STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555727	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Creek Health Center	2800 Estates Dr. Fairfield, CA 94533

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 39 when the controlled drug (a medication that may be abused or cause addiction) record form was not filled out and signed accurately. This failure has the potential to result in diversion of the residents' unused controlled medications.Findings:During an inspection of the Controlled Medication Disposition Log located in a secure locked cabinet at Station 1 on 4/15/26 at 10:25 a.m., the April 2026 Log had a total of five medication entries which coincided with the controlled medication in the bin within the cabinet. The April 2026 Log was missing the transferring licensed nurse's signature as well as the date the medications were removed from the medication carts to be stored in the secured locked cabinet before destruction.During an interview on 4/15/26 at 10:30 a.m. with the Director of Nursing (DON), the DON confirmed the Controlled Medication Disposition Log for April 2026 was missing the signature of the transferring licensed nurse and well as the date the transfer occurred. The DON confirmed this was not the standard process for the facility or pharmacy services.During review of the facility log titled Controlled Medication Disposition Log, dated April 2026, the log input data included, Resident Name, Medication number and Pharmacy, Medication and Strength, Quantity of Medication, Transferred By, Received By, and Date.During review of the facility policy and procedure (P&P) titled, Discarding and Destroying Medications, dated 6/2025, the P&P indicated, Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with the federal and state and local regulations governing .controlled substances.the collector is responsible for managing .and training facility staff on the procedures associated with collection and storage of controlled substances awaiting disposal.The medication disposition records contains, as a minimum, the following information . i. Signature of witnesses.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication rate did not exceed 5% for 2 of 4 sampled residents (Resident 23 and 39) for a census of 39.1. For Resident 23, a licensed nurse administered the wrong strength of eye drops, a medication to treat and prevent dry eye, per Physician Orders.2. For Resident 39, a licensed nurse did not educate and instruct the resident per manufacturer guidelines when administering a Metered Dose Inhaler (MDI), (a handheld, pressurized device used to treat breathing issues by delivering a specific amount of medicine directly into the airways). These failures resulted in 2 errors identified out of 34 opportunities for error during the observation of medication administration; the facility medication error rate was 5.88%. Findings:1. During an observation of medication administration on 4/14/26 at 9:05 a.m., Licensed Nurse (LN) 2 was observed preparing and administering Sodium Chloride Hypertonicity Ophthalmic (saltwater solution for the eyes) Solution, Brand name Muro 128 (an eye drops for dry eyes) 5% (percentage, strength of medication), one drop in each eye for Resident 23.Reconciliation of the observation of medication administration with Resident 23' s current Physician Orders, dated 2/23/26, indicated, Muro 128 2% eye drops one drop in each eye daily for dry eyes.During an interview on 4/14/26 at 10:45 a.m. with LN 2, LN 2 opened the medication cart and confirmed that in the resident medication drawer Muro 128 5% eye drops had been administered. LN 2 reviewed Resident 23's current order and acknowledged physician order was for a 2% strength eye drop, not the 5% which was given. During an interview on 4/15/26 at 10:50 a.m. with the DON, the DON acknowledged the nurse should have followed the Physician Order and administered the right medication.During a review of the facility policy and procedures titled, Administering Medications, dated April 2019, the P&P indicated, 4. Medications are administered in accordance with prescriber orders.2. During an observation of medication administration on 4/14/26 at 8:40 a.m., LN 3 was observed preparing and administering Fluticasone-Salmeterol (a combination of two medications used to treat breathing issues) 250/50 mcg (microgram, unit of measure) During administration of MDI, LN 3 instructed Resident 39 to place their mouth around the device and breathe in and out while LN 3 held device and pressed a button administering the powder medication. Reconciliation of the medication administration per manufacturer's guideline on the packaging box Before you breathe in your dose, breathe out (exhale) as long as you can while you hold the device away from your mouth. Do not breathe into the mouthpiece. Put the mouthpiece to your lips. Breathe in quickly and deeply through the mouthpiece. Do not breathe in through your nose. Remove the device from your mouth and hold your breath for about 10 seconds, or for as long as is comfortable for you. Breathe out slowly for as long as you can.During an interview on 4/14/26 at 10:30 a.m. with LN 3, LN 3 stated, she did not instruct the Resident to take a breath out pre-administration and then take a deep breath in while she presses button to release medication. LN 3 was not aware of the manufacture's guidelines post administration to hold breath for 10 seconds to properly deliver the medication. LN 3 confirmed these steps were not part of her instructions for Resident 39.During an interview on 4/15/26 at 10:50 a.m. with the DON, the DON acknowledged the nurse should have followed the manufacturer's instructions to administer the medication.During a review of the facility policy and procedures titled, Administering Medications, dated April 2019, the P&P indicated, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication .and right method and route of administration before giving the medication.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were properly labeled and stored in accordance with accepted standards of practice when:1. Multiple opened and undated multidose containers of glucose test strips (strips that can be used to measure blood sugar levels) were found in the medication carts, which had the potential to result in staff using expired, or ineffective glucose test strips to monitor residents blood glucose levels.2. Two over-the-counter eye drop bottles were found at Resident 55's bedside dresser.These failures may result in medications not being stored and maintained in a manner that will will ensure their safety, integrity and proper use placing the residents at risk for contamination, reduced effectiveness, and medication errors. Findings: 1. During an inspection of medication cart 2 located at nursing station 2 on [DATE] at 9:00 a.m. with Licensed Nurse (LN) 3, two open bottles of glucose test strips were found without an open date label. During an interview on [DATE] at 9:15 a.m. with LN 3, LN 3 was unable to find the open date and therefore was unable to provide the product's expiration date. LN 3 acknowledged that without the open date the product expiration date could not be calculated and both sets of test strips should have been removed and discarded from the active medication area. During an inspection of medication cart 1 located at nursing station 3 on [DATE] at 9:50 a.m. with LN 2, an open bottle of glucose test strips was found without an open date label. During an interview on [DATE] at 9:55 a.m. with LN 2, LN 2 was also unable to find the open date and therefore was unable to provide the product's expiration date. LN 2 confirmed the product expiration date could not be calculated and the test strips should have been removed and discarded from the active medication area. During an interview on [DATE] at 10:45 a.m. with the Director of Nursing (DON), the DON acknowledged that open dates were needed to be documented on the glucose test strip bottles to know the expiration date. During a review of the manufacturer's label printed on all three test strip bottles, the label indicated, Use within 90 days, (3) months after opening. During a review of the facility's Policy and Procedures (P&P) titled, Administering Medications, April dated 2019, the P&P indicated, When opening a multi-dose container, the date opened shall be recorded on the container. 2.During a review of Resident 55's Detailed Summary (DS) indicated, Resident 55 was admitted [DATE] with diagnoses including Wedge Compression Fracture Lumbar Vertebrae (the spine bones on the lower back has been crushed more in the front than the back.) During a review of Minimum Data Set (MDS- a federally mandated resident assessment tool) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, Resident 55 has moderate cognitive impairment. During an observation on [DATE], at 10 a.m. in Resident 55's room, two different bottles of eye drops were found on top Resident 55's bedside dresser. Resident 55 stated, she uses the two eye drops for her dry eyes. During a concurrent interview and record review on [DATE] at 11:28 a.m. with LN2, LN 2 was asked to locate a physician order and self-administration assessment for Resident 55. LN2 confirmed that no physician order and no self-administration assessment were found in Resident 55's electronic medical records. LN 2 stated, the expectation for medication storage, is that all medications need to be kept in the medication cart for safe storage. LN 2 further stated, keeping the over-the-counter medications in the medication cart will prevent misuse and will prevent contamination of the medication being used. During a review of the facility's policy and procedure titled, Medication Labeling and Storage. Dated, February 2023, indicated, .Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident medications are assigned to an individual cubicle, drawer.to prevent the possibility of mixing medications of several residents.

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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, prepare, and distribute food in accordance with professional standards for food service safety for 39 out of 39 residents when:1. Several various metal sheet pans and lids in clean and ready-to-use storage areas a. Were stacked wet while stored away b. Were dusty and oily2. Three large food storage bins had plastic containers for scoops inside the three food storage bins3. Pantry had four open milk cartons without an opened and use by dates written.4. Breakfast meal cart was left wide open, and unattended. These failures had potential to cause food borne illnesses in a highly susceptible population who received food from the kitchen. Findings: 1.During a concurrent observation and interview with Certified Dietary Manager (CDM) on 4/14/26 at 8:20 a.m., at the kitchen's initial tour, several metal sheet pans stored at the clean and ready-to use storage areas were observed stacked wet and were dusty and oily. The metal pans included: 5 full sheet table pans (wet) 6 full sheet covers/lid (dusty and oily) 1 full sheet muffin tray (dusty and oily) The CDM confirmed that the metal sheet pans, and lids were wet, dusty and oily. CDM confirmed and stated that dishes must be fully dry before stacking, and the trays must be kept clean when stacked at the ready-to-use storage area to prevent food -borne- illnesses. During a telephone interview on 4/16/26 at 11:38 a.m. with Registered Dietician (RD) stated, dishes, trays, and tray covers must be fully air dried before stacking and storage. RD further stated, all metal trays and lids need to be properly cleaned before storage in the ready-to-use area. During a review of facility's Policy and Procedure (P&P) titled, Cleaning and Sanitizing Basics, dated 2023, P&P indicated, .All utensils and equipment should be allowed to air dry. Never towel dry. During a review of facility's P&P titled, Food Preparation and Service, dated, 2001, the P&P indicated, .Food and nutrition services prepare, distribute, and serve food in a manner that complies with safe food handling practices. 2. During a concurrent observation and interview with CDM on 4/14/26 at 9:06 a.m., at the kitchen's initial tour three large food storage bins were found to have plastic containers inside used as a scoop. CDM confirmed the observation and stated there should not be any containers inside the food bin. CDM further stated, it can cause contamination and cause food-borne-illnesses. During a telephone interview on 4/16/26 at 11:38 a.m. with RD, RD stated, there should not be any scoops or any plastic containers inside the food storage bins. RD further stated, the scoops should be left outside the food storage bins in a clean and dry location to prevent any contamination. During a review of the facility's P&P titled, Scoops, dated 2023, the P&P indicated, .To store all (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scoops outside of ice machine and food storage bins.4.all other scoops used for flour, sugar, oats and similar bulk items will be stored outside of the storage container.a.scoops will be washed and sanitized on a daily basis. 3. During an observation on 4/16/26 at 10:20 a.m. in the Nurses' Station and Dining Room Pantry, four cartons of open milk without an open and use by date. CDM confirmed the observation. CDM stated that the milk cartons must have an open and use by date to prevent any food-borne illnesses. During a telephone interview on 4/16/26 at 11:38 a.m. with RD, the RD stated, her expectation is that the staff must write the open and use by date when opening any milk carton that is being used in the pantry. RD further stated, this will protect the residents and prevent food-borne illnesses. During a review of the facility's P&P titled, Food Storage, dated 2023, the P&P indicated, .All open food items will have an open date and use-by-date per manufacturer's guidelines. 4. During a concurrent observation and interview on 4/15/26 at 8:35 a.m. in hallway 2 with Certified Nursing Assistant (CNA) 2, the breakfast food cart containing 10 trays was left open in the hallway without staff present. CNA 2 confirmed the cart was left open and unattended and stated that when a food cart is left open, it may be accessed by others, and the food could become cold and exposed to contamination, including potential foodborne pathogens. During a telephone interview on 4/16/26 at 11:38 a.m. with RD, RD stated food cart doors should be kept closed to maintain food temperature and reduce the risk of foodborne pathogen growth and contamination. The RD stated food carts should be monitored at all times and not left unattended, as food may be accessed by others, potentially leading to contamination. The RD also stated food could be taken by another resident, including those with dietary restrictions or modified diets, which could pose a safety risk such as chocking. During a review of the facility's policy and procedure (P&P) titled, Food Preparation and Service, revised 11/2022, the P&P indicated, .food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices.food distribution means the processes involved in getting food to the resident . this may include.delivering meals to residents' rooms or dining areas.when meals are assembled in the kitchen and then delivered to residents' rooms or dining areas to be distributed, covering foods is appropriate, either individually or in a mobile food cart.

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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** Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented when:Resident 1's nasal cannula tubing was found on the floor,Resident 10 and Resident 56's oxygen tubing were on the floor, Resident 10's nebulizer mask was not stored in a bag, and Resident 56's nasal cannula was not stored in a bag,Resident 25's nebulizer mask was not stored in a bag,Resident 19's CPAP (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) mask was not stored in a bag, and;Resident 4's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) tubing was on the floor and his CPAP mask was not stored in a bag.These failures had the potential to compromise resident's health and safety and potentially lead to the spread of communicable illnesses. Findings: 1.Review of a Detailed Summary (DS), Indicated Resident 1 was admitted February of 2026 with several diagnoses including bacterial pneumonia, pleural effusion (collection of fluid in the lung), interstitial pulmonary disease (a condition that causes progressive inflammation and irreversible scarring of lung tissue), and pulmonary candidiasis (a rare, severe lung infection that causes shortness of breath). Review of Physician's orders for Resident 1, indicated an order dated 2/12/25 for Oxygen via Nasal Canula (a lightweight, flexible tube used to deliver supplemental oxygen to a person who has trouble breathing) titrate (adjust) up 5 liters per minute (LPM-amount of oxygen that comes out every minute) for shortness of breath, or O2 sat (measures the percentage of oxygen in a person's blood) for saturation less than 90%. During a concurrent observation and interview on 4/14/26 at 9:54 a.m. with Licensed Nurse (LN) 1, Resident 1's nasal cannula tubing was observed on the floor between Resident 1's nightstand and garbage can. LN 1 confirmed the above findings and stated nothing should be on the floor due to the risk of bacterial contamination. During an interview on 4/16/26 at 11:05 a.m. with the Infection Preventionist (IP), the IP stated that the nasal cannula tubing should be stored in a infection prevention pouch after it is cleaned and dried by the LN. If the nasal cannula tubing is on the floor, it can increase the chance of infection to the resident. 2.During a review of Resident 10's DS, DS indicated, Resident 10 was admitted [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD- a long-term lung condition that makes it hard to breathe) and Bacterial Pneumonia (a lung infection caused by bacteria). During a review of Resident 10's Physician Orders (PO), dated 4/2/26, the PO indicated, .Continuous oxygen (O2- gas in the air we breathe) inhalation at 4 liters per minute (LPM-amount of oxygen that comes out every minute)/ Nasal Cannula (NC-small tube that goes under the nose to give oxygen.) During a review of Resident 10's medication order, dated 4/8/26, indicated, Ipratropium 0.5mg-albuterol 3mg (milligram) (2.5 mg base)/3 ml(milliliter) nebulization (breathing in medication through a mist to help with breathing) 4x a day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 56 DS indicated, Resident 56 was admitted [DATE] with diagnoses including malignant neoplasm (harmful abnormal growth of cells) of the tongue, and gastrostomy (a feeding tube made through the belly to give food, fluids and medicine.) During a review of Resident 56's PO, dated 4/15/26, indicated Oxygen 2 LPM via NC. During an observation on 4/14/26 at 10:40 a.m. in Resident 10's room, Resident 10's nebulizer mask was found on top of the bedside dresser without a storage bag, and her oxygen tubing was on the floor. During an observation on 4/14/26 at 11:10 a.m. in Resident 56's room, Resident 56 nasal cannula was on the top of her bedside dresser without a storage bag, and her oxygen tubing was on the floor. During an interview on 4/14/26 at 11:26 a.m. with LN 2, LN 2 confirmed the oxygen tubing for Resident 10 and Resident 56 were on the floor, and the Resident 10's nebulizer mask and Resident 56 nasal cannula were on top of their bedside dresser without a storage bag. LN 2 further stated, he does not store it in a bag. During an interview on 4/16/26 at 11:05 a.m. with the Infection Preventionist (IP), the IP stated that the nasal cannula tubing should be stored in an infection prevention pouch after it is cleaned and dried by the LN. If the nasal cannula tubing is on the floor, it can increase the chance of infection to the resident. IP further stated nebulizer tubing should be in an infection prevention pouch after it is cleaned and dried. The Licensed Nurse (LN) is responsible for making sure it gets in the bag. If on the floor it can cause an infection to the resident. 3. During a review of Resident 25's DS, the DS indicated Resident 25 was admitted on [DATE] with diagnoses that included sleep apnea (OSA-breathing repeatedly stops and starts during sleep) and bronchiectasis (lung airways are permanently widened, damaged and scarred). During a review of Resident 25's PO, the PO indicated, Resident 25 had an order for ipratropium 0.5 mg (milligram)-albuterol 3 mg (2.5mg base)/3 mL (milliliter) nebulization solution (inhalation solution use to treat and prevent wheezing and shortness of breath) .every 4 hours as needed for coughing and wheezing. During a concurrent observation and interview on 4/14/26 at 9:40 a.m. in Resident 25's room, Resident 25's nebulizer mask was stored in an upright position, hooked to the side of the nebulizer machine. Licensed Nurse (LN) 2 confirmed the nebulizer mask was not stored in a bag and stated it had not been stored in a bag. During an interview on 4/16/26 at 11:05 a.m. with IP, IP stated nebulizer equipment should be stored in an infection prevention pouch after cleaning and drying and that licensed nursing staff were responsible for ensuring proper storage. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, dated 11/2011, the P&P indicated, infection control considerations related to oxygen administration . keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when not in use .infection control considerations related to medication nebulizers.store the circuit in plastic bag, marked with date and resident's name, between uses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 19's DS, the DS indicated Resident 19 was admitted on [DATE] with diagnoses that included obstructive sleep apnea. During a review of Resident 19's PO, the PO indicated, Resident 19 had an order for CPAP-On @ HS (at bedtime)/ OFF @ AM (morning).for OSA. During a review of Resident 19's Care Plan (CP), the CP indicated, Resident 19 required CPAP during sleep and interventions included assisting with donning/doffing (putting on/removing) CPAP daily. During an observation on 4/14/26 at 9:45 a.m. in Resident 19's room, Resident 19's CPAP mask was hanging on an open shelf and was not stored in a bag. 5. During a review of Resident 4's DS, the DS indicated Resident 4 was admitted on [DATE] with diagnoses that included benign prostatic hyperplasia (enlargement of the prostate gland), retention of urine and OSA. During a review of Resident 4's PO, the PO indicated Resident 4 had on order for .CPAP OFF at AM; ON at HS.Foley Catheter for urinary retention. During a review of Resident 4's CP, the CP indicated Resident 4 had CAUTI (catheter-associated urinary tract infection) and intervention included foley catheter care. During an observation on 4/14/26 at 10:35 a.m. in Resident 4's room, Resident 4 was sitting in a recliner chair. Resident 4's catheter tubing was on the floor, and the CPAP mask was hanging on a wall hook and was not stored in a bag. During an interview on 4/16/26 at 11:08 a.m. with IP, IP stated that CPAP masks should also be stored in an infection prevention pouch and that failure to do so could increase the risk of infection. IP further stated catheter tubing should not be on the floor due to the risk of infection. During a review of the facility's P&P titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, dated 09/2017, the P&P indicated, .it is the responsibility of the interdisciplinary team to maintain vigilant practices to prevent CAUTIs.after aseptic insertion, maintain a sterile closed drainage system. P&P for CPAP mask storage was requested; however, facility did not provide the requested policy.

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and record review, the facility failed to ensure residents received appropriate meals/diets for 12 out of 39 sampled residents (Residents 3, 4, 16, 22, 23, 25, 26, 27, 28, 37, 39 and 43) when meal trays were being checked by unlicensed staff prior to delivery.This failure had the potential for residents on therapeutic diets to receive the wrong foods; residents with food sensitivities/allergies receiving inappropriate foods; and those on modified texture diets receiving inappropriate food items all of which could lead to complications and adverse reactions.Findings: During dining observation in the dining room on 4/16/26 at 11:55 a.m., observed Residents 3, 4, 16, 22, 23, 26, 27, 28, 37, 39 and 43 sitting at tables waiting for lunch to be served.During a concurrent observation and interview on 4/16/26 at 12:04 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 checked the meal trays prior to serving them to residents in the dining room. CNA 1 stated he was the only staff member that checked the meal trays and they were not checked before coming to the dining room.During an interview on 4/17/26 at 9:09 a.m. with the Director of Nursing (DON), the DON stated her expectation was that a Licensed Nurse (LN) should be checking the meal ticket and tray before the meal is served to the resident. The DON stated a potential negative outcome would be that the CNA may miss a change in the residents' diet.Review of the facility's policy titled, Menu Planning dated 2023, it indicated, NA(Nurse's AIDE)/CNAs deliver trays to the resident after licensed nursing has checked the trays according to Verification of Diets served by nursing policy.