1's mouth. The ADON stated that Resident 1's clinical record did not address the coughing episode and the need for oral suctioning in the plan of care. The ADON further stated that the physician and the responsible party (RP) will be notified and the care plan for respiratory will be updated. 2. During a review of Resident 146's Face Sheet (FS), dated 6/25, the FS indicated that Resident 146 was admitted to the facility on [DATE] with the following medical diagnosis: encephalopathy (brain not working properly), osteomyelitis of the lumbar vertebra (infection of the bone in the lower back), squamous cell carcinoma of the skin (skin cancer) and methicillin resistant staphylococcus aureus infection (MRSA - a type of bacteria that is immune to common antibiotics). During the facility tour observation conducted on 6/22/26, 10:35 a.m. observed a signage at the entry of room [ROOM NUMBER] for Enhanced Barrier Precautions (EBP - an infection control measures to prevent the spread of infection) the signage indicated, Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities - Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting, Device Care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. During the facility tour observation conducted on 6/22/26, 11:20 a.m. a signage at the entry of room [ROOM NUMBER] for Contact Isolation (specialized infection control used in healthcare setting). The signage indicated, Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gowns before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During a review of Resident 146's Physician's order (PO), dated 3/27, the PO indicated an order to place Resident 146 on Transmission Based Precautions (TBP - specialized infection control used in healthcare setting), contact isolation precaution (PPE - Personal Protective Equipment including mask, gown, eye protection, and gloves, single room placement with all services be brought to the resident (rehabilitation, activities, dining). Further review of the PO indicated an order for EBP, the same date the TBP was ordered. During a review of Resident 146's plan of care (POC) for wound infection related to MRSA, dated 3/31, the POC indicated TBP and EBP. During interview on 6/24/26, at 3:30 p.m. with the Infection Preventionist (IP 1), IP 1 explained that residents on contact isolation precaution must do hand hygiene first, put on PPEs that is gown, gloves, including mask if it is respiratory airborne precaution before entering the room, provide care, and then discard the used PPE in the trash bin inside the room then hand hygiene before exiting the room. While residents on EBP, the staff must put on the PPE for high contact resident care activities like doing patient care and wound care. If staff just talking to the resident and high contact activities are not expected, you don't need to put on PPE. During a concurrent interview and record review with the MDS coordinators (MDSC 1 & 2), Resident 146 MDS admission Assessment, PO, Medication Administration Record (MAR) and POC for wound infection were reviewed. MDSC 1 verbalized that Resident 146 was admitted with MRSA of the wound, was placed in strict contact isolation in a single room by herself and that all services were provided in the room. Resident 146's PO and POC indicated both TBP and EBP, and the MAR was signed off by the nurses. Both MDSC 1 & 2 was unable to provide the reason why the POC indicated both the TP and EBP if Resident 146 was on strict isolation precautions. During an interview on 6/25/26, at 1:28 p.m. with the Director of Nursing (DON), the DON acknowledged that the care plan was not updated and did not reflect the planned interventions implemented for caring for Resident 1's respiratory condition and Resident 146's contact isolation precautions. The DON further acknowledged that between EBP and TBP, the resident will be placed on stricter precautions, which is the contact isolation. During a review of the P&P titled, IPCP Standard and Transmission-Based Precautions, dated 1/2026, the P&P indicated, 2. Contact Precautions (Transmission-Based Precautions or TBP) are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment. a. Room placement: i. Residents on Contact Precautions should be restricted to their rooms and restricted from participation I group activities; Exception is for medically necessary care. ii. Contact Precautions are generally intended to be time limited and, when implemented include a plan for discontinuation or de-escalation due to room restrictions. Personal protective equipment (PPE): i. wear a gown and gloves for all interactions that may involve contact with the patient or patient's environment. ii. [NAME] PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens. Further review of the P&P indicated I part, .3. Enhanced Barrier Protection (EBP): used in conjunction with standards precautions and expand the use of PPE through the use of gowns and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. c. Examples of high-contact resident care activities requiring gown and glove use for Enhance Barrier Precautions include: i. Dressing, ii. Bathing/showering, iii. Transferring, iv. Providing hygiene, v. Changing linens, vi. Changing briefs or assisting with toileting, vii. Device care or use: central vascular lines, indwelling catheters, feeding tube. d. Room restriction: Residents are not (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restricted to their rooms or limited from participation in group activities while on EPB.e. Duration: Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that places them at higher risk.During a review of the facility policy and procedure (P&P) titled, Comprehensive Person Centered Care Planning, dated 4/2025, the P&P indicated in part, .the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.		

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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** Based on observation, interview, and record review, the facility failed to ensure an extended-release medication (medication formulated to release its active ingredients slowly into the bloodstream over a prolonged period) was administered accurately in accordance with written orders of the attending physician for one of 35 sampled residents (Resident 127). This failure had the potential to alter the absorption of the medication and can increase the risk of side effects and overdose. During a review of Resident 127's admission Record (AR), the AD indicated Resident 127 was admitted to the facility on [DATE] with diagnoses that include heart failure (condition where the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), chronic kidney disease (condition where the kidneys are unable to remove waste and excess fluid from the blood), and essential hypertension (high blood pressure). During a concurrent observation and interview on 6/23/26 starting at 8:36 a.m., with Licensed Nurse (LN) 2, LN 2 was observed preparing Resident 127's medications. LN 2 stated Resident 127 is unable to swallow whole tablets. LN 2 was observed crushing Resident 127's morning medications which included one tablet of Metoprolol Succinate Extended Release (ER) (long-acting medication used to treat high blood pressure). LN 2 was observed mixing the crushed medications in applesauce then administering it to Resident 127. During a concurrent interview and record review on 6/23/26 at 2:10 p.m., with LN 2, Resident 127's Order Summary Report (OSR), was reviewed. Resident 127's OSR indicated a physician's order for Metoprolol Succinate ER oral tablet 50 milligrams (mg - unit of measure) by mouth one time a day for hypertension and the order specifically indicated do not crush. LN 2 stated she was unaware that the metoprolol was extended release and explained that extended-release tablets should not be crushed. LN 2 confirmed she crushed the medication and should not have. During an interview on 6/25/26 at 2:12 p.m., with the Director of Nursing (DON), DON acknowledged extended-release medications should not be crushed. During a review of the facility's policy and procedure (P&P) titled Medication Administration - General Guidelines, undated, the P&P indicated, If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube fed, using the following guidelines. a. Long acting or enteric coated dosage forms should generally not be crushed; and alternative should be sought.		

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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 were properly stored when rectal and oral medications were observed stored next to each other in one medication cart. This failure had the potential to result in medication administration errors leading to adverse drug reactions, reduced effectiveness of treatment, and a decline in the resident's physical or mental well-being. During a review of the facility's policy and procedure (P&P) titled Storage of Medications, undated, the P&P indicated Orally administered medications are kept separate from externally used medications such as suppositories, liquids and lotions. During a concurrent observation and interview on 6/24/26 at 3:52 p.m. with the Assistant Director of Nursing (ADON), the following medications were observed next to each other in one compartment of the top drawer of the [NAME] Hall East medication cart: Two packages of acetaminophen suppositories (medication inserted rectally to reduce fever or for pain) One package of bisacodyl suppositories (medication inserted rectally to facilitate bowel movements) One bottle of dicyclomine (oral medication used to relieve stomach cramping) One bottle of antacid tablets (oral medication for upset stomach) One package of ibandronate (oral medication used to treat or prevent weak bones) Additionally, in the third drawer of the same medication cart, the following were observed next to each other: Two packages of bisacodyl suppositories Two packages of ondansetron oral tablets (medication for nausea) One package of sumatriptan oral tablets (medication for headaches) The ADON confirmed the above-mentioned medications were stored next to each other. During an interview on 6/24/25 at 4:25 p.m., ADON stated rectal medications and oral medications should not have been stored together. ADON confirmed they should have been stored separate and they were not.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its infection prevention and control practices when: Staff was observed handling soiled linen for one of 35 sampled residents (Resident 146), resulting in contaminated linen being improperly placed and managed, posing a risk of transmission of infectious agents. Soiled linen was observed left in the bathroom occupied by two unsampled residents (Resident 2 and Resident 3). 2. During a review of the facility's P&P titled, Soiled Linen, dated 5/2026, the P&P indicated, It is the policy of this facility to handle, collect, transport, process, and store soiled linen in a manner that minimizes the transmission of microorganisms, protects residents and healthcare personnel from exposure to infectious materials, and compiles the current CDC Standard Precautions and applicable federal, state, and local regulations. All personnel are responsible for following proper infection prevention practices when handling soiled linen. Collecting Soiled Linen 1. Soiled linen shall not come into contact with floor and furniture. During an observation and interview on 6/5, at 12:15 p.m. with the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) in room [ROOM NUMBER], Residents 2 and 3's bathroom, IP and DON identified and acknowledged that used soiled linens should never remain in the resident environment and should be disposed of properly. During a review of Resident 2's FS, dated 6/26, the FS indicated that Resident 2 was admitted on [DATE] with diagnoses including: Metabolic Encephalopathy (a temporary brain problem caused by the body being out of balance (such as dehydration, infection, or toxins)), Acute Kidney Failure (the kidneys suddenly stop working well, causing waste and toxins to build up in the blood), Vascular Dementia (memory loss, confusion, and changes in behavior caused by reduced blood flow to the brain), and Need for Assistance With Personal Care (the resident needs help with bathing, dressing, grooming, toileting, etc.). During a review of Resident 3's FS, dated 6/26, the FS indicated that Resident 3 was admitted on [DATE] with diagnoses including: Unspecified Dementia With Behavioral Disturbance (memory loss and thinking problems with possible agitation, wandering, or poor safety awareness), Cognitive Communication Deficit (problems with thinking skills that affect communication&mdash;like attention, memory, understanding, planning, and judgment), Need for Assistance With Personal Care (the resident needs help with bathing, dressing, grooming, toileting, etc.) and Acute Kidney Failure (the kidneys suddenly stop working well, causing waste and toxins to build up in the blood). Findings: During a review of the facility's P&P titled, Soiled Linen, dated 5/2026, the P&P indicated, It is the policy of this facility to handle, collect, transport, process, and store soiled linen in a manner that minimizes the transmission of microorganisms, protects residents and healthcare personnel from exposure to infectious materials, and compiles the current CDC Standard Precautions and applicable federal, state, and local regulations. All personnel are responsible for following proper infection (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention practices when handling soiled linen. Collecting Soiled Linen 1. Soiled linen shall not come into contact with floor and furniture. 3. Heavily soiled linen shall be put in a plastic bag before being taken to the soiled linen room. During an observation and interview on 6/23, at 2:30 p.m. with the hospice aid (HA), the HA was observed to be providing care to Resident 1. A pile of contaminated soiled linen was observed directly in contact with the floor. The HA was taken aback and then stated that the soiled linen must be in a plastic bag. During a review of Resident 146's Face Sheet (FS), dated 6/2026, the FS indicated that Resident 146 was admitted on [DATE] under hospice care services due to malignant neoplasm of the unspecified part of bronchus (lung) and bone, surgical aftercare following surgery of the nervous system (body's nerve signal communication), and anemia (lack of healthy blood cells that carry oxygen to the body). During an interview on 6/24, at 3:30 p.m. with the Infection Preventionist 1 (IP 1), IP 1 explained the facility's procedures for handling soiled linen. The IP 1 emphasized that soiled linens must never be placed on the floor instead, immediately following patient care, contaminated linens should be placed in a plastic bag and transported to the soiled linen room. IP 1 added that the IP is responsible for educating staff and ensures that all personnel, including hospice staff, are properly educated on infection prevention practices and protocols. During an interview on 6/25, at 1:28 p.m. with the Director of Nursing (DON), the DON acknowledged the current practices did not meet the required standards for infection control. In response to these deficiencies, the DON indicated that the facility would implement prompt coordination with the hospice agency to ensure that proper protocols are followed for the handling of soiled linens.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure routine inspections and maintenance of electrical equipment in the facility to ensure safe operating condition and the welfare of residents and staff. This failure resulted in a burnt electrical wall socket in the kitchen and had the potential to result in a fire in the facility. During an observation, on 6/22/26, at 9 a.m., in the kitchen, a burnt electrical wall socket was noted. The electrical wall socket is a multi-plug with 4 plug sockets which can accommodate 4 different appliances plugged simultaneously. The electrical wall socket is a 3-pronged plug socket (standard electrical connector that attaches a device to a power source. The third pin is called the ground pin. It connects to the metal casing of an appliance directly to the ground to protect users from electric shocks in case of an electric fault). During observation, 3 plugs were unused while the juicer machine was plugged into the 4th plug. During an interview, on 6/22/26, at 9:10 a.m., with the dietary supervisor (DS), in the kitchen, the DS said the burnt electric socket was due to a food warmer that used to be plugged in that location. During an interview, on 6/23/26, at 11 a.m., with the maintenance director (MNTD) and assistant maintenance director (AMD), in the lobby, both the MNTD & AMD acknowledged that the electric socket located in the kitchen was burnt. The AMD said this was caused by a food warmer that was plugged into the electric socket. It caused sparks causing burns/burn marks in the electrical wall socket and tripping the circuit breaker. (an automatic electrical safety switch designed to protect from fires and equipment damage caused by electrical overloads or short circuits). When asked if the food warmer was inspected and approved by maintenance prior to use, both MNTD & AMD said no. The kitchen staff failed to notify them of the food warmer. When asked how often the maintenance department inspects electrical appliances in the kitchen, the MNTD & AMD said once a year. When asked if the maintenance department inspects, certifies and approves any electrical and electronic appliances either owned by the facility or brought in by residents/family members prior to use in the facility, both MNTD & AMD said no. When asked if the maintenance department kept logs to record and keep track of electrical equipment inspected and approved for use in the facility and for preventive maintenance tracking, both MNTD & AMD said no. During a review of the facility policy and procedure (P&P), titled, Electrical Equipment, dated/reviewed 1/2026, indicated the following, 1. Approved Electrical Equipment Use Only facility approved electrical equipment may be used in resident rooms and common areas. Personal electrical items (e.g., fans, televisions, radios, heaters, extension cords, etc.) brought by residents or staff must be inspected and approved by the maintenance department before use. 2. Inspection & Maintenance Routine inspections. Maintenance staff must inspect electrical equipment monthly for frayed cords, loose plugs, or signs of damage. Repairs & Replacements: Damaged or malfunctioning equipment must be reported immediately and removed from service until repaired or replaced. 4. Staff & Resident Safety Responsibilities Staff must immediately report any signs of electrical hazards, such as sparks, burning smells, or flickering lights.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, and sanitary environment when a water leak was observed underneath the sink in one medication storage room. This failure had the potential for mold growth and unsanitary and unsafe conditions for the staff. During a review of the facility's policy and procedure (P&P) titled Environmental Conditions Environmental Rounds, dated 1/2026, the P&P indicated It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public through monthly environmental rounds. During a concurrent observation and interview on 6/24/26 at 2:46 p.m., with the Minimum Data Set Coordinator (MDSC) 2, the [NAME] medication room was inspected. The cabinet beneath the sink in the medication room was observed with a damaged cabinet base with broken and lifted surface material and dark discoloration. Upon further inspection, water was observed actively leaking from the drain assembly beneath the sink. MDSC 2 wiped the base of the cabinet with a dry paper towel, and the paper towel became wet. MDSC 2 confirmed that the base of the cabinet is wet and stated there is an active water leak. During an interview on 6/24/26 at 2:47 p.m., with Licensed Nurse (LN) 1, LN 1 stated he is the nurse assigned to the [NAME] nursing station. LN 1 stated the sink inside of the medication room is not used and he was not aware of the water leak or the condition of the cabinet underneath the sink. During an interview on 6/24/26 at 4:55 p.m., with the Assistant Maintenance Director (AMD), AMD stated the sink is non-operational and the water supply to the sink is cut off. AMD explained the water leaking out of the pipe is condensation from the air conditioning system. AMD acknowledged that the leaking water is not clean. During an interview on 6/24/26 at 4:50 p.m., with the Maintenance Director (MNTD), the MNTD confirmed there is a water leak under the sink and stated, it looks like it's been there a long time. MNTD stated he was unaware of the water leak or the condition of the cabinet. MNTD explained that maintenance inspection rounds are done monthly to ensure equipment is in working order. MNTD stated the medication room sinks are not part of the monthly rounds but should be. During an interview on 6/25/26 at 10:58 a.m., with the Administrator (ADM), ADM stated the sink has not been used in a very long time and staff were not checking on it therefore no one was aware that there was a water leak. ADM stated it has the potential to grow mold. ADM acknowledged that the issue should have been identified and it was not.		